**Table of Contents**

| intro | Introduction ........................................................................................................ | 1 |
| Section 1: | **How to Reach Us** ............................................................................................ | 2 |
| | Providing Official Written Notice, 2 |
| | - Tax Identification Number Changes or Adding a Physician or Health Care Provider, 2 |
| | - Practice or Facility Demographic Information, 2 |
| | - Other, 2 |
| | Other Communication Avenues/Issues, 2 |
| | - Online / Electronic, 2 |
| | - By Fax, 2 |
| | - By Telephone, 3 |
| | - In Writing, 3 |
| Section 2: | **Empire Plan Product Overview** ...................................................................... | 4 |
| Section 3: | **ID Cards and Eligibility Verification** .............................................................. | 5 |
| | ID Cards, 5 |
| | - Empire Plan, 5 |
| | - Additional Covered Groups, 6 |
| | Determining Eligibility of Plan Participants, 6 |
| | - Eligibility Information Cannot Be Guaranteed, 7 |
| Section 4: | **Billing and Payments** ..................................................................................... | 8 |
| | Fees Paid by Plan Participants, 8 |
| | Contracted Amounts / Prohibition on Billing Plan Participants, 9 |
| | Incomplete / Missing Claim Information, 9 |
| | Non-Notification, 10 |
| | Covered Services Not Medically Appropriate, 10 |
| | Covering Physicians, 10 |
| | Coordination of Benefits, 10 |
| | Subrogation, 12 |
| | Post-Payment Audits, 12 |
| | Overpayments, 13 |
| Section 5: | **Claims Overview** .................................................................................................. | 14 |
| | Claims Process, 14 |
| | Complete Claims, 14 |
| | Correspondence, 15 |
| | Coverage Payment Policies, 16 |
| | - Coding Criteria, 16 |
| | - Provider Payment Methodologies, 16 |
| | Claim Reconsideration Requests, 20 |
| | - Online, 20 |
| | - Paper, 20 |
| | - Timely Filing, 20 |
| | Appeals, 21 |
| | - Level 1 Appeals, 21 |
| | - Level 2 Appeals, 21 |
| | - Appeals Involving Urgent Situations, 21 |
| Section 6: | **Explanation of Benefits Form** ............................................................................ | 22 |
| | Sample EOB, 23 |
Empire Plan Network physicians, providers, and facilities play a key role as we pursue our commitment to improve the health and well-being of the individuals we serve. This manual is designed to provide information needed when treating an Empire Plan enrollee. Please share it with others in your office or organization.

The Empire Plan is a unique health insurance program developed by New York State and its employee unions especially for employees of New York State and their families. It is the most selected group health insurance option under The New York State Health Insurance Program (NYSHIP), covering over 1,000,000 employees, retirees and eligible dependents from over 740 participating employers and agencies. UnitedHealthcare Insurance Company of New York (UnitedHealthcare) administers the Empire Plan’s medical/surgical portion, and its Empire Plan Network was specifically developed to serve the needs of the Empire Plan. It is separate from UnitedHealthcare’s commercial networks which serve the company’s standard health plan products, such as HMO, PPO, and POS plans.

However, there are a limited number of other UnitedHealthcare customers with whom you should be familiar because they are granted access to the Empire Plan Network. These customers are noted in your provider agreement. The ID cards for their members contain most of the information you will need, and we encourage you to call the telephone numbers on the ID cards with any questions regarding their plans. Brief reference information concerning these customers is included in certain sections of this manual, but the manual focuses primarily on the Empire Plan’s programs, procedures, and policies.

This manual is not intended to include every administrative policy or procedure, and only general procedures and descriptions are outlined here. The manual should not be used for determining coverage in any particular case. Should the information in this manual conflict with the terms of the enrollee’s certificate of coverage, the enrollee’s certificate will control.

This manual is reviewed periodically and may be changed by UnitedHealthcare in its sole discretion. Every effort will be made to keep you updated regarding changes, including notifications of policy changes and updates via our newsletter, The Empire Plan Network News. Updated versions of this manual are made available at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols & Guides → Administrative Guides.

Should you have any questions or need additional information, please see “Section 1: How to Reach Us.”
**Providing Official Written Notice**
You must notify Empire Plan Network Management of the following events, in writing, **within 10 working days**. Changes which must be reported include, but are not limited to, tax identification number changes/additions, name changes, practice ownership changes, billing or service address changes, additions or departures of health care providers from your practice, and new locations.

**Tax Identification Number Changes or Adding a Physician or Health Care Provider**
You must include the physician’s or health care provider’s W-9 form to make a tax identification number change or to add a physician or health care provider to your practice. To submit the change, please submit the written notice and the W-9 form to Empire Plan Network Management by fax at 845-382-7993 or by mail at 505 Boices Ln, Kingston, NY 12401.

The W-9 form is available at UnitedHealthcareOnline.com → Contact Us → Service & Support → Forms.

**Practice or Facility Demographic Information**
You can make other demographic updates to your practice information by submitting the change directly through UnitedHealthcareOnline.com by using the Practice/Facility profile function found on the global navigation at the top of any UnitedHealthcareOnline.com page. You can also submit your change by completing and faxing the physician/provider demographic update fax form to the appropriate fax number listed on the bottom of the form.

**Other**
For the following, notify us at Empire Plan Network Management, 505 Boices Ln, Kingston, NY 12401.

- Material changes in, 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 or suspension of your license to practice;
- Transfer of member records to another physician/facility due to relocation or closing of your practice.

**Other Communication Avenues/Issues**

- **Online / Electronic**
  Empire Plan network physicians and providers are expected to conduct business with UnitedHealthcare on an electronic basis wherever possible, including but not limited to determining whether the patient is currently covered, verifying the covered person’s benefit, and submitting the claim.

  - [UnitedHealthcareOnline.com](#)  To check eligibility, submit claims, view claim status, request claim adjustments, update demographic information, view reimbursement policies.

  - [www.EmpirePlanProviders.com](#)  Search for physicians and providers that participate in UnitedHealthcare’s or MPN’s Empire Plan Network.

- **By Fax**
  - **1-855-773-3156**  To notify us of demographic and practice changes - see Fax Form in Section 9.
- **By Telephone**

1-877-7NYSHIP (1-877-769-7447)

- **Empire Plan Medical/Surgical Program**
  (UnitedHealthcare)
  
  **Customer Care**
  To inquire about a patient's eligibility, plan benefits, claim status, claim forms or network provider directories.

- **Managed Physical Medicine Program**
  (Managed Physical Network, Inc.- MPN)
  
  To inquire about coverage, referral assistance, concurrent review, or notify MPN of physical medicine services (chiropractic, physical therapy) services.

- **Benefit Management Program**
  
  To inquire about or notify us of outpatient radiology services, outpatient medical case management, home health services including nursing & infusion therapy, durable medical equipment & integral supplies, mastectomy prosthetics over $1,000, infertility services, and diabetic shoes.
  
  The Empire Plan’s dedicated Care Coordination unit is available Monday through Friday from 8:00am to 4:30pm EST. An automated Voice Response System allows callers to reach the appropriate level of staff member to handle their specific requests.

- **Network Management**
  
  To ask questions about your participation/contract, discuss vendor alert notifications, request participation for other members of your practice, or notify us of demographic and practice changes. Select the option to leave a message for your network account manager and enter his/her voice mailbox number.

- **Cancer Resources Program**
  
  To speak with a nurse consultant regarding cancer resources available to Empire Plan enrollees.

- **Empire Plan Hospital Program**
  (Empire Blue Cross and Blue Shield)
  
  To inquire about coverage/claims or notify Blue Cross of hospital, skilled nursing facility, or transplant services.

- **Empire Plan Mental Health & Substance Abuse Program**
  
  To inquire about coverage/claims, referral assistance, or notify the Behavioral Health Program of mental health & substance abuse services.

- **Empire Plan Prescription Drug Program**
  
  To inquire about prescription drug coverage, notify Prescription Drug Program of certain medications, speak to a pharmacist, or take advantage of mail service pharmacy.

- **Empire Plan NurseLine**
  
  To inquire about health information and support resources available to Empire Plan enrollees.

1-866-UHC-FAST (1-866-842-3278)

To inquire about, register for, or request assistance with UnitedHealthcareOnline.com, Electronic Payments & Statements, electronic claim submission.

- **In Writing**

**Empire Plan Network Management**

UnitedHealthcare Insurance Company of New York

505 Boices Ln

Kingston, NY  12401

**Empire Plan Claims, Claim Forms & Claim Issues**

UnitedHealthcare Insurance Company of New York

PO Box 1600

Kingston, NY  12402-1600
## Section 2: Empire Plan Product Overview

This table provides information regarding some common features of The Empire Plan.

<table>
<thead>
<tr>
<th>Attributes</th>
<th>The Empire Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do enrollees access physicians and health care professionals?</td>
<td>Enrollees are not required to designate a primary physician*, although they are encouraged to develop and maintain a relationship with one. To receive the highest level of benefits, the enrollee must obtain medical care from a network physician or provider.</td>
</tr>
<tr>
<td>Does the primary physician* have to make a referral to a specialist?</td>
<td>No formal referral is required. Enrollees can choose any physician or health care professional.** The benefit level for services from non-network physicians and health care professionals may be less than that for services from network physicians and health care professionals.</td>
</tr>
<tr>
<td>Is the treating physician responsible for required notifications of certain services?</td>
<td>No. Enrollees are responsible for the notifications outlined in Section 7, “Empire Plan Care Coordination.” However, network physicians/providers are encouraged to be aware of when their services require notification, and notice from the physician/provider is accepted.</td>
</tr>
<tr>
<td>Does the physician or provider collect a copayment from enrollees?</td>
<td>Yes, at the time of visit, when required. Please refer to the Empire Plan Copayment Guide for more information regarding required copays.</td>
</tr>
</tbody>
</table>

*Primary physician is defined as a physician or health care professional who has been designated as his/her primary care physician by the enrollee.

**Physicians and health care professionals must be licensed for the health services provided and covered under the enrollee’s benefit plan.
Section 3: ID Cards and Eligibility Verification

ID Cards

Empire Plan

Empire Plan participants are furnished with New York State Health Insurance Program (NYSHIP) identification cards by the State of New York Department of Civil Service, the Empire Plan policyholder. Multiple versions of NYSHIP identification cards are displayed below. Some list the Empire Plan name and/or carriers involved in coverage; others do not. All are valid Empire Plan identification cards.

For most enrollees, the cards include a Copay Code which can be used by participating physicians and providers to assist in determining copayment amounts due at the time of service. The Copay Code is a letter that represents the copayment dollar amount for services covered under the UnitedHealthcare portion of the plan. The maximum number of copayments per service date is not reflected in the Copay Code, but for most enrollees, there is a maximum of two copayments. (See Section 4 of this manual as well as the Empire Plan Copayment Guide for more details on copayment amounts and how copayments may be combined on a single service date.)
Additional Covered Groups

Other employer groups that access the Empire Plan Network, as noted in your agreement, receive UnitedHealthcare ID cards 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, these cards essentially display the same information (such as claims address, copayment information, and telephone numbers).

Determining Eligibility of Plan Participants

Be sure to check the customer's ID card at each visit - especially the first visit of a new year, when information may change - and to copy both sides of the card for your files. At each visit verify that the plan participant continues to participate in the same health plan. You can do this by checking at UnitedHealthcareOnline.com. If you do not have internet access, call 1-877-7NYSHIP for the Empire Plan or the telephone number listed on the ID card for other groups.

Occasionally, new plan participants do not receive their cards prior to an office visit. Eligibility verification can be obtained by contacting us via UnitedHealthcareOnline.com or at the numbers noted above.

While participants are advised to present their identification cards before services are rendered, this is not required for your participating provider agreement to be binding. And, there is no penalty imposed upon the patient for failure to do so if that patient is otherwise eligible for coverage. In those instances where a patient’s initial failure to identify him/herself leads a participating practitioner to collect a fee greater than the appropriate copayment, it is the obligation of the provider to refund the excess amount.
Eligibility Information Cannot Be Guaranteed

UnitedHealthcare will verify a plan participant’s eligibility based on the data available at the time the request is made. Subsequent changes to eligibility may not be available at the time of the request and may alter the plan participant's eligibility on that particular date. Accordingly, verification of eligibility is not a guarantee of coverage.

Eligibility under a benefit contract may change retroactively if:

- We receive information that an individual is no longer a plan enrollee;
- The individual’s policy/benefit contract has been terminated;
- The enrollee decides not to purchase continuation coverage; or
- The eligibility information we receive is later determined to be false.

If you have submitted a claim(s) that is impacted by a retroactive eligibility change, a claim adjustment may be necessary. The reason for the claim adjustment will be reflected on the EOB.
**Fees Paid by Plan Participants**

You should bill plan participants for the following:

- Copayments
- Non-Covered Services

**Full Payment**

A patient may be billed directly if it cannot be proved that a patient is a plan participant at the time of service. If it is later determined that the patient is a plan participant and has paid for rendered services which are covered under his or her benefit plan, you must refund the plan participant any amounts collected in excess of applicable copayments.

**Non-Covered Services**

After the benefit determination has been made, you may seek and collect payment from the plan participant for services not covered under the applicable benefit plan, provided you have first obtained the plan participant’s written consent. Such consent must be signed and dated by the plan participant prior to rendering the specific service(s) in question. Retain a copy of this consent in the plan participant’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 plan participant, with knowledge of UnitedHealthcare’s determination, agrees to be responsible for those charges.

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

- We have provided general notice through an article in a newsletter or bulletin, or information provided on our website (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 plan participant;
- We have made a determination that planned services are not Covered Services and have communicated that determination to you on a previous occasion; or
- We have provided a benefit predetermination for the planned services in question, thereby providing all parties with a clear understanding of the coverage, or lack of coverage, available before provision of the service. Benefit predeterminations are particularly helpful when a service/item is not specifically mentioned as a plan exclusion and provide clarity for services that may be considered cosmetic or where the case appears to involve both cosmetic and functional aspects.

You must not bill plan participant for non-covered services if you do not comply with this protocol. And, you must still submit a claim to UnitedHealthcare for benefit consideration.

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

**Determining Copayment Amounts**

A copayment is a specific dollar amount paid by a plan participant for covered services under the benefit plan (e.g., physician office services).

For Empire Plan members, services that require a copayment are classified into four basic categories:

- Therapeutic/Diagnostic/Preventive Office Treatment,
• Office Surgery,
• Diagnostic Tests – Laboratory Services, and
• Diagnostic Tests – Radiology Services.

In general, one copayment is due for any one service or multiple services within each category during a single visit. This would result in a maximum of four (4) copayments per visit. However, for most plan enrollees, one copayment will be due for office treatment and office surgery on the same date, and only one copayment will be due when laboratory and radiology services are performed on the same date. This results in a maximum of two (2) copayments per visit.

Copayment requirements are subject to change, and an Empire Plan Copayment Guide is periodically distributed to network physicians and providers. Be sure to refer to the most current Empire Plan Copayment Guide. For questions or confirmation, you can also check UnitedHealthcareOnline.com, or call 1-877-7NYSHIP.

**Billable Copayments**

At the time of service, plan participants can be charged the indicated copayment for billable services performed. A copayment should be collected only for services which are reimbursable under the plan participant’s benefit plan.

- If the copayment is more than your contracted fee for the service, collect the contracted fee rather than the copayment amount.
- If the plan participant is covered by more than one benefit plan, see COB, Fee Schedule under Coordination of Benefits later in this section concerning collection of copayments.
- Certain services are excluded from copayment requirements under the Empire Plan. These are listed on the Empire Plan Copayment Guide.
- No copayment should be collected for services that are not normally identified/billed separately. Some examples of these services for which no copayment should be collected include:
  - Prenatal visits and six week checkup after delivery
  - Surgical visits included within the global benefits
  - Minor services that would not be normally billed
  - Dispensing of prescription drugs
  - Telephonic care

**Additional Fees for Covered Services (ie, Administrative Fees, etc.)**

You may not charge plan participants for Covered Services beyond copayments, coinsurance, or deductible as described in their benefit plans. You may not charge Covered Persons 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. This does not prevent you from charging plan participants nominal fees for missed appointments or completion of camp/school forms.

**Contracted Amounts / Prohibition on Billing Plan Participants**

By entering into a contract with UnitedHealthcare, you have agreed to accept payment directly from us. Payment from us constitutes payment in full for the covered services you render to plan participants, except for copayments and those covered services that fall outside the Empire Plan’s Participating Provider Program and are reimbursed subject to deductibles and coinsurance. **This means that you may not balance bill plan participants for the difference between your actual charge and the contracted amount.**

**Incomplete/Missing Claim Information**

A plan participant may not be billed for services for which a claim submission has been returned to the physician or provider for lack of information or where a claim has never been submitted. For required information on claim submission, please refer to Section 5, "Claims Overview."
Non-Notification

Although you are encouraged to assist your patients with program compliance, enrollees are responsible for fulfilling notification requirements where necessary. Varying levels of benefit reductions are applied when required notifications are not made. You may bill the patient for the amount of the reduction if/when one applies to your services. Additional information concerning notification requirements can be found in Section 7, “Empire Plan Care Coordination.”

Covered Services Not Medically Appropriate

Benefits are provided for only those covered services which are determined to be medically appropriate by UnitedHealthcare. When the medical appropriateness cannot be established for an otherwise covered service rendered by a participating provider, no benefits are issued. And, the provider cannot bill the plan participant, unless the patient agreed in writing to make payment prior to receiving the service having specific knowledge that plan reimbursement would not be forthcoming. This is often accomplished by having the patient give written consent after receiving a predetermination of benefits decision from UnitedHealthcare.

Covering Physicians

If you are unable to provide care and want to arrange for a substitute, we ask that you try to arrange for care from other physicians and health care professionals who participate with the UnitedHealthcare Empire Plan Network. For the most current listing of network physicians and health care professionals, review our physician and provider directory at www.EmpirePlanProviders.com.

Should a non-network physician/provider be used, benefits will be paid out-of-network.

Coordination of Benefits

Coordination of benefits (COB) is the procedure used to pay health care expenses when a person is covered by more than one insurer or plan which provides health care benefits. Coordination of benefits is administered according to the customer's benefit contract and in accordance with applicable statutes and regulations.

Identification of the Primary Payer and Claim Submission

Prior to submitting a claim, it is important to determine if any other payer, including Medicare, has primary responsibility for payment of a claim. The identification of the primary payer prior to claim submission will improve the efficiency and accuracy of the claim payment process. “Primary plan” means a plan whose benefits for a person’s health care coverage must be determined without taking the existence of any other plan into consideration.

For the Empire Plan, when more than one plan covers the person making the claim, the order of benefit payment is determined using the first of the following rules which applies:

- The benefits of the plan which covers the person as an enrollee are determined before those of other plans which cover that person as a dependent;
- When the Empire Plan and another plan cover the same child as a dependent of different persons called “parents” and the parents are not divorced or separated:
  - The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year; but
  - If both parents have the same birthday, the benefits of the plan which has covered one parent for a longer period of time are determined before those of the plan which has covered the other parent for the shorter period of time;
  - If the other plan does not have the rule described in preceding two bullets, but instead has a rule based on gender of the parent and, if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits:
    - The word “birthday” refers only to month and day in a calendar year, not the year in which the person was born.
    - If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
      - First, the plan of the parent with custody of the child;
• Then, the plan of the spouse of the parent with custody of the child; and
• Finally, the plan of the parent not having custody of the child; and
• If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of the terms, the benefits of that plan are determined first. This paragraph does not apply to any benefits paid or provided before the entity had such knowledge.

• The benefits of a plan which covers a person as an employee or as the dependent of an employee who is neither laid-off nor retired are determined before those of a plan which covers that person as a laid-off or retired employee or as the dependent of such an employee. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored.

• If none of these rules determined the order of benefits, the plan which has covered the person for the longest period of time determines its benefits first.

If it is determined that another payer is primary, that payer or Medicare should be billed prior to billing UnitedHealthcare. When a balance is due after receipt of payment, submit a claim for that balance including the following information:

- The amount received from the primary plan
- A copy of the other plan’s Explanation of Benefits statement.

Note: If the patient is enrolled in Medicare Crossover, it is not necessary to submit a claim to UnitedHealthcare for secondary payment. Medicare does this for you electronically.

If a condition is related to the patient’s employment or is the result of an automobile accident, workers’ compensation or no fault may apply. For workers’ compensation claims, the patient’s employer should be contacted. For automobile accident claims, the no fault carrier should be billed as the primary payer.

If UnitedHealthcare is primary, submit the claim as usual.

**Impact of Medicare**

**Retired Employees and/or their Dependents**

If a retired employee or dependent is eligible for primary coverage under Medicare - even if s/he fails to enroll - covered medical expenses will be reduced by the amount that would have been paid by Medicare, and UnitedHealthcare will consider the balance for payment, subject to applicable copayments. When Medicare pays primary, covered expenses will be based on Medicare's limiting charge, as established under federal or, in some cases, state regulations rather than the network fee schedule.

**Active Employees and/or their Dependents**

The Empire Plan will automatically be the primary payor for active enrolled employees, regardless of age, and for the employee's enrolled dependents (except for domestic partner eligible for Medicare due to age) unless end stage renal disease provisions apply. Medicare will be secondary payor. (Note for domestic partners: Under Social Security law, Medicare is primary for an active employee's domestic partner who becomes Medicare eligible at age 65. If the domestic partner becomes eligible due to disability, the Empire Plan is primary.)

**Disability**

Medicare provides coverage for persons under age 65 who are disabled according to the provisions of the Social Security Act. The Empire Plan is primary for disabled active employees and disabled dependents of active employees. Retired employees, vested employees and their enrolled dependents who are eligible for primary Medicare coverage because of disability must enroll in Parts A and B of Medicare and apply for available Medicare benefits. Empire Plan benefits are reduced to the extent that Medicare benefits could be available.

**End Stage Renal Disease**

For those eligible for Medicare due to end stage renal disease, whose coordination
period began on or after March 1, 1996, the Empire Plan will be primary for the first 30 or 33 months of treatment, depending on the situation. Then, Medicare becomes primary. Benefits are reduced to the extent that Medicare benefits could be available.

Medicare+Choice HMOs
If an Empire Plan enrollee enrolls in a Health Maintenance Organization under a Medicare+Choice Contract, the Empire Plan will not provide benefits for any services available through the HMO or services that would have been covered by the HMO if the patient had complied with the HMO’s requirements for coverage. Covered medical expenses under the Empire Plan are limited to expenses not covered under the Medicare+Choice Contract with the HMO. If the HMO Medicare+Choice Contract has a Point-of-Service option that provides partial coverage for services received outside the HMO, covered medical expenses under the Empire Plan are limited to the difference between the HMO’s payment and the amount of covered expenses under the Empire Plan.

COB, Fee Schedule
When Medicare or another primary carrier pays benefits first, the total of the primary payer’s payment, UnitedHealthcare’s payment, and the plan participant’s copayment represents payment in full to participating providers. This remains true even if the total paid is less than the amount initially billed and/or the primary payer applies all or a portion of its approved amount to a deductible and pays $0 or a nominal amount.

When the patient is covered by more than one plan, you should not collect charges that may be covered through coordination of benefits. This would include not collecting copayments. By following this procedure, you will save the time and expense of reconciling payments and remitting reimbursement checks to plan participants who have dual coverage. However, if you do collect payments from the plan participants in error, you are required to reimburse the plan participant.

After Payment Has Been Received
After payment is made, if it is determined that another payer or Medicare is primarily responsible for all or a portion of the claim, UnitedHealthcare requests your cooperation in collecting from the other payer, including providing any documents reasonably required or appropriate for this purpose.

Subrogation
We reserve the legal right to recover benefits paid for a customer’s health care services when a third party causes the customer’s injury or illness. Subrogation does not change the procedure for processing claims. We process the claim and pay for covered services at established fees. Subrogation activities take place after claims have been processed for payment.

Many subrogation cases result from automobile accidents. You can help us identify subrogation cases by using the accident codes found in the ICD-9-CM book; you should also provide additional information regarding the nature of the injury or illness in the space provided on the claim form.

Post-Payment Audits
Post-payment audits may be conducted by UnitedHealthcare, UnitedHealthcare’s customer (e.g., New York State), or a UnitedHealthcare representative. In such cases, an independent audit firm may be employed by to conduct the audit. You must make the necessary information available (e.g., patient’s medical and billing records) to ensure a successful audit.

Administrative Fees
UnitedHealthcare will not pay administrative fees for or connected with audit purposes.
Overpayments

If you or UnitedHealthcare identifies a claim where you were overpaid, we ask that you refund the overpayment within 60 calendar days from the date you identify the overpayment or from the date of our written refund request. If your payment is not received by that time, we may apply the overpayment against future claim payments.

Examples of situations that may require a refund are:

- If UnitedHealthcare pays benefits for covered medical expenses and it is subsequently found that we paid more benefits than we should have paid because all or some of the expenses would not have been the participant’s liability or were paid by another source.
- If benefits are paid by UnitedHealthcare for non-covered expenses.
- Overpayments identified through claim audits or administrative reviews.

Depending on the type of overpayment, we may make the claim adjustment(s) without requesting additional information from the network physician. You will see the adjustment on the Explanation of Benefits (EOB). When additional or correct information is needed, we will ask you to provide it.

If you disagree with a claim adjustment, you can appeal the determination (see claim appeals).
Section 5: Claims Overview

You are required to submit complete and accurate claims for all services rendered for Empire Plan enrollees and enrollees of the additional covered groups. In addition to facilitating claim payment, this information may be used for physician and provider profiling and to identify candidates for disease management and preventive care programs.

Claims Process

1. Register for UnitedHealthcareOnline.com, our free Web site for network physicians and health care professionals. At UnitedHealthcareOnline.com, you can check eligibility and claims status – and submit claims electronically, for faster claims payment. To register, go to the site and select “New User” or call 1-866-UHC-FAST (1-866-842-3278).

2. Once you’ve registered, review the patient’s eligibility on the Web site at UnitedHealthcareOnline.com. To check patient eligibility by phone, call Customer Care using the number found in Section 1 or on the patient’s ID card.

3. Notify us of planned procedures and services on the notification list. See Section 7 for list.

4. Prepare a complete and accurate claim form. See “Complete Claims” later in this section.

5. Submit the claim no later than 120 days after the end of the calendar year in which covered services are rendered. When payment is denied because the claim was submitted late, the participating provider cannot bill the patient for the services in question.

   - Electronic Claims. Claims must be submitted electronically whenever possible using UnitedHealthcareOnline.com or any of a number of other electronic options available. Our electronic payer ID is 87726. For more information or assistance regarding electronic claim submission, call our EDI unit at 1-800-842-1109.

   - Paper Claims. For claims that cannot be submitted electronically, submit paper claims for the additional covered groups to the claims address on the patients ID card and claims for The Empire Plan to:

     Empire Plan Claims
     UnitedHealthcare
     PO Box 1600
     Kingston, NY  12402-1600

6. Receive Electronic Payments and Statements (EPS). With EPS, we transfer claim payments electronically via the automated clearinghouse network to the financial institution you designate. EOBs matching each deposit are sent via UnitedHealthcareOnline.com. To sign up for EPS, call 1-866-UHC-FAST (1-866-842-3278) or email EPSenrollment@uhc.com.

Complete Claims

Whether you use an electronic or a paper form, complete an Empire Plan form, a CMS form, or any other industry standard accepted form, a complete claim includes the following information. For particular types of services or based on particular circumstances or state requirements, additional information may also be required.

General Requirements:

   - Patient’s name, sex, date of birth and relationship to subscriber
   - Subscriber’s name, address and ID number
   - Subscriber’s employer group name and group number
   - Name, signature, ‘remit to’ address and phone number of physician or provider performing the service, as in your contract document
   - Physician’s or provider’s federal tax ID number
   - Physician’s or provider’s NPI number
   - Referring physician’s name (if applicable)
   - Referring physician’s NPI number (if applicable)
   - Date of service(s), place of service(s) and number of services (units) rendered
   - Current CPT-4 and HCPCS procedure codes with modifiers where appropriate
   - Current ICD-9 diagnostic codes by specific service code to the highest level of specificity
   - Charges per service and total charges
   - Information about other insurance coverage, including job-related, auto or accident information, if available
   - Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers
- Attach a detailed description of the procedure or service provided for claims submitted with unlisted medical or surgical CPT or “other” revenue codes as well as experimental or reconstructive services
- Attach the current NDC number for claims submitted with unlisted drug codes
- Include nursing shift hours and attach nursing notes and treatment plan for claims submitted for home health care, nursing or skilled nursing services
- If you need to correct and resubmit a claim, use UnitedHealthcareOnline.com, call Customer Care, or submit a Request for Reconsideration form found in Section 9 of this manual.

**Laboratory Claim Requirements:**
- All laboratory claim requests must include the NPI of the referring physician.

**Anesthesia Claim Requirements:**
- 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 qualifier MJ in loop 2400 SV103. For CMS-1500 (12-90) paper claims, report the actual number of minutes in Box 24G with qualifier MJ in Box 24H. For CMS-1500 (08-05) paper claims, report the duration in minutes with start and end times in shaded areas of fields 24 A-K, the total minutes in field 24G for each applicable service line, and qualifier 7.
- When medically directing residents for anesthesia services, the modifier GC must be reported in conjunction with the modifier AA or QK
- When reporting obstetrical anesthesia services, use add-on codes 01968 or 01969, as applicable, on the same claim as the primary procedure 01967
- When reporting qualifying circumstance qualifier codes 99100, 99116, 99135 and/or 99140, report the qualifier on the same claim as the anesthesia service
- Additional anesthesia claim and payment information is available under Provider Payment Methodologies, via UnitedHealthcareOnline.com.com, and upon request from Customer Care or your network account manager.

**Additional information needed for a complete UB-04 form:**
- Date and hour of admission and discharge as well as patient status-at-discharge code
- Type of bill code
- Type of admission (e.g. emergency, urgent, elective, newborn)
- Current revenue code and description
- Current principal diagnosis code (highest level of specificity)
- Current other diagnosis codes, if applicable (highest level of specificity)
- Attending physician ID
- Referring physician's name (if applicable)
- Bill all outpatient surgeries with the appropriate revenue and CPT code if reimbursed according to ambulatory surgery groupings
- Provide specific CPT and/or HCPCS code(s) and appropriate revenue code (e.g. laboratory, radiology, diagnostic or therapeutic) for services reimbursed based on a contractual fee maximum
- Attach an itemized list of services or complete box 45 for physical, occupational or speech therapy services (revenue code 420-449) submitted on a UB-04
- Submit claims according to any special billing instructions that may be indicated in your agreement (or letter of agreement)

Claims missing any of the required information cannot be processed. Physicians and providers submitting claims without the required information will be notified the claim cannot be processed and advised what additional information is needed to enable adjudication. An enrollee cannot be billed for services where the claim submission has been returned to the physician or provider for lack of information.

**Correspondence**
Any correspondence concerning claims should include the control number on the Explanation of Benefits (or a copy of the Explanation of Benefits). Also include the plan enrollee’s name, alternate identification number, and the group contract holder name and number, all of which also appear on the EOB.
Coverage Payment Policies

Coding Criteria
UnitedHealthcare’s standard is to accept current CPT, ICD-9-CM and HCPCS codes and modifiers. This is the accepted methodology for coding all claim submissions. However, acceptance of a code or modifier does not imply payment or additional payment for the service or situation identified by that code or modifier.

Level III local HCPCS codes should not be used. Level III local HCPCS codes are those codes within the range from W0000 to Z0000.

Provider Payment Methodologies
Unique billing situations and provider payment methodologies may exist or develop. UnitedHealthcare calculates covered expenses following evaluation and validation of all provider billings in accordance with the methodologies in the most recent edition of CPT or as reported by generally recognized professionals or publications. Expenses denied due to our provider payment methodologies cannot be billed to the plan enrollee. Some of the more common provider payment methodologies are described on the following pages. Please note that this is only a brief description of the policy referenced and is not the complete list of reimbursement methodologies which are periodically updated. Additional information and updates are available via UnitedHealthcareOnline.com and upon request from Customer Care or your network account manager.

After-Hours and Weekend Care
UnitedHealthcare covers after-hours and weekend care in addition to the office visit charge (CPT codes 99050-99060) when an office visit is used in lieu of an emergency room or urgent care visit. After-hours and weekend care are defined as care provided when the physician is required to open his or her office outside of regular posted office hours to treat a patient’s urgent illness or condition or is required to leave or disrupt his/her regular practice. Please note only one of the after-hours codes can be used per visit (i.e., after regular hours, weekend, holiday, etc.). Charges for after-hours services will not be covered when billed for Emergency Department, Urgent Care, Critical Care, Hospital Care or Nursing Facility.

Anesthesia
UnitedHealthcare’s anesthesia policy was developed using guidelines from the American Society of Anesthesiologists (ASA), the American Medical Association (AMA) and the Health Care Financing Administration (HCFA). Anesthesia services may be billed using codes from the ASA Relative Value Guide or the CPT manual; however, both an anesthesia code and a surgical code are not allowed for the same procedure by the same provider on the same date of service.

When multiple procedures are performed during a single anesthetic administration, only the code for the procedure with the highest basic value should be submitted. Consistent with CMS guidelines, UnitedHealthcare requires time-based anesthesia services be reported with actual time in one-minute increments. For example, if the Anesthesia Time is one hour, then 60 minutes should be submitted. Appropriate anesthesia modifiers must be used to denote whether the procedure was personally performed, medically directed or medically supervised. Some qualifying circumstances are covered. Some physical status modifiers are covered upon review of supporting documentation.

Time-based anesthesia management services are reimbursed according to the following formula when modifier AD is not reported:

\[(\text{[Basic Value} + \text{Time Increments} + \text{Modifying Units}] \times \text{Conversion Factor}) \times \text{Modifier Percentage}\]

When modifier AD is reported, time-based anesthesia management services are reimbursed according to the following formula:

\[(\text{[Basic Value of 3 + 1 Additional Unit if anesthesia notes indicate the physician was present during intubation]} \times \text{Conversion Factor}) \times \text{Modifier Percentage}\]

Any procedures outside the actual delivery of anesthesia, identified by a
basic value only, without any associated time units, are subject to the multiple surgical reduction guidelines explained later in this section of the manual. Services that are considered to be an integral part of the anesthesia delivery service are not covered separately.

Monitored anesthesia and IV sedation are covered, as if general or regional anesthetic had been administered, when the service criteria are met. A –QS,G8 or G9 modifier must be attached to the procedure code to indicate monitored services were performed. For the charges to be considered for payment, documentation which supports these criteria must accompany the claim.

Epidural anesthesia during labor and delivery is covered using CPT 01967 (vaginal delivery) and 01968 (cesarean delivery). A predetermined maximum delivery time of 60 minutes has been established. This will apply for all deliveries. For unusual circumstances where the delivery exceeds 60 minutes, the use of modifier 22 may apply. Claims submitted with modifier 22 must include medical record documentation which supports the use of the modifier and will be reviewed by United Healthcare.

Labor time is the total number of minutes submitted minus 60 minutes allotted for delivery, calculated proportionately for services. Labor minutes are multiplied by one quarter of each hour or 25%. This is equal to one unit per hour of labor time submitted. The number of labor time calculated plus the 60 minutes for delivery equal the total number of minutes reimbursed.

When anesthesia services are performed in an office by an anesthesiologist, payment is allowed. If the anesthesia is administered by the surgeon/physician performing the procedure, the anesthesia is considered part of the primary procedure and not covered separately.

Examination under anesthesia services is not covered if performed in conjunction with another service. If the service is performed as a stand-alone service, it is covered, when medically appropriate.

**Assistant Surgeons**

Charges for assistant surgeons are not covered for those procedures where an assistant surgeon is not considered appropriate. The UnitedHealthcare plan participant cannot be balance billed for those charges.

**Care Plan Oversight**

UnitedHealthcare does not cover care plan oversight (CPT codes 94005, 99339, 99374, 99377, 99379, 99380), since it does not involve direct patient care.

**Charges for Medical Records**

Medical record charges are fees for duplicating a patient’s medical record. Medical record charges will be denied for network physicians, ancillary providers and facilities. Please refer to section 7.0 of the Base Agreement for additional information.

**Copayment/Coinsurance Waiver**

It is considered an unacceptable billing practice for a physician or provider to waive a copayment or coinsurance obligation. A copayment is an expense that the plan participant is legally obligated to pay. Physicians and providers should collect copayments and coinsurance as defined by the plan participant’s benefit plan.

**Facility Based Private Duty Nursing**

UnitedHealthcare does not cover inpatient private duty nursing rendered in a hospital or skilled nursing facility. Hospital and skilled nursing facilities are required to determine and provide the appropriate level of nursing care for each patient.

**Facility Fees for Professional Office Visit Services**

UnitedHealthcare does not cover clinic facility fees, often billed under revenue codes 510-529. Payment for facility fees associated with office services is included in the physician professional fee and is not paid separately.
**Immunizations**

Coverage standards vary by customer and health plan. For the Empire Plan, routine well-child immunizations are covered for children up to age 19 including the cost of oral and injectable substances, according to prevailing pediatric clinical guidelines. In addition, for certain Empire Plan members, coverage is also available for flu vaccinations and certain adult immunizations, according to prevailing Centers for Disease Control and Prevention (CDC) guidelines.

**Lab Handling**

As part of our Laboratory Rebundling Policy, UnitedHealthcare does not cover laboratory handling charges separately. Lab handling is considered included in the primary evaluation and management service or a routine part of office overhead.

**Maternity Care**

As part of our Obstetrical Policy, routine maternity care is to be billed using the appropriate global maternity code. Do not bill for each office visit for routine maternity care; these visits are included in the payment for the global maternity bill. Antepartum or global OB services appended with modifier 22 to signify that greater than 13 antepartum visits were provided do not meet the required criteria to be considered unusually complex services qualifying for additional reimbursement. Refer to UnitedHealthcare's "Unusual Services Policy" for more information.

If a cesarean section or VBAC delivery is performed, please use the appropriate codes. If you do not perform the global maternity services, bill with the appropriate non-global maternity CPT codes.

**Multiple Procedures**

If you are performing multiple procedures, bill your full normal charge for each procedure; we will adjust payment appropriately per our guidelines for multiple procedures. For the Empire Plan, coverage for multiple procedures is 100% of the allowable amount for the primary procedure and 50% of the allowable amounts for the secondary procedure and non-incidental subsequent procedures. For the other covered groups that access the Empire Plan network, the payment guidelines may vary by customer benefit plan design.

**Non-Medically Appropriate Services**

UnitedHealthcare does not cover charges for services that are not medically appropriate. This includes facility, physician and ancillary charges.

**Preventive Medicine Services**

Preventive Medicine services [Current Procedural Terminology (CPT®) codes 99381-99387, 99391-99397, Healthcare Common Procedure Coding System (HCPCS) code G0402] include annual physical and well child examinations, usually separate from disease-related diagnoses. Occasionally, an abnormality is encountered or a pre-existing problem is addressed during the Preventive visit, and significant elements of related Evaluation and Management (E/M) services are provided during the same visit. When this occurs, UnitedHealthcare will reimburse the Preventive Medicine service plus 50% of one of the following problem-oriented E/M service codes only--99201-99205 or 99212-99215--when that code is appended with modifier 25. If the problem-oriented service is minor, or if the code is not submitted with modifier 25 appended, it will not be reimbursed.

When a Preventive Medicine service and an E/M service from the following code series--CPT codes 99211, 99241-99245, 99251-99255, 99281-99285, HCPCS codes G0245-G0246, M0064--are provided during the same visit, only the Preventive Medicine service will be reimbursed.

Screening services include cervical cancer screening; pelvic and breast examination (G0101); prostate cancer screening/digital rectal examination (G0102); and obtaining, preparing and conveyance of a Papanicolaou smear to the laboratory (Q0091). These screening procedures are included in (and are not separately reimbursed from) the Preventive Medicine service rendered on the same day.
Prolonged services (99354-99355) and counseling services (99401-99412, G0396-G0397) are included in (and not separately reimbursed from) Preventive Medicine codes.

Visual function screening (99172) and visual acuity screening (99173) are included in (and not separately reimbursed from) Preventive Medicine services.

**Professional and Technical Component Payment**

UnitedHealthcare covers the professional and technical components of global CPT procedures based on 21 different professional and technical percentage splits which are updated periodically as appropriate. The appropriate -26 modifier (professional component) and/or -TC modifier (technical component) should be used. This payment methodology closely mirrors HealthCare Financing Administration (HCFA) guidelines.

**Rebundled Charges**

All billed charges are subject to rebundling and other automated logic during the adjudication process. Any services or amounts not covered due to rebundling or other payment logic are not billable to the UnitedHealthcare plan participant.

**Standby Services**

UnitedHealthcare does not cover standby services billed under CPT code 99360. The standby physician is paid for those face-to-face services directly rendered to the patient. Neonatologists or pediatricians will be paid for attendance at delivery under CPT code 99436 (Attendance at delivery [when requested by delivering physician] and initial stabilization of newborn).

**Taxes**

Applicable sales tax is incorporated into the fee schedule allowance and will not be reimbursed as a separate item.

**TB Tine Test**

UnitedHealthcare does not cover TB Tine Tests formerly identified by CPT code 86585. The TB Tine Test is considered to be clinically ineffective in testing for tuberculosis; the Mantoux is now the test of choice (CPT code 86580) for patients at risk. This is supported by the Centers for Disease Control and Prevention and the American Academy of Pediatrics, as well as other respected professional organizations.

**Telephone / Internet Care**

Charges for care by telephone or internet are not covered. CPT codes 98966-98969 or 99441-99444.

**Unusual Procedural Services**

UnitedHealthcare’s standard for additional payment for the -22 modifier is 20% of the normal allowable for the unmodified procedure. The determination to allow additional payment is based on a manual review of documentation that supports the unusual services that occurred during the procedure.

**Urgent Care Centers**

Urgent Care services are covered as professional services and charges for the use of a facility to render office services are included within the payment for the professional charge. Therefore, “facility charges” are NOT covered by UnitedHealthcare and are not billable to the UnitedHealthcare plan participant.

Urgent Care Centers billing on UB-92 forms must include:

- ICD-9 diagnosis coding
- CPT-4 procedure coding
- Code 891 in Box 4 of the form (for identification)
- Revenue code 456.

Urgent Care Centers billing on HCFA 1500 must include:

- ICD-9 diagnosis coding
- CPT-4 procedure coding.

In addition, the Urgent Care Center must bill under a unique facility tax.
identification number, or clearly write URGENT CARE VISIT in Box 19 and the amount of copayment received at the time of the visit.

Venipuncture UnitedHealthcare does not cover a venipuncture (CPT code 36415) when billed by a network laboratory; it is considered to be included in the primary procedure. Venipuncture is covered when billed by a physician or provider other than a network laboratory.

**Claim Reconsideration Requests**
If you believe a claim was not paid correctly, you may request that the claim be reconsidered.

**Online**
The Claim Reconsideration option available at UnitedHealthcareOnline.com is the fastest way to resolve the following claims issues:
- Previously denied/closed for Coordination of Benefits
- Previously processed but contract rate applied incorrectly resulting in under/overpayment
- Inaccurate data entry
- Paid to incorrect physician / health care professional
- Corrected claim
- Claim underpayment
- Received workers’ compensation liability or subrogation
- Change in patient’s eligibility status
- Incorrect copayment
- Claim overpayment

When attachments are not needed, go to:
UnitedHealthcareOnline.com → Claims & Payments → Claim Reconsideration

When attachments are needed, please use Optum Cloud Dashboard. More information is available at:
UnitedHealthcareOnline.com → Tools & Resources → Health Information Technology → Optum Cloud Dashboard

**Paper**
If you don't have internet access, you should manually complete the Claim Reconsideration Request Form. Using this form clearly identifies that you are requesting review of a claim that has already been processed rather than submitting a duplicate claim, and a separate form is required for each claim.
- Complete all of the necessary identifying information.
- Check the reason for requesting the review.
- Attach a copy of the EOB or denial/payment letter, a claim form, and any other required documents as outlined on the form.
- Include any data, questions, or comments you believe support your request.
- Submit the request to the address on the EOB.

UnitedHealthcareOnline.com → Tools & Resources → Forms → UnitedHealthcare Claim Reconsideration Request Form

**Timely Filing**
Benefits may be allowed for claims submitted late if the claim was submitted within 120 days of the date that the circumstance which caused the delay was resolved. If you are requesting review of a claim that was denied because filing was not timely, for:
- Electronic claims - include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.
- Paper claims - include a copy of a screen print from your accounting software to show the date you submitted the claim.
- Delay by primary carrier - include the Medicare or other carrier benefit statement showing the date the primary carrier processed the claim.
- Litigation, court action, or other unique circumstances - include documented evidence that the delay was beyond your control.
**Appeals**

If a post-service claim (a claim for benefits payment after medical care has been received) or a pre-service request for benefits (a request for benefits that requires notification, precertification or benefit confirmation prior to receiving medical care) is denied in whole or in part, two levels of appeal are available. Submit an appeal by writing to the address indicated on the EOB or letter notifying you of the denial/payment.

**Level 1 Appeal**

A request for review must be directed to UnitedHealthcare within 180 days after the claim payment date or the date of the notification of denial of benefits. When requesting a review, you should state the reason why you believe the claim determination or precertification improperly reduced or denied benefits. Also, submit any data or comments to support the appeal of the original determination as well as any data or information requested by UnitedHealthcare. A written acknowledgment of your appeal will be sent to you within 15 days after it is received.

For a first level appeal of a post-service claim, a review of the appeal will be done, and UnitedHealthcare will provide you with a written decision within 30 days of your request.

For a first level appeal of a pre-service request for benefits, a review of the appeal will be done, and UnitedHealthcare will provide you with a written decision within 15 days of your request.

If the determination is upheld, UnitedHealthcare's written response will cite the specific Plan provision(s) upon which the denial is based and will include both of the following:

- Detailed reasons for the determination regarding the appeal. If the case involves a clinical matter, the clinical rationale for the determination will be given.
- Notification of your right to a further review.

**Level 2 Appeal**

If, as a result of the Level 1 review, the original determination of benefits is upheld by UnitedHealthcare, in whole or in part, you can request a Level 2 review. This request should be directed either in writing or by telephone to UnitedHealthcare within 60 days after you receive notice of the Level 1 appeal determination. When requesting the Level 2 review, you should state the reasons you believe the benefit reduction or denial was improperly upheld and include any information requested by UnitedHealthcare along with any additional data, questions, or comments deemed appropriate.

For a second level appeal of a post-service claim, a review of the appeal will be done, and UnitedHealthcare will provide you with a written decision within 30 days of your request.

For a second level appeal of a pre-service request for benefits, a review of the appeal will be done, and UnitedHealthcare will provide you with a written decision within 15 days of your request.

If the determination is upheld, UnitedHealthcare's written response will cite the specific Plan provision(s) upon which the denial is based and will provide detailed reasons for the determination regarding the appeal. If the case involves a clinical matter, the clinical rationale for the determination will be given.

**Appeals Involving Urgent Situations**

If an appeal involves a situation in which a delay in treatment could significantly increase the risk to health, the ability to regain maximum function, or cause severe pain, the appeal will be resolved and you will be notified of the determination in no more than 72 hours following receipt of the appeal. Notice of the determination will be made directly to the person filing the appeal.
Section 6: Explanation of Benefits Form

After you submit a claim to UnitedHealthcare, you will receive an Explanation of Benefits (EOB) form.

**Explanation of Benefits Form (EOB)**

A sample Empire Plan EOB form is provided on the following page. The EOB includes two sections: *Patient Detail*, which contains information about the patient and the plan participant; and *Service Detail*, which contains information about the processed claim. A few features include:

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product</strong></td>
<td>Code used to describe the plan participant's plan. For the Empire Plan, this code is OPT/PPO.</td>
</tr>
<tr>
<td><strong>Patient Relationship</strong></td>
<td>Two-letter code to describe the patient's status under the plan.</td>
</tr>
<tr>
<td>CH</td>
<td>Child</td>
</tr>
<tr>
<td>CD</td>
<td>Collateral Dependent</td>
</tr>
<tr>
<td>EE</td>
<td>Employee</td>
</tr>
<tr>
<td>HC</td>
<td>Handicapped Child</td>
</tr>
<tr>
<td>RR</td>
<td>Retired Employee</td>
</tr>
<tr>
<td>SP</td>
<td>Spouse</td>
</tr>
<tr>
<td>SS</td>
<td>Surviving Spouse</td>
</tr>
<tr>
<td>ST</td>
<td>Student</td>
</tr>
<tr>
<td><strong>Patient Account</strong></td>
<td>Account number YOU have used in your billing to us.</td>
</tr>
<tr>
<td><strong>Control Number</strong></td>
<td>Claims are assigned a unique control number by the claim office.</td>
</tr>
<tr>
<td></td>
<td>If you have any questions regarding a particular claim, the control number will help the claim office locate it.</td>
</tr>
<tr>
<td><strong>Provider of Service</strong></td>
<td>Designates which provider in a group practice treated the patient.</td>
</tr>
<tr>
<td><strong>Description of Service</strong></td>
<td>Indicates the CPT-4 and/or HCPCS codes used to process each claim, or a generic description of the service if no code is available.</td>
</tr>
<tr>
<td><strong>Provider Adjustment/Discount</strong></td>
<td>This is the amount of the “write-off” or discount per the contract agreement. It represents the difference between the billed amount and the fee schedule amount. It may also include dollars that are not covered because of retrospective review determinations and provider payment methodologies.</td>
</tr>
<tr>
<td><strong>Plan Covers</strong></td>
<td>Identifies the percentage of the covered amount actually paid to the provider, in most cases 100% for services covered under the Empire Plan Participating Provider Program.</td>
</tr>
<tr>
<td><strong>Remark Code</strong></td>
<td>References a further description or comment on how the benefit was calculated.</td>
</tr>
</tbody>
</table>

If you have specific questions about an EOB that you have received, please call the number listed in the upper left corner of the EOB.
### PROVIDER EXPLANATION OF BENEFITS

#### PATIENT DETAIL

<table>
<thead>
<tr>
<th>PRODUCT</th>
<th>MEM. ID</th>
<th>PATIENT NAME</th>
<th>PAT REL</th>
<th>PAT ACCOUNT</th>
<th>MEMBER NAME</th>
<th>CONTROL NUMBER</th>
<th>DATE RECEIVED</th>
<th>PROVIDER OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPT/PPO</td>
<td>A 895555555</td>
<td>MARY ABBOTT</td>
<td>SP</td>
<td>98765 98766</td>
<td>J ABBOTT</td>
<td>0000261101</td>
<td>08/28/06</td>
<td>J. SMITH MD</td>
</tr>
<tr>
<td>OPT/PPO</td>
<td>A 896666666</td>
<td>J JONES</td>
<td>EE</td>
<td>J JONES</td>
<td>J JONES</td>
<td>0000261102</td>
<td>08/28/06</td>
<td>J. SMITH MD</td>
</tr>
</tbody>
</table>

#### SERVICE DETAIL

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>DATES OF SERVICE</th>
<th>DESCRIPTION OF SERVICE</th>
<th>AMOUNT CHARGED</th>
<th>NOT COVERED</th>
<th>PROV ADJ DISCOUNT</th>
<th>AMOUNT ALLOWED</th>
<th>DEDUCT/COPAY</th>
<th>PLAN COV</th>
<th>PAID TO PROVIDER</th>
<th>RMK CD</th>
<th>PATIENT RESP</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARY ABBOTT</td>
<td>01/10/06</td>
<td>99213</td>
<td>50.00</td>
<td>12.00</td>
<td>38.00</td>
<td>15.00</td>
<td>100%</td>
<td>23.00</td>
<td>23.00</td>
<td>D1</td>
<td></td>
</tr>
<tr>
<td>J JONES</td>
<td>01/10/06</td>
<td>99213</td>
<td>50.00</td>
<td>12.00</td>
<td>38.00</td>
<td>18.00</td>
<td>100%</td>
<td>20.00</td>
<td>20.00</td>
<td>D1</td>
<td></td>
</tr>
</tbody>
</table>

**Total Paid to Provider:** $43.00

#### REMARKS

(D1) THANK YOU FOR USING A NETWORK PHYSICIAN OR OTHER HEALTH CARE PROFESSIONAL. WE HAVE APPLIED THE CONTRACTED FEE. THE PATIENT IS NOT RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE AMOUNT CHARGED BY THE PHYSICIAN OR HEALTH CARE PROFESSIONAL AND THE AMOUNT ALLOWED BY THE CONTRACT, EXCEPT IN SITUATIONS WHERE THERE IS AN ANNUAL BENEFIT MAXIMUM FOR THIS SERVICE. THE PATIENT IS ALSO RESPONSIBLE FOR ANY COPAY, DEDUCTIBLE AND COINSURANCE AMOUNTS.
Section 7: Empire Plan Care Coordination Activities

Overview of Empire Plan Features
A number of features are included in The Empire Plan to help guide its members through the sometimes complex health care delivery system. These features also help ensure that the health care which plan participants receive is appropriate. In this manual, we refer to these features collectively as Care Coordination Activities.

Some of these features are informational in nature, while others offer a higher level of benefits when certain requirements are met. They include UnitedHealthcare’s Empire Plan provider network procedures and protocols. They also include educational resources and programs administered by UnitedHealthcare and/or other vendors that focus on particular areas of health care.

In general, for those that focus on particular areas of health care, plan participants are responsible for either notifying the program vendor of certain services or for utilizing program providers who are responsible for such. However, UnitedHealthcare’s Empire Plan network providers are expected to assist their Empire Plan patients in complying with these programs whenever possible.

For additional details on the programs that follow, you may wish to ask your patients to share the coverage and/or reference documents they have received. You may also contact each program using the numbers found in “Section 1: How to Reach Us.”

UnitedHealthcare’s Empire Plan Provider Network Procedures

Services Network Providers Are Expected to Perform or Provide
Physicians, facilities, and other health care professionals are expected to perform, at a minimum, all of the following functions applicable to their areas of expertise:

- When initiating care, the physician must remain accountable for his or her patient's care in an acute care facility/hospital, nursing home, and at home.
- Properly coordinate referrals to other physicians and health care professionals.
- Provide 24-hour, seven days per week telephone access and on-call / substitute coverage. When arranging substitute coverage, we ask that you try to arrange for care from other physicians and health care professionals who participate with the UnitedHealthcare Empire Plan Network. For the most current listing of network physicians and health care professionals, review our physician and provider directory at the internet web site address found in "Section 1: How to Reach Us." Should a non-network physician/provider be used, benefits will be paid out-of-network.
- Schedule appointments in a manner that provides enrollees with reasonable access to health care physicians, providers, and services. UnitedHealthcare recommends the following access standards for appointment availability:
  - Initial appointment for routine health assessment, available within four weeks
  - Initial appointment for urgent problem available within one day
  - Initial appointment for non-urgent care available within three weeks
  - Routine follow-up available within 10 days. Follow-up for problems involving symptoms available within five days.
- Supervise physician assistants and advanced nurse practitioners in accordance with state licensing and regulatory requirements.
- Follow-up and coordinate care with physicians, ensuring that consultation notes are filed in the patient's chart, proper actions are taken, and follow-up care is provided.
- Work collaboratively with UnitedHealthcare and other Empire Plan vendors.
Referral Procedures

*Anesthesia Services*  Provider will ensure that all anesthesia services rendered at Provider’s location with regard to Covered Persons are rendered by participating providers for as long as the Agreement is in effect.

*Laboratory Services*  Provider will conduct any office laboratory services in a Clinical Laboratory Information Act (CLIA) certified office laboratory and will be reimbursed for only those services that provider is certified through CLIA to perform. Provider cannot bill plan participants for any laboratory services for which provider lacks the applicable CLIA certification. In those instances where Provider collects the specimen in the office but does not perform the laboratory services, all such laboratory work must be directed to a network commercial laboratory.

*Other Services*  When a UnitedHealthcare Empire Plan network physician or provider determines that an Empire Plan participant requires treatment or care/services from another practitioner, the physician or provider will use reasonable efforts to refer the participant to another network provider or to a provider participating in the programs referenced below, whenever appropriate.

For participating provider directory information, please visit the internet web site address found in Section 1, “How to Reach Us,” or contact the appropriate program vendor(s) as noted in Section 1.

Network Provider Compliance Requirements

All network physicians, hospitals and other health care providers are required by contract to comply with UnitedHealthcare’s programs and protocols. Compliance with the Care Coordination Activities is required in the following areas:

**Provide Timely Information as Requested**

Physicians, hospitals and other health care providers are expected to work collaboratively with UnitedHealthcare and other plan vendors. This includes, but is not limited to, returning telephone calls and providing information, such as medical records, as requested and in a timely manner.

**Provide Timely Care Consistent with the Medical Needs of the Member**

As soon as it is determined that a member requires a medical service, test or procedure, the service should be performed as soon as reasonably possible.

**Confidentiality of Records**

As noted in Section 8 of this manual, physicians, hospitals and other health care providers must maintain the confidentiality of all member medical records in accordance with any applicable statutes and regulations.

Other UnitedHealthcare Procedures / Requirements

**Retrospective Review**

UnitedHealthcare may conduct retrospective review of services provided to an Empire Plan enrollee. Retrospective review of any case may include:

- Review of the appropriateness of care if not reviewed previously
- Review of the coding of diagnoses and procedures
- Review for any quality concerns or opportunities to improve the care or outcome

**Outcomes**

UnitedHealthcare’s Care Coordination Activities are designed to help facilitate and coordinate requested health care services in order to achieve care that is:

- Consistent with national standards of medical care.
- Provided at the appropriate level of care and service.
- Rendered without delays in service.
- Timely in meeting the needs of the enrollee.
- Effective in identifying gaps in care, and opportunities to improve care and reduce re-admissions.
- Covered under the enrollee’s benefit plan.
Medically Necessary or Medical Necessity

Specific benefit plans may include additional criteria UnitedHealthcare must verify and use when conducting Care Coordination activities and making review determinations, including retrospective review. For the Empire Plan, covered health care services and supplies must be medically appropriate, and:

- necessary to meet the basic health needs of the Covered Person;
- rendered in the least intensive and most appropriate setting for the delivery of the service or supply;
- consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by UnitedHealthcare;
- consistent with the diagnosis of the condition;
- required for reasons other than the comfort or convenience of the Covered Person or his/her Physician; and
- demonstrated through prevailing peer-reviewed medical literature to be either:
  - safe and effective for treating or diagnosing the condition or sickness for which their use is proposed, or,
  - safe with promising efficacy for treating a life threatening sickness or condition, in a clinically controlled research setting, and using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of these criteria, the term “life threatening” is used to describe sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or pregnancy does not mean that it is a medically appropriate Covered Medical Expense as defined in the Covered Person’s benefit contract. These criteria relate only to coverage and may differ from the way in which a Physician engaged in the practice of medicine may define a medically appropriate service.

Services and supplies that do not meet these criteria are not covered and will not be paid. Please refer to the “Appeals” heading in this Section 5 of this manual for information regarding appeals of such decisions.

There may be instances when a Medical Director will review the medical treatment plan of a member with you. The Medical Director may discuss the reasoning or indication that led you to the proposed or performed procedure/treatment.

Clinical Review Guidelines

UnitedHealthcare utilizes externally licensed clinical guidelines and internally developed medical policies when conducting Care Coordination Activities and retrospective reviews.

UnitedHealthcare’s Empire Plan Care Coordination Activities

UnitedHealthcare’s Care Coordination Activities focus on assisting members to facilitate and coordinate access to care by offering timely health education programs, helping identify and prevent delays in service(s) and working to eliminate gaps in care while providing support to members with health care needs. For the Empire Plan, UnitedHealthcare’s Care Coordination Activities include:

- **Home Care Advocacy Program**
  - A program designed to facilitate the implementation of the physician’s treatment plan by helping coordinate timely access to home care services, including durable medical equipment/supplies, home nursing, and home infusion.

- **Specialty Care Coordination**
  - Programs designed to provide information and access to Centers of Excellence for highly specialized medical fields, such as infertility treatment.

- **Disease Management**
  - Programs that provide self-care education and condition monitoring for members with chronic health conditions.

- **Health Education**
  - Services that provide an ongoing source of general health information including telephone access to registered nurses and recorded messages as well as online health information resources.
Voluntary Case Management  A voluntary program to help coordinate services for serious conditions.

Physician and Provider Expectations
Physicians, hospitals and other health care providers are required to work collaboratively with UnitedHealthcare and other Empire Plan vendors conducting Care Coordination Activities. This includes, but is not limited to, responding to telephone calls and providing information as requested and in a timely manner. Refer to the Network Provider Compliance Requirements heading in this section for more information.

Health Education
Our health education activities provide an ongoing source of health information, help with self-care and objective data to help members make health care decisions. We offer members:
- 24-hour telephonic health information and assistance services through Empire Plan NurseLine
- Online health information available via the www.myuhc.com web site.

Home Care Advocacy Program
UnitedHealthcare’s Empire Plan Care Coordination Unit administers the Home Care Advocacy Program (HCAP), UnitedHealthcare’s program for Empire Plan home care services, durable medical equipment, and certain supplies. An enhanced level of benefits is available, when Empire Plan participants call HCAP to arrange for certain services/items and use HCAP-approved providers. Services/items covered by HCAP include:
- Durable Medical Equipment & Integral Supplies
- Home Nursing Services
- Home Infusion Therapy
- Certain other home health care services and prescription drugs when the home care arranged through HCAP takes the place of hospitalization or care in a skilled nursing facility.

Specialty Care Coordination

Infertility Benefit Management Program
The Empire Plan Infertility Benefit Management Program is designed to facilitate and coordinate access to infertility specialists. The primary components are UnitedHealthcare’s Care Coordination Unit and Centers of Excellence. If there is a member for whom you are recommending infertility related services, including the initial evaluation, advise the member to contact the Care Coordination Unit prior to services being rendered. Refer to the Notification Requirements heading in this section for more information.

Care Coordination Unit’s Role
UnitedHealthcare’s Empire Plan Care Coordination Unit helps facilitate and coordinate:
- Eligibility and benefit review
- Network education and guidance
- Health care services

Centers of Excellence
Centers of Excellence provide Empire Plan enrollees with access to a network of respected specialists that have demonstrated clinical excellence in the field of infertility. Current infertility services under contract through Centers of Excellence include patient education/program orientation, diagnostic testing, ovulation induction/hormonal testing, surgery to enhance reproductive capability, and certain specialized procedures that facilitate pregnancy but do not treat the cause of infertility.

Disease Management
UnitedHealthcare’s disease management programs consist of interventions designed to help improve the outcome of members with specific chronic diseases by:
- Providing information and education on the member's disease
- Assisting the member in prevention of exacerbations
- Managing the course of their disease
The programs focus on education, self-care, compliance, and health status. The defined interventions are based on nationally accepted medical evidence. The clinical objective of these programs is to work with the member and their physician or other health care providers to achieve desired clinical outcomes.

For The Empire Plan, UnitedHealthcare provides a comprehensive and integrated disease management program for the most prevalent chronic conditions of diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, and co-morbid conditions of hyperlipidemia, hypertension, depression and obesity. The program is completely voluntary and available to Empire Plan non-Medicare enrollees and their dependents.

Program design features include:

- At-risk, high-need individuals gain access to a personal nurse with condition expertise who can assess and address gaps in care, transfer skills and knowledge, and drive meaningful improvements in individual health;
- Scheduled outbound calls – nurse available to receive calls directly;
- Targeted evidence-based information, program overviews, tracking tools, health logs, self-care materials provided to those with low-intensity needs; all can access online condition-specific information;
- Variable intensity of outreach depending on risk stratification and individual needs;
- Integration and coordination with other clinical resources including NurseLine™, case management, behavioral health, and hospital discharge planners.

### Activities by Other Empire Plan Vendors

The following programs are administered by other vendors or other vendors in partnership with UnitedHealthcare. For contact information, please see “Section 1: How to Reach Us.”

#### Prescription Drug Program

Many Empire Plan members are covered by the New York State Empire Plan Prescription Drug Program. The program includes participating pharmacies, copayments, mandatory generic substitution, supply and coverage limits, prior authorization for certain drugs, and mail service pharmacy services. Empire Plan drug lists are available.

Empire Plan network physicians are expected to:

- Prescribe generic drugs whenever therapeutic equivalent drugs are available and/or let your patient know that an equivalent generic drug may be substituted for brand drugs under the benefit program;
- If phoning a prescription to a pharmacy, attempt to utilize a network pharmacy;
- Accept the call from a network pharmacy to notify you of a problem or ask a question regarding the prescribed drug;
- Participate in the prior authorization process when needed.

#### Mental Health and Substance Abuse Program

The Empire Plan’s Mental Health and Substance Abuse Program provides comprehensive coverage for mental health and substance abuse care, including alcoholism. To receive the maximum benefits available under the program, plan participants must call the program administrator before seeking treatment and must follow the administrator’s recommendations. Limited benefits may be available for medically appropriate care when they do not. The program includes a participating provider network, certification of covered services, and concurrent review.

#### Managed Physical Medicine Program

The Empire Plan’s Managed Physical Medicine Program covers medically appropriate services typically performed by a chiropractor or physical therapist. Other providers, such as osteopaths and occupational therapists, may also provide these services. The provider must be licensed to perform such services in the state where the service is received, and physical therapy must be prescribed by a doctor. To receive the maximum benefits available, plan participants must use a provider in the administrator’s network who is responsible for certifying medically appropriate care, or they must follow the administrator’s recommendations when a network provider is not available. Limited benefits may be available for medically appropriate care when they do not.

Practitioners participating in UnitedHealthcare’s Empire Plan network may also render services covered under this program. If so, you are required to comply with reviews conducted by the program administrator.
Summary of Notification Requirements

To ensure claims are considered for payment, notification is required for the procedures and services listed in the chart that follows. These services are likely to identify patients with unmet health care needs who will benefit from UnitedHealthcare’s programs, or those of other Empire Plan vendors. In general, depending on the particular program, plan enrollees are responsible for either notifying Empire Plan program vendors of certain services or for utilizing program physicians or providers who are responsible for such.

Call 1-877-7NYSHIP (1-877-769-7447) and follow the prompts to notify the appropriate program carrier/vendor as outlined below.

This notification list may be modified from time to time. The presence or absence of a procedure or service on this list does not mean that benefit coverage exists for that procedure or service. The enrollee benefit contract will determine whether a procedure or service is covered.

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Advanced Diagnostic Imaging Services</strong>&lt;br&gt;- CT/CTA Scans, MRI/MRA, PET Scans, Nuclear Medicine/Cardiology</td>
<td>UnitedHealthcare Benefits Management Program</td>
</tr>
<tr>
<td><strong>Alcoholism Treatment</strong></td>
<td>Behavioral Health Program</td>
</tr>
<tr>
<td><strong>Chiropractic Services</strong></td>
<td>Managed Physical Network, Inc. (MPN) Managed Physical Medicine Program</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment &amp; Integral Supplies</strong>&lt;br&gt;- Mastectomy Prosthetics Over $1,000&lt;br&gt;- Diabetic Shoes When The Empire Plan Is Primary&lt;br&gt;- DME Items Listed on UnitedHealthcareOnline.com When The Empire Plan Is Primary&lt;br&gt; UnitedHealthcareOnline.com → Tools &amp; Resources → Advance and Admission Notification Requirements → Advance Notification Lists</td>
<td>UnitedHealthcare Home Care Advocacy Program</td>
</tr>
<tr>
<td><strong>Home Health Services That Take the Place of Hospitalization</strong></td>
<td>UnitedHealthcare Home Care Advocacy Program</td>
</tr>
<tr>
<td><strong>Home Infusion Therapy &amp; Enteral Formula</strong>&lt;br&gt;- Except administration of enteral formula via tube for patients whose primary coverage is Medicare</td>
<td>UnitedHealthcare Home Care Advocacy Program</td>
</tr>
<tr>
<td><strong>Home Nursing Services</strong></td>
<td>UnitedHealthcare Home Care Advocacy Program</td>
</tr>
<tr>
<td><strong>Hospital Admissions</strong>&lt;br&gt;- Elective, Including Maternity&lt;br&gt;- Emergency/Urgent (within 48 hours)</td>
<td>Empire Blue Cross Blue Shield Benefits Management Program</td>
</tr>
<tr>
<td><strong>Infertility Services</strong></td>
<td>UnitedHealthcare Infertility Benefit Program</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td>Behavioral Health Program</td>
</tr>
<tr>
<td><strong>Physical Therapy</strong></td>
<td>Managed Physical Network, Inc. (MPN) Managed Physical Medicine Program</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong>&lt;br&gt;- As noted in Preferred Drug List or Flexible Formulary List</td>
<td>Prescription Drug Program</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility Admissions</strong></td>
<td>Empire Blue Cross Blue Shield Benefits Management Program</td>
</tr>
<tr>
<td><strong>Substance Abuse Services</strong></td>
<td>Behavioral Health Program</td>
</tr>
</tbody>
</table>
Section 8: UnitedHealthcare’s Empire Plan Quality Improvement Program

Physician and Provider Participation
Physician and provider participation is an integral component of UnitedHealthcare’s Empire Plan Quality Improvement Program. Network physicians are given a structured forum for input through representation on the committees described below. In addition, individual physicians are encouraged to give feedback to UnitedHealthcare via communication with Empire Plan Network Management.

Credentialing and Quality Improvement Committees
Committees meet on a regular basis. These committees review physician and provider applications and retention information and make recommendations for acceptance, rejection or termination. They also advise on and influence programs to measure, monitor, analyze and apply interventions to improve the quality of health care coverage and services.

Components of Program
You are expected to cooperate with our quality assessment and improvement activities and to comply with our clinical guidelines, patient safety (risk reduction) efforts and data confidentiality procedures. The Quality Improvement Program is a comprehensive program which may include the following components:
- Preventive health services monitors
- Current preventive health guidelines
- Quality improvement measures and studies
- Risk management
- Health promotion activities
- Compliance with all external regulatory agencies
- Care Coordination
- Ongoing monitoring of key indicators (e.g., mortality review, cesarean section rates, over and under utilization, continuity of care)
- Service measures and studies

The Quality Improvement Program is under the leadership of the medical director, Quality Improvement Committee and Network Management.

Selection and Retention of Network Physicians and Providers
UnitedHealthcare has established criteria for the selection and retention of physicians and providers for participation in its Empire Plan network. These credentialing criteria are reviewed at least annually. This section describes the criteria which are used for the initial and ongoing credentialing of physicians, hospitals, and ancillary providers, facilities, and companies. Nothing in this description limits UnitedHealthcare’s discretion to accept and discipline network physicians and providers or grants rights to plan participants, physicians or providers.

Physician Credentialing
All of the information described in this section is reviewed during the initial application process. Review of information to evaluate the continued participation of physicians in UnitedHealthcare’s Empire Plan Network is ongoing and periodic. Every three (3) years, UnitedHealthcare seeks to verify that each network physician continues to meet the established selection and retention credentialing standards. These standards and the method and frequency of validation are listed on the next page and are subject to modification by UnitedHealthcare at its sole discretion.

To streamline the credentialing and recredentialing processes, UnitedHealthcare is pleased to participate in an innovative Web-based credentialing application tool. The Council for Affordable Quality Healthcare’s (CAQH) Universal Credentialing DataSource is a Web-based solution that enables certain health care professionals to complete credentialing applications online. With this tool, available at www.CAQH.org, health care professionals can control the data stored in the database, easily update it, and electronically submit it to participating health plans, like UnitedHealthcare. Once we receive the application, Aperture, our credentialing verification organization, verifies the credentials listed and may contact you as needed during the verification process.
# Physician Credentialing Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Means of Validation</th>
<th>Frequency of Validation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current license or other authorization to practice</strong></td>
<td>• Primary verification with state licensing agency</td>
<td>Every 3 years</td>
</tr>
<tr>
<td><strong>Completion of highest level of education or training, including Board Certification</strong></td>
<td>• Primary verification with certifying entity</td>
<td>Every 3 years if not initially board certified, or at time of required recertification, if applicable</td>
</tr>
<tr>
<td><strong>Current Federal Drug Enforcement Agency (DEA) certificate and State Controlled Dangerous Substance (CDS) certificate, if applicable</strong></td>
<td>• Primary verification with DEA Registration File</td>
<td>Every 3 years</td>
</tr>
<tr>
<td><strong>Current malpractice coverage as required by UnitedHealthcare</strong></td>
<td>• Information submitted on Physician Application and Updates, with verification as necessary</td>
<td>Every 3 years</td>
</tr>
<tr>
<td><strong>Acceptable malpractice claims history</strong></td>
<td>• Physician Application and Updates • National Practitioner Data Bank</td>
<td>Every 3 years</td>
</tr>
<tr>
<td><strong>Privileges at hospital(s), if applicable to profession</strong></td>
<td>• Information submitted on Physician Application and Updates, with verification as necessary</td>
<td>Every 3 years</td>
</tr>
<tr>
<td><strong>Appropriate work history of professional activity</strong></td>
<td>• Information submitted on Physician Application and verification as necessary</td>
<td>Initial credentialing</td>
</tr>
<tr>
<td><strong>Sanction-free status by federal, state and local authorities</strong></td>
<td>• Disclosure questions on Physician Application and Updates • National Practitioner Data Bank reports</td>
<td>Every 3 years</td>
</tr>
<tr>
<td><strong>Acceptable office practice arrangements</strong></td>
<td>• Physician Application and Updates • Physician Office Site Review</td>
<td>Every 3 years</td>
</tr>
</tbody>
</table>

# Hospital and Ancillary Facility and Company Credentialing Criteria

Criteria which are used for initial and ongoing credentialing of hospitals and ancillary facilities and companies include but are not limited to:

- Acceptable accreditation and/or certification
- Site review for facilities and companies that are not accredited.
- In good standing with state and federal regulatory agencies
- Current, applicable state license
- Appropriate insurance coverage
Plan Participant “Bill of Rights”
Plan participants have the following rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you.

Plan participants have the right to:
- Be treated with respect and dignity by UnitedHealthcare personnel, network physicians and health care professionals.
- Privacy and confidentiality for treatments, tests or procedures received.
- Voice concerns about the service and care they receive and to register complaints and appeals concerning your health plan or the care provided to them.
- Receive timely responses to their concerns.
- Participate in a candid discussion of appropriate treatment options for their conditions, regardless of cost or benefit coverage.
- Be provided with access to physicians and health care professionals.
- Participate with their doctor and other caregivers in decisions about their care.
- Receive information about UnitedHealthcare, our services and network physicians and health care professionals.
- Be informed of, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards.
- Choose an advance directive to designate the kind of care they wish to receive should they be unable to express their wishes. 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’ right to accept or refuse treatment, and about your own policies regarding advance directives.

Plan participants have the responsibility to:
- Know and confirm their benefits before receiving treatment.
- Contact an appropriate health care professional when they have a medical need or concern.
- Show their identification card before receiving health care services.
- Verify that the physician or health care professional they receive services from is in the UnitedHealthcare network.
- Pay any necessary copayment at the time they receive treatment.
- Use emergency room services only for injury or illness that, if not treated immediately, could pose serious threat to their lives or health.
- Keep scheduled appointments.
- Provide information needed for their care.
- Follow the agreed-upon instructions and guidelines of physicians and health care professionals.
- Notify UnitedHealthcare Customer Care of a change in address, family status or other coverage information.

Review Programs
As part of the Quality Improvement Program and in conjunction with credentialing and recredentialing, physician office site reviews and medical record reviews are conducted. Appropriate tools are utilized to conduct the reviews and the results are communicated to the physician.

Physician Office Site Review
A physician office site review may be conducted by UnitedHealthcare staff or a representative acting on UnitedHealthcare’s behalf at the time of credentialing and thereafter as necessary. The site review is designed to evaluate accessibility, waiting areas, services/treatment area, office policies and procedures and safety.

Medical Record Review
Medical records and clinical documentation are evaluated based on the minimum standards for record maintenance which are listed below. UnitedHealthcare or a representative acting on its behalf may visit the physician or provider’s office to assess medical recordkeeping practices.
Access to Records
All network physicians and providers are expected to comply with UnitedHealthcare’s policies for reasonable access to records during the term and upon termination of the Physician or Provider Participation Agreement. You must provide access to any medical, financial or administrative records related to the services you provide to UnitedHealthcare Empire Plan enrollees 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.

Parties Who Should Have Access to Records
UnitedHealthcare representatives or their delegates, plan participant’s subsequent physician(s), any duly authorized third party.

Maintenance Period
A minimum of six (6) years (or longer if required by applicable statutes or regulations) from the date of service and/or any time thereafter that such access is required in connection with plan participant’s medical care.

Copies
UnitedHealthcare is entitled to obtain copies of plan participant’s medical records at no cost.

Other Disclosure
Network physicians and providers are required to disclose plan participant’s records as required by law.

Standards for Medical Records
In providing care for UnitedHealthcare customers, we expect that you:
- Maintain a single, permanent medical record for each patient.
- Protect patient records against loss, destruction, tampering or unauthorized use.
- Maintain medical records in accordance with state and federal regulations, in a confidential manner and provide periodic training to office staff regarding confidentiality processes.
- Maintain a mechanism for monitoring and handling missed appointments.

General Documentation Guidelines
We also expect you to follow these commonly accepted guidelines for medical record information and documentation:
- Date all entries, and identify the author.
- Make entries legible.
- Cite significant illnesses and medical conditions on a problem list. Include dates of onset and resolution.
- Give prominence to notes on medication allergies and adverse reactions. Also note if the patient has no known allergies or adverse reactions.
- Make it easy to identify the medical history, and include serious illnesses, injuries and operations for patients seen three or more times. For children and adolescents (through age 18), history includes prenatal care, birth, operations and childhood illnesses.
- For medication record, include name of medication, dosage, amount dispensed and dispensing instructions. Also list over the counter drugs taken by patient.

Document these important items:
- Tobacco habits, including advice to quit, alcohol use and substance abuse for patients age 11 and older
- Immunization record
- Family and social history
- Preventive screening and services
- Blood pressure, height and weight, body mass index
- Copy of advance directive for patient (or other document allowed by state law) or a notation that your patient does not want one.
Demographic Information
The medical record for each patient should include:
- Patient name and/or ID number on every page
- Age or date of birth
- Address
- Marital status
- Occupational history
- Home and work phone numbers
- Name and phone number of emergency contact
- Name of spouse or relative
- Insurance information

Patient Encounters
When you see a patient, document the visit by noting:
- Patient’s complaint or reason for visit
- Relevant history and physical assessment (including subjective and objective findings)
- Unresolved problems from previous visit(s)
- Diagnosis and treatment plans consistent with your findings
- Growth charts for pediatric patients
- Developmental assessment for pediatric patients
- Patient education, counseling or coordination of care with other providers
- Date of return visit or other follow-up care
- Lab and other studies you ordered
- Review by the primary physician (initialed) on consultation, lab, imaging and special studies
- Consultation and abnormal studies are initialed and include follow-up plans

Patient Hospitalization
When a patient is hospitalized, your records should include:
- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information

Clinical Decision and Safety Support Tools in place to ensure evidence-based care is provided. Examples include:
- ALT/AST laboratory test done if patient taking Statins
- Immunization tracking sheet
- Flow sheet for chronic diseases (eg, diabetes, asthma)
- Patient reminder system
- Electronic medical records
- E-prescribing
- Epocrates

Preventive Guidelines
UnitedHealthcare has adopted preventive care guidelines for healthy children, adolescents and adults based on the recommendations of the U.S. Preventive Services Task Force. To view our preventive guidelines, visit UnitedHealthcareOnline.com.
**Plan Participant Satisfaction / Plan Participant Grievance**

UnitedHealthcare may survey plan participants to measure their satisfaction with our Empire Plan network and its network physicians and providers. Plan participants, family members, physicians, other providers, or discharge planners may also contact UnitedHealthcare directly of their own accord.

If a UnitedHealthcare receives a complaint about a network physician or provider, customer care will attempt to resolve the problem. If a problem cannot be successfully resolved, Empire Plan Network Management may be asked to intervene.

This procedure may require UnitedHealthcare to contact the physician or provider, to access medical or billing records, and, as necessary, to call upon physicians and providers other than those who provided treatment to the plan participant. Network physicians and providers are required to cooperate fully in resolving plan participant complaints and grievances.

**Confidentiality of Patient Data**

UnitedHealthcare Empire Plan customers have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates that need that information to fulfill our obligations and to facilitate improvements to our customers’ health care experience. We require our affiliates and business partners to protect privacy and abide by privacy law. If a customer requests specific medical record information, we will refer the customer to you as the holder of the medical records.

**Termination and Transfer of Plan Participants**

Physicians and providers may not seek or request to have a plan participant’s participation in plans administered by UnitedHealthcare terminated, or to have plan participants transferred to another physician or provider of medical care or an alternative health benefit program, due to the plan participant’s medical condition or amount, variety or cost of covered services required by the plan participant.

If your network participation terminates for any reason, and your patient chooses to transfer to a different physician/provider, you are required to participate in the transition of your patient toward timely and effective care.

**Closing of Physician Panel**

Network physicians and providers are expected to adhere to the following protocol when closing their panel (practice) to new plan participants and other patients. A physician or provider is expected to:

- Keep his or her panel open to those plan participants who were patients before the closing of his or her panel.
- Uniformly close his or her panel to all new patients, including all commercial or governmental insureds, as well as private payers.

**Clinical Practice Guidelines**

Although claim payment policies may vary based on plan design and specific customer coverage and benefit wording, UnitedHealthcare’s overall medical policies are consistent across all products and businesses. Our core beliefs about the effectiveness and appropriateness of medical care are based upon scientific evidence.

The Medical Policy Committee is a team of professional staff that includes medical directors and physician consultants. The Committee’s primary function is to write clinical practice guidelines and to approve externally licensed guidelines that are used throughout UnitedHealthcare.
The following forms are available to assist you in complying with our claims and network participation processes and procedures. Copies of these forms are provided to you at the time of initial contracting. Additional copies or updated versions can be obtained as noted below. Whenever possible, network providers are expected to interact with UnitedHealthcare electronically.

Available via UnitedHealthcareOnline.com:

- Provider Demographic Update Fax Form
- Request for Reconsideration

Available by calling 1-877-7NYSHIP (1-877-769-7447) or writing to Empire Plan Claims, UnitedHealthcare, PO Box 1600, Kingston, NY 12402-1600:

- Empire Plan Claim Form (NYS)
- Empire Plan Claim Form (Outside NYS)
- Predetermination Request