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

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

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**Focus on CMS’ Star Ratings**

**Patient Care Opportunity Reports**

The CMS Star Ratings program is one of several national programs used to measure quality. These programs emphasize quality of care, physician collaboration and patient engagement. Using national clinical and service quality measures, CMS emphasizes health outcomes, preventive screenings and patient satisfaction in its Star Ratings assessments.

UnitedHealthcare is committed to working together with physicians to improve clinical and Part D quality adherence rates. The Patient Care Opportunity Report is a tool that provides clear and actionable information for physician groups and organizations to use to identify their patients’ adherence status. The report uses UHC pre and adjudicated claims and other supplemental data to provide clinical and Part D information on members, either assigned or attributed to a PCP, in the group that have at least one open or closed care opportunity for the reporting year, for any of the 11 HEDIS and 5 Part D metrics being reported. In addition to the actual adherence rates, additional information has been included such as date of last physical, a Care Score calculation to assist in prioritizing based on the number of open gaps in care, and displaying if the patient is tied to our Member Reward program.

The 11 HEDIS Measures are: Breast Cancer, Colorectal Cancer, LDL-C Screening, LDL-C Control<100 md/dl, Glaucoma, Fracture/BMD or Rx, Osteoporosis Fract Dte, Eye Exam, Nephropathy Screen, Hemoglobin HbA1c, and Rheumatoid Arthritis. The 5 Part D measures are: High Risk Medication, Diabetes, Med Ad. For Oral Diabetes, ACEI or ARB, and Statins. The Part D information includes both 2012 results as well as 2013 "predictive result" based on the members current "behavior".

The report is generated monthly and shows progress at the member level as "gaps" are closed throughout the year. The information is reported at the Health System (if applicable), group (TIN), PCP (MPIN) levels. Reports are available from the UHN account manager and beginning in mid-July, directly from UnitedHealthcareOnline.com. For additional information, please contact your UHN account manager.

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*Revision to: Focus on CMS’ Star Ratings Patient Care Opportunities Report article on pg. 1. (7/10/2013)*
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Affordable Care Act – Preventive Care Updates

Women’s Preventive Care Services

Under the Affordable Care Act, non-grandfathered health plans must cover Food and Drug Administration-approved contraception methods, sterilization procedures and patient education and counseling for women with reproductive capacity without cost-sharing under the expanded women’s preventive services benefit.

Coverage for contraceptives that fall under the medical benefit became effective for non-grandfathered plans on the first plan year starting on or after Aug. 1, 2012.

Intrauterine devices (IUDs), including their insertion and removal, are one of several contraceptives available to members without cost-share under the health reform law. Because IUDs can be expensive for physicians to purchase and stock in their offices, physicians who do not stock IUDs can obtain the Mirena® brand and Skyla® brand IUDs as needed from CVS Caremark Specialty Pharmacy by calling 800-237-2767 or faxing to 800-323-2445.

Mirena (code J7302) or Skyla (code Q0090) IUDs should be billed according to our Preventive Care Services Coverage Determination Guideline.

Please note that ParaGard® (J7300) brand IUDs cannot be obtained from a specialty pharmacy. UnitedHealthcare members who choose ParaGard IUDs will need to have it inserted by a network doctor who must buy and bill for the ParaGard IUD to help members receive it at no member cost-share.

Members should not be directed to purchase IUDs from a pharmacy or manufacturer. Because IUDs are a covered medical benefit, we cannot reimburse members who purchase IUDs directly at a pharmacy or manufacturer. Pharmacies and manufacturers are not part of UnitedHealthcare’s medical provider network, and the member will not be reimbursed.

UnitedHealthcare’s Approach to Preventive Colonoscopy

Colorectal cancer screening, including optical colonoscopy, beginning at age 50 and continuing until age 75 has an “A” recommendation by the U.S. Preventive Services Task Force (USPSTF). As such, it is considered a preventive service under the health reform law and covered by non-grandfathered health plans without member cost-share.

UnitedHealthcare does not impose age or frequency limits. When performed as a preventive colon cancer screening, we cover colonoscopy, sigmoidoscopy, fecal occult testing, as well as CT colonography without member cost-sharing. This includes all services for a preventive colonoscopy (e.g. associated facility, anesthesia, pathologist, and doctor fees) as outlined in our Preventive Care Services Coverage Determination Guideline (CDG). However, we expect physicians to adhere to professional specialty society guidelines in deciding how frequently colonoscopy should be done. For example, colonoscopy in persons at standard risk and in whom no earlier abnormality was found, should be done every 10 years.

Preventive v. Diagnostic Colonoscopy

UnitedHealthcare has determined that a colonoscopy performed on a person without symptoms will be considered preventive, rather than diagnostic, even if a polyp is found and removed during the procedure. While the removal of a polyp during a preventive screening colonoscopy will not convert the procedure to a diagnostic colonoscopy, all future colonoscopies are then considered diagnostic because the time intervals between future colonoscopies would be shortened.

(continued on next page)
If a patient has a polyp removed, then subsequent colonoscopies will be subject to deductibles, coinsurance or copayments. The recommended screening intervals for colonoscopy are:

1. Annual high-sensitivity fecal occult blood testing,
2. Sigmoidoscopy every five years combined with high-sensitivity fecal occult blood testing every three years, and
3. Screening colonoscopy at 10-year intervals.

Correct coding guidelines for subsequent colonoscopies are outlined in our CDG. Reimbursement of colonoscopies as preventive or diagnostic depends on which diagnosis codes doctors submit.

If a patient requires a colonoscopy to determine the cause of any symptoms, the colonoscopy is considered diagnostic.

Information about coding preventive colonoscopy screenings as well as other preventive services can be found in our Coverage Determination Guidelines at UnitedHealthcareOnline.com (Home > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines). UnitedHealthcare provides a comprehensive CDG as well as a CDG Summary for a quick reference. Providers may also visit the United for Reform Resource Center at UHC.com/Reform and click Preventive Services for the latest health reform news, timelines and FAQs about health reform.

Provider Remittance Advice and 835 File Changes Due to Sequestration

The Centers for Medicare & Medicaid Services (CMS) recently announced sequestration reductions to Medicare payments to physicians, facilities and other health care professionals, as well as Medicare Advantage plans.

As a result, UnitedHealthcare implemented these reductions to payments from its Medicare Advantage plans to physician, facility, ancillary provider and other health care professionals. Specifically, UnitedHealthcare Medicare Advantage plans, including Medicare Advantage Dual Special Needs Plans (SNP), are reducing payments by two percent for dates of service or discharge on or after April 1, 2013 to providers whose reimbursements are based on current year Medicare reimbursement methodology or rates. We communicated our intention to make these reductions in a statement posted on UnitedHealthcareOnline.com on March 29, 2013.

For fee-for-service claims submitted under original Medicare, CMS is using Claim Adjustment Reason Code (CARC) 223 – the code for a mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created – to report the sequestration reduction to providers. On May 1, 2013, CMS issued a bulletin to Medicare Advantage plans regarding sequestration. In the bulletin, CMS does not specify which CARC should be used by Medicare Advantage plans. Therefore, due to system limitations, for claims processed on certain platforms, UnitedHealthcare is using codes other than CARC 223 to report the sequestration reduction.

The table on the next pages can help you recognize and understand how the two percent reduction will be displayed on provider remittance advice (PRA) and 835 files and help you make any necessary adjustments to your systems for posting 835 files.
<table>
<thead>
<tr>
<th>Website</th>
<th>Health Plan or Platform Provider or Claim Type, if Applicable</th>
<th>835 Claim Adjustment Reason Code</th>
<th>Provider Remittance Advice</th>
</tr>
</thead>
</table>
| UnitedHealthcareOnline.com   | Medicare Solutions Platform¹  
• Participating physicians and other health care professionals  
• Excludes Wisconsin                                                        | CARC 104 (Managed Care Withholding) will be displayed. | The 2% reduction for sequestration will be displayed in the ‘Withhold’ field and combined with any other amounts being withheld.  
No explanation code will be displayed. |
|                              | Medicare Solutions Platform  
• Non-participating physicians and other health care professionals  
• Participating and non-participating providers in Wisconsin                                                                 | CARC 45 (Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement) will be displayed. | The 2% reduction for sequestration will be included with any other fee schedule reductions displayed in the ‘Inelig-Prov’ field.  
Remark Code 1133 (Medicare Allowed Red 2% for sequester) will be used. |
|                              | Medicare Solutions Platform  
• Facility claims                                                                                                                  | For facility claims, the payment for the entire claim will be applied to the first revenue code and/or procedure code service line and the 2% reduction will be included in this amount.  
• If the paid amount on the service line (as reduced for sequestration) exceeds or is greater than the balance of the billed charges minus the provider contract adjustment amount minus the patient cost share amount, then CARC 94 will be applied.  
• If the paid amount on the service line (as reduced for sequestration) is equal to or less than the balance of the billed charges minus the provider contract adjustment amount minus the patient cost share amount, then CARC 45 will be applied. | The 2% reduction for sequestration will be included in the ‘Discount’ field and combined with any other discounts.  
No explanation code will be displayed. |
<table>
<thead>
<tr>
<th>Website</th>
<th>Health Plan or Platform Provider or Claim Type, if Applicable</th>
<th>835 Claim Adjustment Reason Code</th>
<th>Provider Remittance Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHCWest.com</td>
<td>UnitedHealthcare West</td>
<td>CARC 094 (Processed in excess of charges.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CARC 045 (charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>The 2% reduction for sequestration will be displayed in the 'Payable Amount' field as a (-).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Remark Code 65 (2% sequestration) will be displayed.</td>
</tr>
<tr>
<td>UHCCommunityPlan.com</td>
<td>UnitedHealthcare Community Plan of New York, New Jersey, Arizona and Wisconsin</td>
<td>CARC 45 (charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement) will be displayed.</td>
<td>The 2% reduction for sequestration will be included in the 'Discount' field and combined with any other discounts. No explanation code will be used.</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>UHCCommunityPlan.com</td>
<td>UnitedHealthcare Community Plan of Iowa, Mississippi and Tennessee</td>
<td>CARC 104 (Managed Care Withholding) will be displayed.</td>
<td>The 2% reduction for sequestration will be displayed in the 'Withhold' field. No explanation code will be used.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UHCCommunityPlan.com</td>
<td>UnitedHealthcare Community Plan of District of Columbia, Delaware, Ohio, Pennsylvania, South Carolina</td>
<td>CARC 223 (adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created) will be displayed.</td>
<td>The 2% reduction for sequestration will be included in the 'Net Paid' field. No explanation code will be used.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>UHCCommunityPlan.com</td>
<td>Great Lakes Health Plan (GLHP)</td>
<td>CARC 104 (Managed Care Withholding) will be displayed.</td>
<td>The 2% reduction for sequestration will be displayed in the 'Withhold' field and combined with any other amounts being withheld. No explanation code will be used.</td>
</tr>
</tbody>
</table>

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Electronic Claim Reconsideration With Attachments Coming Soon to the Optum Cloud Dashboard

Coming soon, we will launch Optum Cloud Dashboard’s application for claim reconsideration requests with attachments. It can be used for Commercial, UnitedHealthcare Medicare Solutions, Oxford, UnitedHealthcare West and UnitedHealthcare Community Plan claims.1

With the claim reconsideration app, you search for your patient and claim online, enter a reason for reconsideration and then upload your documentation. After submission, you receive a tracking number that allows you to check the status. You will also be able to update and resubmit your request.

Here’s what some providers in our pilot program have said:

“The reconsideration tool is easy to use and allows me to attach medical records directly from my desktop...”

“We found that using the electronic claim reconsideration with attachment process reduces the need for a follow up phone call.”

You can learn more about Optum Cloud Dashboard on UnitedHealthcareOnline.com. Keep an eye on In the Spotlight on the home page to find out when you can register.

UnitedHealthcare and Optum, a leading information and technology-enabled health services business, are using cutting edge cloud

(continued on next page)
technology to drive change and improvements in revenue cycle processes. Strategic collaboration between UnitedHealthcare and physicians, hospitals and other health care facilities allows testing of solutions that streamline and simplify the administrative experience.

If a state has specific provider dispute or appeal rights, then items received through Optum Cloud Dashboard will be handled and reported as a dispute or appeal, and appropriate acknowledgement and closure notices will be sent according to state requirement.

The claim reconsideration application will not be available for UnitedHealthcare Plan of the River Valley, Inc. (Commercial and UnitedHealthcare Community Plan), TRICARE West, UnitedHealthcare Community Plan of District of Columbia, UnitedHealthcare Community Plan of Kansas, UnitedHealthcare Community Plan of Louisiana, UnitedHealthcare Community Plan of District of Columbia, UnitedHealthcare Community Plan of Nevada, and UnitedHealthcare Community Plan of Texas claims.

UnitedHealth Premium® Designation Assessment Update

Updated UnitedHealth Premium designation assessment results will be available this fall and are based on an updated methodology and new time frame of paid claims (January 1, 2010 - February 28, 2013).

We will send the Premium designation assessment result letters to physicians and practice administrators in markets where the program is available and who are practicing in one of the 27* Premium-eligible specialties. Letters will include assessment results and instructions on how to access assessment reports.

Program and Methodology Updates

Enhanced Quality:

• Addition of appropriateness and outcomes measures for the OB-GYN specialty.

Enhanced Cost Efficiency:

• Evaluation of risk-adjusted population cost (total cost of care) in addition to episode cost for both primary care and select non-surgical specialist physicians.
• Addition of surgical episodes for the OB-GYN specialty.

Addition of New Specialties*:

• General Surgery
• General Surgery - Colon/Rectal
• Ophthalmology
• Ear Nose Throat
• Urology

For more information, call 866-270-5588 or go to UnitedHealthcareOnline.com and select "UnitedHealth Premium" on the top navigation bar to find resources and tools explaining the program. Be sure to check the Program News section on a regular basis for program updates.

1 The number of included specialties is subject to change if we conclude that data is insufficient for assessment of any of the following specialties: Ear Nose Throat, General Surgery, General Surgery - Colon/Rectal, Ophthalmology and Urology.

100@100 Survey Results: Centenarians Don’t Take Health for Granted

Over the years, we have found one constant with our 100@100 survey of centenarians: they do not take their health for granted. Again this year, the majority of survey participants said that they are exercising every week and making healthy choices when it comes to their diet.
This year’s findings also shed new light on how the oldest Americans are coping with the emotional and mental aspects of aging. Half of the 100-year-olds polled said they wouldn’t change a thing about the way they lived their lives. In comparison, just 29 percent of the 60-to 65-year-old baby boomer respondents said the same.

To find out more about how the attitudes and lifestyles of Americans entering their retirement years compare to those who have held the title of “senior citizen” for 35 years or more, view the full survey results here.

UnitedHealthcare serves more than 12,800 of the estimated 53,000 centenarians nationwide through its portfolio of Medicare health plans. The company conducts the 100@100 survey annually to learn about the secrets of longevity from America’s most senior seniors.

**Nationwide Quality Initiative**

In an effort to improve quality of care, UnitedHealthcare is working with Medicare Solutions members to close gaps in care. During telephone outreach calls, Optum health advocates and nurses will educate members about preventive care (e.g., mammograms, osteoporosis screenings) and medication adherence and encourage members to make appropriate appointments to close their gaps in care. Members will also be reminded about the Member Rewards program and will be offered assistance with transportation if needed.

The multi-state initiative began in April in Connecticut, Massachusetts, New Jersey, New York, Rhode Island and Vermont and will roll out nationally throughout the year. Please note that you may see an increase in office visits due to this initiative.

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**UnitedHealthcare Commercial: Important Changes to and Expansion of Radiology and CardiologyNotification and Prior Authorization Protocols – Effective July 1**

**Effective July 1, 2013,** UnitedHealthcare’s existing Outpatient Radiology Notification Protocol and Cardiology Notification Protocol will include a prior authorization requirement when a UnitedHealthcare commercial member’s benefit document requires health services to be medically necessary in order to be covered. For those members, after you notify UnitedHealthcare of a planned service subject to the protocols, we will conduct a clinical coverage review to determine whether the service is medically necessary and you will be informed of the decision. You do not need to determine whether a clinical coverage review is required in a given case or for a given member because we will advise you whether the review is required once you notify us of the planned service.

**Radiology Prior Authorization**

**Beginning July 1, 2013:**

Ordering providers that are subject to UnitedHealthcare’s Physician, Health Care Professional, Facility and Ancillary Provider 2013 Administrative Guide for Commercial and Medicare Advantage Products must notify UnitedHealthcare prior to scheduling certain CT, MRI/MRA, PET scan, nuclear medicine and nuclear cardiology procedures for UnitedHealthcare Commercial members. The advanced imaging procedures requiring advance notification are referred to as Advanced Outpatient Imaging Procedures. For a complete list of CPT codes requiring notification, please...
Once advance notification of a planned Advanced Outpatient Imaging Procedure is received, UnitedHealthcare will conduct a clinical coverage review to determine whether the service is medically necessary if the member’s benefit document requires health services to be medically necessary to be covered. If the member’s benefit document does not require clinical coverage review to determine medical necessity, and if the service does not meet evidence-based clinical guidelines, or if additional information is needed, we will let you know whether you must engage in a physician-to-physician discussion.

Treating providers that are subject to the Administrative Guide must confirm that the prior authorization process has been completed and a coverage decision has been issued before rendering any Advanced Outpatient Imaging Procedure. If the ordering provider does not participate in UnitedHealthcare’s network and is unwilling to complete the prior authorization process, the treating provider must complete the prior authorization process and verify that a coverage decision has been issued prior to rendering the Advanced Outpatient Imaging Procedure.

Providers are not required to notify UnitedHealthcare of any advanced imaging procedures rendered in an emergency room, urgent care center, observation unit or during an inpatient stay.

Cardiology Prior Authorization

Beginning July 1, 2013:

Treating providers that are subject to the Administrative Guide must notify UnitedHealthcare prior to scheduling any of the following services for UnitedHealthcare Commercial members:

- Diagnostic catheterizations
- Electrophysiology implants

Ordering providers that are subject to the Administrative Guide must notify UnitedHealthcare prior to scheduling any of the following services for UnitedHealthcare Commercial members:

- Echocardiograms
- Stress echocardiograms

The cardiology procedures for which advance notification is required are referred to as Cardiology Procedures. For a complete list of CPT codes requiring notification, please go to UnitedHealthcareOnline.com > Clinician Resources > Cardiology > Cardiology Notification Program > 2013 Cardiology Notification Table and CPT Code Crosswalk.
Once notification of a planned Cardiology Procedure is received, UnitedHealthcare will conduct a clinical coverage review to determine whether the service is medically necessary if the member’s benefit document requires health services to be medically necessary in order to be covered. If the member’s benefit document does not require clinical coverage review to determine medical necessity, and if the service does not meet evidence-based clinical guidelines, or if additional information is needed, we will let you know whether you must engage in a physician-to-physician discussion.

Treating providers that are subject to the Administrative Guide must confirm that the prior authorization process has been completed and verify that a coverage decision has been issued before rendering any Cardiology Procedure.

Providers must provide notification for cardiology procedures rendered in all settings (e.g., outpatient, inpatient and office-based). This new notification requirement does not apply to echocardiograms and stress echocardiograms rendered in an emergency room, observation unit, urgent care facility or during an inpatient stay.

To see the Commercial benefit plans subject to and excluded from the prior authorization requirements described in this article, see the Outpatient Radiology Notification Protocol and Cardiology Notification Protocol in the Administrative Guide. Please note that excluded plans may have separate radiology or cardiology prior authorization requirements. Please refer to the respective Supplements in the Administrative Guide for details.
Treating providers that practice in the states of Washington and Texas must confirm that the prior authorization process has been completed and a coverage decision has been issued before rendering any Advanced Outpatient Imaging Procedure. If the ordering provider does not participate in UnitedHealthcare’s network and is unwilling to complete the prior authorization process, the rendering provider must complete the prior authorization process and verify that a coverage decision has been issued before rendering the Advanced Outpatient Imaging Procedure.

Providers are not required to obtain prior authorization for any advanced imaging procedures rendered in the emergency room, urgent care center, observation unit, or during an inpatient stay.

Cardiology Prior Authorization

Beginning July 1, 2013, in Maryland and the state of Washington; beginning July 15, 2013 in Nebraska; beginning August 5, 2013 in Texas; and beginning September 1, 2013 in New Jersey, ordering providers that practice in these states must obtain prior authorization before scheduling any of the following services for UnitedHealthcare Community Plan members:

- Diagnostic catheterizations
- Electrophysiology implants
- Echocardiograms
- Stress echocardiograms

The cardiology procedures for which prior authorization is required are referred to as Cardiology Procedures. For a complete list of CPT codes requiring authorization, please go to UnitedHealthcareOnline.com > Clinician Resources > Cardiology. Once a prior authorization request for a planned Cardiology Procedure is received, UnitedHealthcare will conduct a clinical coverage review to determine whether the service is medically necessary and inform you of the decision.

Treating providers that practice in Maryland, Washington, Nebraska, Texas, and New Jersey must confirm that the prior authorization process has been completed and verify that a coverage decision has been issued before rendering any Cardiology Procedure.

Providers must obtain prior authorization for Cardiology Procedures rendered in all settings (e.g., outpatient, inpatient and office-based). This new requirement does not pertain to prior authorization for echocardiograms and stress echocardiograms rendered in an emergency room, observation unit, urgent care facility or during an inpatient stay.

For Florida Participating Providers Only: UnitedHealthcare Community Plan Prior Authorization Requirement – Outpatient Injectable Chemotherapy

Effective fourth quarter, 2013, UnitedHealthcare Community Plan will require all Florida participating providers who administer chemotherapy to our members on an outpatient basis to obtain a prior authorization.

Today’s UnitedHealthcare Community Plan drug policy which supports coverage based upon the National Comprehensive Cancer Network Drugs and Biologics Compendium will be used for coverage determination.

Details on how to obtain a prior authorization will be mailed to providers and included in an upcoming issue of the Network Bulletin.

Beginning July 1, 2013, participating physicians, facilities and other health care professionals that are subject to the Administrative Guide and practice in Idaho, Nebraska, Oregon and the state of Washington must obtain prior authorization for certain outpatient radiology and cardiology procedures before they are rendered to UnitedHealthcare Medicare Advantage members.

Radiology Prior Authorization
Beginning July 1, 2013:

Ordering providers that are subject to the Administrative Guide and practice in Idaho, Nebraska, Oregon and the state of Washington must obtain prior authorization before scheduling certain CT, MRI/MRA, PET scan, nuclear medicine and nuclear cardiology procedures for UnitedHealthcare Medicare Advantage members. The advanced imaging procedures requiring prior authorization are referred to as Advanced Outpatient Imaging Procedures. For a complete list of CPT Codes that require prior authorization, please go to UnitedHealthcareOnline.com > Clinician Resources > Radiology > Medicare Advantage Radiology Prior Authorization Program > 2013 Radiology Prior Notification/Authorization CPT Code List.

Once a prior authorization request for a planned Advanced Outpatient Imaging Procedure is received, UnitedHealthcare will conduct a clinical coverage review to determine whether the service is medically necessary and inform you of the decision.

Treating providers that are subject to the Administrative Guide and practice in Idaho, Nebraska, Oregon and the state of Washington must confirm that the prior authorization process has been completed and a coverage decision has been issued before rendering any Advanced Outpatient Imaging Procedure. If the ordering provider does not participate in UnitedHealthcare’s network and is unwilling to complete the prior authorization process, the treating provider must complete the prior authorization process and verify that a coverage decision has been issued before rendering the Advanced Outpatient Imaging Procedure.

Providers are not required to obtain prior authorization for any advanced imaging procedures rendered in an emergency room, urgent care center, observation unit or during an inpatient stay.

(continued on next page)
Cardiology Prior Authorization

Beginning July 1, 2013:

Ordering providers that are subject to the Administrative Guide and practice in Idaho, Nebraska, Oregon and the state of Washington must obtain prior authorization before scheduling any of the following services for UnitedHealthcare Medicare Advantage members:

- Diagnostic catheterizations
- Electrophysiology implants
- Echocardiograms
- Stress echocardiograms

The cardiology procedures for which prior authorization is required are referred to as Cardiology Procedures. To see a complete list of CPT codes requiring notification, please visit UnitedHealthcareOnline.com > Clinician Resources > Cardiology > Medicare Advantage Cardiology Prior Authorization Program > 2013 Cardiology Prior Authorization Table and CPT Code Crosswalk.

Once a prior authorization request for a planned Cardiology Procedure is received, UnitedHealthcare will conduct a clinical coverage review to determine whether the service is medically necessary and inform you of the decision.

Treating providers that are subject to the Administrative Guide and practice in Idaho, Nebraska, Oregon and the state of Washington must confirm that the prior authorization process has been completed and verify that a coverage decision has been issued before performing any Cardiology Procedure.

Prior authorization for diagnostic catheterizations, echocardiograms and stress echocardiograms is required for outpatient and office-based services only. Prior authorization for electrophysiology implants is required for outpatient, office-based and inpatient services. Cardiology Procedures performed in and appropriately billed with any of the following places of service do not require prior authorization: emergency room, urgent care center or inpatient setting (except for electrophysiology implants, which requires prior authorization during an inpatient stay).

To see the Medicare Advantage benefit plans that are subject to, and excluded from, the prior authorization requirements described in this article, see the Outpatient Radiology Prior Authorization Protocol and the Cardiology Prior Authorization Protocol in the Administrative Guide. Please note that excluded plans may have separate radiology or cardiology prior authorization requirements. Please refer to the respective Supplements in the Administrative Guide for details.

Additional Resource Information

Prior Authorization Process

Providers must:

a. Provide notification and complete the prior authorization process, and

b. Confirm that a coverage decision has been made as follows:

- Online at UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Radiology Notification & Authorization – Submission & Status
- Online at UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Cardiology Notification & Authorization – Submission & Status

Call 866-889-8054 (7 a.m. to 7 p.m., local time, Monday through Friday).

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Please note that payment for covered services is contingent upon coverage under the member's benefit plan, the provider's eligibility for payment, any claim processing requirements and the provider's participation agreement with UnitedHealthcare.

Failure to Complete the Prior Authorization Process and Meet Medical Necessity Criteria

Failure to provide notification and complete the prior authorization process, or verify that a coverage determination has been issued, prior to performing an Advanced Outpatient Imaging Procedure or Cardiology Procedure will result in an administrative claim reimbursement reduction, in part or in full. Members cannot be billed for claims that are administratively denied.

For Commercial benefit plans, a clinical denial will be issued, and a prior authorization number will not be issued, if it is determined during the clinical coverage review process that the service does not meet medical necessity criteria.

For UnitedHealthcare Community Plan and Medicare Advantage benefit plans, an authorization number is issued for both approved and clinically denied prior authorizations. A clinical denial will be issued if it is determined during the clinical coverage review process that the service does not meet medical necessity criteria. The clinical denial will be communicated by a letter faxed to the provider and mailed to the Medicare Advantage member.

Members can be billed for requested services that are clinically denied only if adequate written consent is obtained from the member before you perform the service.

Additional Information About the Process

UnitedHealthcare Commercial and Medicare Advantage Plans

More information regarding the requirements you must follow with respect to urgent requests and the retrospective notification process can be found in the Administrative Guide under:

a. Outpatient Radiology Notification Protocol for Commercial Members,

b. Outpatient Radiology Prior Authorization Protocol for Medicare Advantage Members,

c. Cardiology Notification Protocol for Commercial Members, and


When reviewing the Outpatient Radiology and Cardiology Notification Protocols for Commercial members, please remember that effective July 1, 2013, if the member's benefit document requires health services to be medically necessary in order to be covered, we will require prior authorization of the service.
UnitedHealthcare Community Plan

Additional information regarding the UnitedHealthcare Community Plan requirements, including the plans that are subject to the requirements set forth in this article, will be mailed to impacted providers.

For more information about the Radiology and Cardiology Prior Authorization programs, including Frequently Asked Questions and Quick Reference Guides, please go to UnitedHealthcareOnline.com > Clinician Resources (select Radiology or Cardiology).

If you have any questions, please contact your UnitedHealthcare Network Management representative at 800-637-5792; email radiology@customrelation.com or cardiology@customrelation.com for UnitedHealthcare Commercial and UnitedHealthcare Medicare Advantage plan requirements; or call 888-362-3368 for UnitedHealthcare Community Plan requirements.

New York State DOH Expands Meningococcal Vaccination Recommendation Statewide

The New York State Department of Health (DOH) has issued a health alert in response to a recent outbreak of invasive meningococcal disease in New York City. For more information, click here.

UnitedHealthcare Prior Authorization Requirement – Outpatient Injectable Chemotherapy – Florida Providers Only

Effective fourth quarter, 2013

UnitedHealthcare will require all Florida providers administering chemotherapy to UnitedHealthcare members on an outpatient basis to obtain a prior authorization.

Today’s UnitedHealthcare drug policy which supports coverage based upon the National Comprehensive Cancer Network Drugs & Biologics CompendiumTM will be used for coverage determination.

Details on how to obtain a prior authorization will be documented in a future Network Bulletin newsletter as well as letters to impacted providers.
UnitedHealthcare Medical Policy, Drug Policy, Coverage Determination Guidelines and Utilization Review Guidelines Updates

For complete details on new and/or revised policies and guidelines listed in the following table, refer to the monthly Medical Policy Update Bulletin at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines > Medical Policy Update Bulletin.

The appearance of a service or procedure on this list does not imply that UnitedHealthcare provides coverage for the service or procedure. In the event of an inconsistency or conflict between the information provided in this Bulletin and the posted policy, the provisions of the posted policy prevail.

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UnitedHealthcare Commercial Reimbursement Policy

Unless otherwise noted, these reimbursement policies apply to services reported using the 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent or its successor form. UnitedHealthcare reimbursement policies do not address all factors that affect reimbursement for services rendered to UnitedHealthcare members, including member benefit plan documents, UnitedHealthcare medical policies and the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide. Meeting the terms of a particular reimbursement policy is not a guarantee of payment. Once implemented the policies may be viewed in their entirety at UnitedHealthcareOnline.com >Tools & Resources > Policies and Protocols > Reimbursement Policies-Commercial. In the event of an inconsistency or conflict between the information provided in the Network Bulletin and the posted policy, the provisions of the posted policy prevail.
Correction: Physical Medicine and Rehabilitation: Speech Therapy Policy
An article in the March Network Bulletin incorrectly stated that UnitedHealthcare will not reimburse speech language therapists/pathologists for CPT code 97532. This code is, in fact, payable to speech language therapists/pathologists. We apologize for any confusion caused by this error.

Revision to the Radiology Multiple Imaging Reduction Policy
UnitedHealthcare currently applies an imaging reduction to the technical component of secondary and subsequent eligible diagnostic imaging services provided to the same patient during the same session by the same physician or health care professional.

To further align with the Centers for Medicare and Medicaid Services, UnitedHealthcare will change the Radiology Multiple Imaging Reduction Policy (RMIR) to administer the technical component reduction for secondary and subsequent diagnostic imaging services when provided on the same patient during the same session by the same group practice. Same group practice will be identified as all physicians or health care professionals reporting the same federal tax identification number.

This change will be effective fourth quarter of 2013.

Same Day, Same Service Policy Revised – Edits Being Added
CPT codes 90791, 90792, 90832, 90834 and 90837 will be added to the identical code logic, allowing these services to be reimbursed only once per day when reported by physicians of the same group and specialty on the same date of service. These edits follow correct coding guidelines as set forth by the American Medical Association and CMS, and will be implemented in the fourth quarter of 2013.

Revision to Add-on Policy – CPT 90460 With 90461
Effective in the fourth quarter of 2013, UnitedHealthcare’s Add-on Policy will consider the CPT add-on code +90461 (each additional vaccine or toxoid component administered) for reimbursement only when reported with the CPT primary code 90460 (immunization administration for a patient through age 18 via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered) on the same date of service by the same physician or other qualified healthcare professional.

According to AMA CPT guidelines, CPT 90460 should be used for each vaccine administered when the physician or other qualified health care professional provides face-to-face counseling to the patient/family during the administration of a vaccine. For vaccines with multiple components [combination vaccines], report CPT 90460 with CPT 90461 for each additional component in a given combination vaccine where face-to-face counseling has been provided. Per CPT guidelines, it is also appropriate to report CPT

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For more information, visit UnitedHealthcareOnline.com

90460 with an add-on code of 90472 or 90474 for immunization administration of each additional vaccine provided without face-to-face counseling.

It is our expectation that when physicians submit codes for administration of vaccines that include counseling about the multiple components, that the physicians have performed such multiple component counseling.

**Revision to the Professional/Technical Component Policy – Anatomic Modifiers Inclusion**

Consistent with Centers for Medicare and Medicaid Services guidelines, UnitedHealthcare will change the current list of modifiers that allows for reimbursement of duplicate submissions of the same code within the Professional/Technical Component Policy. The list will be expanded to include anatomic modifiers (E1, E2, E3, E4, LC, LD, LM, RC, RI, TA, T1, T2, T3, T4, T5, T6, T7, T8, T9, FA, F1, F2, F3, F4, F5, F6, F7, F8 and F9). These modifiers are used to report procedures performed on anatomical body parts such as, eyelids, fingers, toes and coronary arteries. The appropriate use of these modifiers will prevent claim line denials when duplicate procedures are performed on different anatomical sites or different sides of the body on the same date of service.

This revision will be effective in the third quarter of 2013.

**Professional/Technical Component Policy – Policy Language Revision**

The Professional/Technical Component Policy has undergone cosmetic and verbiage changes to more clearly state UnitedHealthcare’s reimbursement parameters for services where the professional/technical component concept applies, in accordance with the Centers for Medicare and Medicaid Services National Physician Fee Schedule. The policy intent and associated claims processing are unchanged. In addition, this publication includes the changes announced in the November 2012 Network Bulletin that were implemented in June 2013.

The new version of the policy was posted on June 24, 2013.

**Revision to the Multiple Procedure Policy**

UnitedHealthcare currently applies multiple procedure reductions for secondary and subsequent eligible surgical and medical procedures when they are provided on the same day to the same patient by the same physician or health care professional. To further align with CMS guidelines, UnitedHealthcare will change the Multiple Procedure Policy to administer multiple procedure reductions to eligible services provided on the same day and reported by the same group practice – which will be identified as all physicians and other health care professionals with the same federal tax identification number.

Services for physicians and non-physicians in the same group practice acting in different capacities (surgeon, co-surgeon, team surgeon and assist at surgery) will be ranked separately.

For example this means that all assistant surgeon services will be ranked separately for services reported by the group than those services reported by the group serving as the primary surgeon.

This change will be effective in the fourth quarter of 2013.
Revision to the Assistant Surgeon and Co-Surgeon/Team Surgeon Policies

To further align with CMS and the American Medical Association (AMA), the Assistant Surgeon and the Co-Surgeon/Team Surgeon Policies will be revised to reflect that assistant surgeon, co-surgeon and team surgeon services are not eligible for reimbursement when reported by surgical technicians/technologists.

Assistant at surgery eligible services should only be reported by:

• Physicians, using modifiers 80, 81, or 82 as appropriate.
• Physician assistants, nurse practitioners and clinical nurse specialists, using modifier AS.

Assistant at surgery services reported by surgical technicians/technologists are included in the payment to the facility and not separately reimbursed.

According to coding guidelines, co-surgeon and team surgeon services are only reimbursable to a physician and are identified by appending modifier 62 to the eligible procedure code.

These changes will be effective in the fourth quarter of 2013.

Reminder: Revision Coming to Rebundling Policy – Edits Being Added

Effective third quarter 2013, to align with CMS’ National Correct Coding Initiative (NCCI) and the AMA’s CPT, UnitedHealthcare will deny Evaluation and Management (E/M) services (CPT 99201-99380, 99401-99499) when reported on the same date of service as an immunization administration service (CPT codes 90460-90461 and 90471-90474). If the E/M code is reported with Modifier 25 indicating it is a significant and separately identifiable service provided on the same day, both codes would be reimbursed. According to correct coding guidelines, it is not appropriate to additionally report an E/M code for the counseling provided when a vaccine is administered. At this time, this policy change will not apply to preventive medicine services (CPT codes 99381-99397, HCPCS code G0402).

Inpatient Conversion to Observation Billing Required With Code 44

The following information can help you avoid problems when billing with Code 44.

Centers for Medicare and Medicaid Services (CMS) resources links:

• CMS, “Clarification of Medicare Payment Policy When Inpatient Admission is Determined Not to Be Medically Necessary,” MLN Matters® SE0622, on the Centers for Medicare and Medicaid Services (CMS) website.
• Condition Code 44: Inpatient admission changed to outpatient-For use on outpatient claims only, when the physician ordered inpatient services, but upon internal review performed before the claim was initially submitted, the hospital determined the services did not meet its inpatient criteria.

Including the Use of Condition Code 44: “Inpatient Admission Changed to Outpatient”, MLN Matters® SE0622, on the Centers for Medicare and Medicaid Services (CMS) website.

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Per the Medicare Managed Care Manual, chapter 13, section 150.2, Condition Code 44 requirements should be applied to members of Medicare Advantage plans.

Tips on avoiding problems when billing with Code 44:

The type of billing on the claim MUST match the physician order.

- Physician orders inpatient (IP), must bill IP (11x: For mandatory inpatient CPT coding procedures furnished during an inpatient stay covered under Part A, or 12x: for mandatory inpatient CPT coding procedures furnished to an inpatient where payment is under Part B because the stay is not covered under Part A). If a patient does not meet the inpatient level of care in its entirety, Condition Code 44 - Inpatient Admission Changed to Outpatient (OP), the provider must bill with a 12x.

- Physician orders observation (OBS) and there is no IP order, must bill OP.

- Physician orders do not have documentation for IP or OBs must bill outpatient.

Focus on the OBS order:

- If OBS is ordered, the facility cannot decide that the stay should be IP and bill IP unless there is a subsequent order to admit the patient by the physician responsible for the patient’s care at the hospital.

- If OBS is ordered and the patient is subsequently admitted based on an IP order, the admission must be medically reasonable and necessary at the time the order is written. In this case, charges for OBS are included on the IP bill.

- If IP is ordered, and the hospital wishes to change the patient to OBS, this can be done using condition code (CC) 44 if the practitioner responsible for the patient’s care agrees to the change and the patient is notified prior to discharge.

- Observation is a set of services provided to determine if the patient requires to be admitted to the hospital. It is not a status.

- No changes to a patient’s status (IP order or CC44) may be made after the patient has been discharged.

Resources:

- Medicare Claims Processing Manual, Chapter 1 - General Billing Requirements, 50.3.2 - Policy and Billing Instructions for Condition Code 44
- Medicare Managed Care Manual, Chapter 13, Section 150.2, Special Considerations

UnitedHealthcare Medicare Advantage Coverage Summary Updates

The following UnitedHealthcare Medicare Advantage coverage summaries were revised on Apr. 29, 2013. A detailed summary of the updates is available at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Medicare Advantage Coverage Summaries > Medicare Advantage Coverage Summary Updates: May 2013.

The appearance of a service or procedure on this list does not imply that UnitedHealthcare provides coverage for the service or procedure.
Title

Artificial Disc Replacement, Cervical and Lumbar (LARD)
Chiropractic Services
Cosmetic and Reconstructive Procedures
Experimental Procedures and Items, Investigational Devices and Clinical Trials
Genetic Testing
Home Health Services and Home Health Visits
Incontinence - Urinary and Fecal Incontinence, Diagnosis and Treatments
Laboratory Tests and Services
Mobility Assistive Equipment (MAE)
Observation Care (Outpatient Hospital)
Rehabilitation - Medical Rehabilitation (OT, PT and ST, including Cognitive Rehabilitation)
Respiratory Therapy, Pulmonary Rehabilitation and Pulmonary Services
Septoplasty, Rhinoplasty and Vestibular Stenosis Repair
Skilled Nursing Facility (SNF) Care and Exhaustion of SNF Benefits
Spine Procedures
Wound Treatments

CLARIFICATION: Notification/Prior Authorization Requirements List Effective January 1

The Notification/Prior Authorization Requirements List effective January 1, 2013 stated UnitedHealthcare Medicare Advantage members no longer require prior authorization for "Other than Home" services.

This update DOES NOT APPLY to UnitedHealthcare West Medicare Advantage members who are managed by delegated medical groups or who are referred to Optum Physical Health providers. Contracted Optum Physical Health facilities will still follow existing notification requirements and those Medicare Advantage members will be managed using current guidelines. Delegated medical groups must be contacted directly for authorizations for their members who will receive therapies at non-Optum Physical Health facilities.

Part D Vaccine Billing for Our Medicare Advantage Members

Payment for UnitedHealthcare Medicare Part D-covered vaccines and their administration are made solely by OptumRx, our pharmacy benefits manager. Part D vaccines cannot be processed under Part B medical benefits and therefore should not be submitted for payment directly to UnitedHealthcare.

Physicians participating with UnitedHealthcare’s Medicare Advantage products (Part B services) are not in-network with OptumRx for Part D services.

Seeing a non-participating provider for a Medicare Advantage member’s care can mean additional out-of-pocket costs for the member. In fact, members who have no

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out-of-network benefits may be responsible for the entire cost of the services received from non-participating providers.

To assist members in making informed health care decisions and effectively controlling their out-of-pocket costs please consider the following options:

1. Preferred Method: Web-Assisted Out-of-Network Billing: Physicians electronically submit member out-of-network claims to Part D plans for vaccines dispensed and administered in the physician’s office through a web-assisted portal. The physician is responsible for submitting the claim for the member and agrees to accept Part D plan payment as payment-in-full.

   To submit claims electronically, use TransactRx to file Part D claims to OptumRx. TransactRx is a service available to providers at no cost. A demo and subscription information are available at transactrx.com/physician-vaccine-billing.

2. Physicians may write their patient a prescription for preventive vaccines which can be administered at a contracted pharmacy. This option meets Part D requirements since the pharmacy will directly bill OptumRx for the vaccine. There is no up-front cost to the member other than the appropriate copayment.

OR

3. Physicians should advise members when they are not in-network for Part D services and let them know that their out-of-pocket costs may be higher by not using a participating provider. We also ask physicians to offer to refer these patients to a participating provider.

   • You may collect payment from our members for services not covered under the applicable benefit plan if you first obtain the member’s written consent.
   • A copy of the Advanced Notification of Non-Coverage (ANN) form and instructions for use can be found at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Protocols.

Contact Information:

Prescription Drug Plan
P.O. Box 29046
Hot Springs, AR 71903
Pharmacy Help Desk:
877-889-6481

Medicare Advantage Part D
P.O. Box 29045
Hot Springs, AR 71903
Pharmacy Help Desk:
877-889-6510

UnitedHealthcare Community Plan
Pharmacy Help Desk:
888-306-3243

General Commercial
Pharmacy Help Desk:
800-788-7871

For more information please reference the following sources:

CMS MLN Matters SE0727 Revised.

Reminder: Changes to Prior Authorization Requirements for Polysomnography and Portable Monitoring for Sleep-related Breathing Disorders for UnitedHealthcare Community Plan Members in Certain States¹

Effective for dates of service on and after July 1, 2013, UnitedHealthcare Community Plan members in Maryland, Michigan, Nebraska, New Jersey, New York, Ohio and Rhode Island require prior authorization for attended sleep testing performed in a health care facility. Effective for dates of service on or after August 1, 2013, UnitedHealthcare Community Plan members in the state of Tennessee will require prior authorization for attended sleep testing performed in a health care facility. Effective for dates of service on or after September 9, 2013, UnitedHealthcare Community Plan members in the state of Texas will require prior authorization for attended sleep testing performed in a health care facility. Prior authorization is not required for unattended sleep testing.

Please refer to the May 2013 Network Bulletin announcement for full details. IMPORTANT NOTE: As previously communicated, the May 2013 Network Bulletin had announced that UnitedHealthcare Community Plan Members in Tennessee would require prior authorization for attended sleep testing effective July 15, 2013 and members in Texas would require prior authorization for attended sleep testing effective August 1, 2013. The effective date for Tennessee members is August 1, 2013.

¹ Some states currently require prior authorization for sleep testing. Effective on the dates noted above only attended sleep testing will require prior authorization.

TRICARE Provider Webinar Available

TRICARE Basics for Medical/Surgical Professionals, Facility, and Ancillary Providers is now available at www.uhcmilitarywest.com. It is recommended for participating providers and office staff new to TRICARE.

This webinar reviews TRICARE programs for medical/surgical professionals, facility and ancillary providers as well as TRICARE and UnitedHealthcare Military & Veterans administrative requirements and provider resources.

The recorded webinar allows providers and their staff an opportunity to learn about TRICARE from their office, home or any location with Internet access at a time convenient for you. You will need headphones or speakers on your computer.

No pre-registration is required.
Website Provides Access to Tools to Help Manage TRICARE Beneficiaries

If you are a UnitedHealthcare Military & Veterans participating TRICARE provider, www.uhcmilitarywest.com is a great source for program information and tools to help you manage your TRICARE patients. To register and access these tools, please follow these steps:

1. From the Providers Overview page, click “Register Now.” https://prod.uhcmilitarywest.com/uhcmw/portal/provider/overview/

2. Select “Provider.”

3. Read the terms and conditions. Click “I Agree” at the bottom of the page.

4. Enter your first name, last name and zip code. Enter your tax ID, zip code, first name and last name. Enter an NPI, license number, or Medicare ID.

   Note that this information must match your UnitedHealthcare TRICARE contract information.

5. Create a username and password. Enter your email address.

6. Select a personal image and personal image phrase.

7. Select three challenge questions and provide answers.

8. Review your information and then activate your account.

Please contact us at 877-988-9378 (WEST) if you need assistance. For detailed instructions on how to register for the UnitedHealthcare Military & Veterans website, please go to www.uhcmilitarywest.com > “Providers” > “Quick Reference Guide.”

2013 TRICARE Provider Handbook – Revised June 1, 2013

An updated version of the UnitedHealthcare Military and Veterans TRICARE Provider Handbook was posted on June 1 to uhcmilitarywest.com > Providers. The updated version is also available at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols & Guides.

This revision of the Handbook contains only minor edits and updated references to the extended ICD-10 implementation date of October 2014.

Reminders of the existing requirements regarding Active Duty Service Members (ADSM) are highlighted as well. Please note that all civilian care requires prior approval from the ADSM’s Service Point of Contact. Please follow the UnitedHealthcare Military and Veterans Referral and Authorization request and inpatient admission notification processes as outlined in the TRICARE Provider Handbook.

Please refer to the new Handbook for complete information on these and other updates.
Pharmacy Update

Specialty Medication Prescriptions

As a reminder, UnitedHealthcare members who participate in our Specialty Designated Pharmacy Program must fill their specialty medication prescriptions at OptumRx or one of our designated specialty pharmacies (depending on therapeutic class) for maximum benefits.

Please send all specialty prescriptions directly to OptumRx or the appropriate designated specialty pharmacy.

After you call or fax a members’ prescription in, the member must call the designated specialty pharmacy or the number on the back of their ID card to coordinate payment and delivery of their specialty medication to their preferred address.

Program members who try to fill their specialty medication at a retail pharmacy instead of a designated specialty pharmacy will not be able to fill the prescription and will be directed to call OptumRx or the number on the back of their health plan ID card for assistance. OptumRx will assist members when urgent access to their specialty medication is needed to avoid a lapse in therapy.

Providers can send specialty prescriptions directly to OptumRx via:
  • Phone: 888-702-8423
  • Fax: 800-853-3844

To determine in-network designated pharmacies, please see the following list, visit UHC SpecialtyRx.com or call the Provider Services number listed on your patient’s health plan ID card.
Pharmacy Update

(continued from previous page)

The Specialty Designated Pharmacy Program aims to improve adherence and provide support and resources by specially trained pharmacists while helping control escalating specialty medication costs for members. Please visit [UHC SpecialtyRx.com](http://UHC SpecialtyRx.com), for more information.

<table>
<thead>
<tr>
<th>Therapeutic Class</th>
<th>Provider</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Cystic Fibrosis</td>
<td>OptumRx</td>
<td>888-739-5820</td>
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<tr>
<td>Hematologic</td>
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<td>Hepatitis B</td>
<td>CVS/Caremark (NJ)</td>
<td>877-287-1234</td>
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<td>HIV/AIDS</td>
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<tr>
<td>Immune Modulator</td>
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<td>Hepatitis C</td>
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<td>Neutropenia</td>
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<td>Freedom</td>
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<td>CVS/Caremark (NJ)</td>
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<tr>
<td>Oral Oncology</td>
<td>OptumRx</td>
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<tr>
<td></td>
<td>BioScrip</td>
<td>866-788-7710</td>
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<tr>
<td>Pulmonary Arterial Hypertension</td>
<td>Accredo</td>
<td>866-591-9075</td>
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<td>CVS/Caremark (NJ)</td>
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<td>Hemophilia</td>
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<td>Blood Center of Wisconsin</td>
<td>414-937-6160</td>
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<td>Hemophilia of Georgia</td>
<td>770-518-8272</td>
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<td>Cascade Hemophilia Consortium</td>
<td>800-996-2575</td>
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<td></td>
<td>Nationwide HTC</td>
<td>614-722-3250</td>
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</tbody>
</table>
After-Hours Care

To support your patients whom we insure in cases of emergency, you must provide access to after-hours care and ensure that patients calling your office after hours receive appropriate instructions based on their needs.

Urgent Care

In non-emergent situations, please advise callers who are unable to wait until the next business day to:

• Stay on the line to be connected to the doctor on call
• Leave a name and return telephone number for a physician or qualified health care professional to respond within a specified time frame
• Call an alternate phone or pager number to contact the physician on call
• Go to a contracted urgent care facility

Emergency Care

Whether your practice’s phone is answered live or by recording, callers with an emergency should be provided emergency instructions. These callers should be told to:

• Hang up and dial 911, or its local equivalent, or
• Go to the nearest emergency room if they are able to do so safely.

Arrange Substitute Coverage

If you are unavailable to provide care directly, please arrange care by another physician, hospital or health care provider who participates with UnitedHealthcare to ensure services are covered by the member’s in-network benefit. For the most current directory of our network physicians and health care professionals, go to UnitedHealthcareOnline.com.

Access to Care Standards

Accessibility to care, tests and treatment is a key driver of overall patient satisfaction both with the physician and the health plan. Per NCQA and regulatory requirements, and to support your practice in meeting patient needs in a timely way, we have established standards for appointment access and after-hours care for UnitedHealthcare members:

• Preventive Care: within four weeks
• Regular/Routine Care Appointment: within 14 days
• Urgent Care Appointment: same day
• Emergent Care Appointment: immediately
• After-Hours Care: 24 hours a day/seven days a week for PCPs

Some states have specific regulatory requirements that are more stringent. In those states, the state requirements supersede any UnitedHealthcare standard.
UnitedHealthcare and Harvard Pilgrim Health Care have had an alliance since 2005 that has resulted in a variety of innovative product offerings. This year, we have added some new joint products in 2013, that you may see at your facility or practice.

The following card examples are for products which use the UnitedHealthcare Choice Plus and Options Networks for services rendered outside of MA, ME and NH. Some of these joint products may be administered on different platforms, so please reference the back of the ID card for the corresponding contact and claims information.

(continued on next page)
The following card examples represent products which use the UnitedHealthcare Options Network for services rendered outside of MA, ME, NH, VT, RI and CT. Please remember to reference the back of the ID card for corresponding contact and claims information.

**Commercial Members’ Rights and Responsibilities**

Feel free to distribute the following information to your patients regarding their member rights and responsibilities. If your patients have questions about their rights as UnitedHealthcare members, or need help communicating, such as assistance from a language interpreter, please ask them to call the customer service phone number on the back of their health care member ID card.

**Member Rights and Responsibilities**

You have the right to:

- Be treated with respect and dignity by UnitedHealthcare personnel, network doctors and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive. See Notice of Privacy Practices in your benefit plan documents for a description of how UnitedHealthcare protects your personal health information.

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Doing Business Better

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- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your health plan or the care provided to you.
- Receive timely responses to your concerns.
- Participate in a candid discussion with your doctor and other health care professionals about appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Be provided with access to doctors, health care professionals and other health care facilities.
- Participate with your doctor and other health care professionals in decisions about your care.
- Receive and make recommendations regarding the organization’s rights and responsibilities policies.
- Receive information about UnitedHealthcare, our services, network doctors and other health care professionals.
- Be informed about and/or refuse to participate in any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an Advance Directive to designate the kind of care you wish to receive if you are unable to express your wishes.

You have the responsibility to:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your ID card before receiving health care services.
- Pay any necessary copayment at the time you receive treatment.
- Use emergency room services only for injury or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow agreed-upon instructions and guidelines of doctors and health care professionals.
- Participate in understanding your health problems and developing mutually agreed upon treatment goals.
- Notify your employer of changes in your address or family status.
- Visit myuhc.com, or call Customer Care if you have questions about your eligibility, benefits, claims and more.
- Go to myuhc.com, or call Customer Care to verify that your doctor or health care professional participates in the UnitedHealthcare network before receiving services.
**Depression, Alcohol and Drug Abuse/Addiction and ADHD Preventive Health Program**

United Behavioral Health has developed an online preventive health program which offers up-to-date information and practice tools to support your treatment of major depressive disorder, alcohol and drug abuse/addiction and Attention Deficit Hyperactivity Disorder (ADHD). A convenient, reliable and free source of pertinent health information, the preventive health program includes a library of articles addressing aspects of each condition; information about co-morbid conditions; links to nationally recognized practice guidelines; a printable self-appraisal to use or refer your patients to; and a listing of support resources for you, your patients and their families. Physicians and other health care professionals may access the program at [http://prevention.liveandworkwell.com](http://prevention.liveandworkwell.com).

**Postpartum Care**

Timely postpartum care contributes to successful health outcomes for women after delivery and is a measure of quality care. Since the period immediately following birth is when many physical and emotional adjustments occur, the postpartum visit is a good time to educate new mothers on what to expect and address any concerns. It is also an opportunity to schedule follow-up tests and exams and reinforce the importance of routine preventive health care.

The American College of Obstetricians and Gynecologists recommends that a routine postpartum visit occur between four and six weeks after delivery to assess the health of the infant, patient’s mood, contraceptive plan, return to sexual activity and breastfeeding.

UnitedHealthcare uses HEDIS guidelines to measure postpartum visit compliance. The standard is a postpartum visit on or between 21 and 56 days after delivery.

The following documentation should be included in the medical record:

- Date when the postpartum care visit occurred, and one of the following:
  - Pelvic exam - Evaluation of weight, blood pressure, breasts and abdomen (notation of “breastfeeding” is acceptable for “evaluation of breasts”).
  - Notation of “postpartum care,” such as: “PP care,” “PP check,” etc.
  - Preprinted “Postpartum Care” form in which info was documented during visit.

Here are tips for improving compliance with postpartum visits:

- Stress the importance of postpartum care during prenatal visits.
- Schedule the postpartum visit prior to discharge from the hospital.
- Provide an appointment reminder via phone call or postcard.
- Ensure proper documentation in medical record.
- Use of correct diagnosis and procedure codes.
UnitedHealthcare Controlled Substances Monitoring Program

Our Controlled Substances Monitoring Program identifies members who may be over-utilizing opioid analgesics, or seeking these medications inappropriately. The program is designed to make physicians aware of patients receiving opioids and, in some cases, other medications with a high potential for misuse and/or abuse from multiple physicians/prescribers. Program results show a decrease in the number of prescriptions per patient and a decrease in the use of multiple physicians and pharmacies.

We use the following criteria to identify potential medication misuse:

- Overlapping use of multiple controlled substances.
- Multiple providers prescribing the same or similar controlled substances.
- Multiple pharmacies dispensing the same or similar controlled substances.
- Physicians or prescribers associated with the identified members are given patient-specific prescription information through periodic confidential mailings to assist in the review of pharmacy utilization and are encouraged to contact identified members to facilitate appropriate treatment. In addition, you may be able to request access to state reporting systems through the Alliance of States with Prescription Monitoring Programs (pmalliance.org) to allow you to further identify patients who may be paying cash for opioids or controlled substances to avoid being identified.

Clinical Update

Chemotherapy Drug Review on Hospital Claims

Effective July 1, 2013 UnitedHealthcare changed our review process for chemotherapy drugs administered in an outpatient facility setting to align with our review process for chemotherapy drugs in a physician office setting.

Review process changes include:

- Outpatient claims with a date of service after the effective date or later will be reviewed using the NCCN Compendium.
- A primary cancer diagnosis is required on claims. Claims submitted with only a V58.1 diagnosis code may need more information before a coverage decision can be made.
- Claims submitted on a UB-04 form without injectable drug details (e.g., J code, NDC, charge amount, service units) may need more information before a coverage decision can be made.
- If the NCCN compendium lists the drug with a recommendation level 1, 2A or 2B for the condition, the service is eligible for reimbursement on the basis of the member’s coverage documents. Drugs that are not listed or which have a Level 3 recommendation are not covered unless the member has an exception in their coverage document.
- The NCCN updates its compendium frequently. New drugs and/or indications for a drug are not eligible for

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Claims, Billing and Coding

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reimbursement until a recommendation of 1, 2A or 2B for the condition is listed in the NCCN compendium.

You may have an outpatient chemotherapy regimen reviewed prior to service. To submit a predetermination request:

• Call 877-842-3210
• Fax to 866-756-9733
• Go to UnitedHealthcareOnline.com and submit a notification case.

Billing Without Appropriate Modifiers for DME Claims

We randomly review samples of claims submitted to ensure we meet Centers for Medicare and Medicaid (CMS) regulations and mandates. This also allows us to correct payment issues in a timely manner and update our processes and systems to prevent potential disruption to your business and our members.

Recently, we identified payment issues relating to some DME claims in which providers are billing without the appropriate modifiers. Per CMS regulations, providers must submit claims with the appropriate modifiers when the “indications and limitations of coverage and/or medical necessity” have been met.

UnitedHealthcare is updating our processes and policies to ensure they are fully compliant with these CMS regulations. The implementation date for these updates was January 1, 2013. As a result, providers must submit claims with the appropriate modifiers. Claims billed without the appropriate modifiers will be rejected for missing information.

This process will impact physician claims billed on the CMS-1500 form and 873P, for Medicare members. More information including a full list of CMS Local Coverage Determinations and requirements can be found at UnitedHealthcareOnline.com.

Advanced Claim Editing Coming Soon – New Clearinghouse Error Messages Save Time and Reduce Rejections

New error messages will appear on claims rejection reports as UnitedHealthcare deploys Advanced Claim Editing (ACE) to the electronic claim submission process for professional claims with Payer ID 87726. ACE returns pre-adjudicated claims through the claim acknowledgment (277CA) transaction report sent by your clearinghouse via your normal report format. Claims failing the pre-adjudication editing process are not forwarded to the claims adjudication system.

ACE works with your current clearinghouse workflow so you can modify claims before the UnitedHealthcare claim adjudication system receives them. If you choose not to change the claim, you can resubmit in its original format and it will pass to the UnitedHealthcare claim adjudication system for processing.

Benefits of using ACE include:

• Reduces the need to work on denied or rejected claims in the accounts receivable work stream.
• Automated and consistent standards for compliance.
• Fewer days in accounts receivable due to fewer denied claims.
• Detailed, actionable messages so you can easily modify claims.
• Reduced accounts receivable balances.
• Increased first-pass rates for claims.
• Reduced need for assistance and appeals.
• Shorter revenue cycle.

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ACE is available to you at no cost. You will receive the error messages along with the Health Insurance Portability and Accountability Act (HIPAA) edits you already receive. Here are the new error messages:

### 277CA Error Messages:

- Procedure Code XXXXX [AAA] and procedure code XXXYY [AAA] have an unbundle relationship. Review clinical documentation to determine if a modifier is appropriate.
- Procedure Code XXXXX is not permitted for a patient whose age is (XX years). The allowed age range for this procedure is XX years - XX years.
- Dx XXXXX is a nonspecific diagnosis code and requires a fourth and/or fifth digit.
- The Billing Provider ID is missing.
- Procedure Code XXXXX has been deleted as of MM/DD/YYYY.
- Procedure XXXXX is invalid, or procedure XXXXX is missing.
- Procedure Code XXXXX is not permitted for a patient whose gender is X.
- The beginning or ending Date of Service (MM/DD/YYYY) is invalid or missing.
- The place of service XX is invalid, or the place of service is missing.
- Patients Date of Birth is missing, or Patients Date of Birth (MM/DD/YYYY) is invalid.
- The patient ID is missing.
- The Billing Provider Taxonomy or Specialty code is missing, or the Billing Provider Taxonomy or XXX Specialty code is invalid.
- The Gender for this patient is missing or the Gender X for this patient is invalid.
- The diagnosis XXXX is invalid
- Dx XXXXX is not permitted for a patient whose gender is Y.
- Modifier XX is not valid.
- Dx XXX has been deleted.

If you have any questions, please contact your clearinghouse. For more information contact Adam Rein at adam_c_rein@uhc.com.
Neighborhood Health Partnership Prior Authorization Requirement – Outpatient Injectable Chemotherapy

Effective fourth quarter, 2013 Neighborhood Health Partnership’s process for submitting the required prior authorization for outpatient therapy will change. Details on how to obtain a prior authorization will be mailed to impacted providers and updates will be included in upcoming issues of the Network Bulletin.

Additional Precertification Codes for Neighborhood Health Partnership – Outpatient Echocardiogram

For dates of service on or after July 1, 2013, Neighborhood Health Partnership will require the ordering physician to provide precertification for the following outpatient echocardiogram procedure CPT codes: 93303, 93304, 93306, 93307 and 93308. This is in addition to the current Stress Echo CPT codes 93350 and 93351.

CareCore National will process preauthorization requests and make medical necessity determinations based on evidence-based clinical guidelines on our behalf. CareCore is an outpatient diagnostic imaging utilization management service provider that manages quality and use of outpatient diagnostic and cardiac imaging, cardiac implantable devices, oncology drugs and therapeutic agents, radiation therapy, sleep, pain and lab services.

Submit requests by:

- Phone: 866-242-9546 Monday–Friday, 7 a.m. –7 p.m. (EST)
- Online: mynhp.com > access e-services.

For information about preauthorization requirements, please go to mynhp.com.

Effective July 1, 2013, the retrospective review process for Cardiac Catheterization and Electrophysiology Implants will only apply to urgent, emergent or after-hours procedures, changing from 30 days to 15 days.

Outpatient Cardiology Stress Echocardiograms and Echocardiograms for UnitedHealthcare of River Valley

For dates of service on or after July 1, 2013, ordering physicians for UnitedHealthcare of River Valley must obtain prior authorization for outpatient stress echocardiograms and echocardiograms. The CPT codes subject to this requirement are:

Echocardiogram

- CPT Codes: 93303, 93304, 93306, 93307, 93308

Stress Echocardiogram

- CPT Codes: 93350, 93351

CareCore National will process all preauthorization requests for these procedures and make all medical necessity determinations based upon evidence-based clinical guidelines. Please submit all requests by calling 866-889-8054 from 7 a.m. to 7 p.m. local time or online at UHCRiverValley.com > eServices. Additional information regarding these preauthorization requirements are available at UHCRiverValley.com > preauthorization > procedures.

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Effective July 1, 2013, the retrospective review process for cardiac catheterization and electrophysiology implants only applies to urgent, emergent or after hours procedures, changing from 30 days to 15 days.

New Precertification Requirements for Non-preferred Diabetes Medications and Test Strips for Oxford Members Pharmacy

Effective July 1, 2013, Oxford Health Plans in Connecticut and New York will implement new precertification requirements for Oxford fully-insured members who use certain non-preferred diabetes medications and test strips.

Precertification will be required for Oxford members to continue to receive coverage for a non-preferred product. Please write a new prescription for a preferred alternative for these patients. If a preferred alternative is not appropriate, beginning July 1, 2013 you must submit a request for precertification by taking the following steps:

• Verify your patient’s eligibility and benefits by calling 800-666-1353.
• After eligibility and benefits are confirmed and your initial evaluation is complete, please request a precertification review for the diabetes medications and supplies.
• Please complete the precertification form and return via fax to 800-837-0959.

After receiving your request for precertification, Oxford will evaluate it and notify both you and your patient by mail of our decision.

Here is information regarding the preferred and non-preferred product options:

Glucose Test Strips and Meters*

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<thead>
<tr>
<th>Non-PREFERRED Products - Require Precertification</th>
<th>Preferred Products - No Precertification Required</th>
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<tbody>
<tr>
<td>Bayer Healthcare</td>
<td>Ascensia Autodisc</td>
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<tr>
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<td>Breeze 2</td>
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<tr>
<td></td>
<td>Contour</td>
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<td>Contour Next</td>
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<tr>
<td>Abbott Diabetes</td>
<td>Freestyle Insulinx</td>
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<td>Freestyle Lite</td>
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<td>Freestyle</td>
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<td></td>
<td>Precision Xtra</td>
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</table>

* Members switching to a preferred test strip will be eligible for a free glucose meter.

Insulin Vials/Pens/Cartridges

<table>
<thead>
<tr>
<th>Non-PREFERRED Products - Require Precertification</th>
<th>Preferred Products - No Precertification Required</th>
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</thead>
<tbody>
<tr>
<td>Apidra/Apidra Solostar</td>
<td>Novolin 70-30</td>
</tr>
<tr>
<td>Novolog</td>
<td>Novolin N</td>
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<tr>
<td>Novolog Mix 70-30</td>
<td>Novolin R</td>
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Select Oral Diabetic Agents for controlling blood sugar (DPP-4 Inhibitors)

Letters were mailed to members taking a non-preferred drug listed in the table above in late April, and in late May, notifying them of the change.

Visit OXHP.com/secure/policy/medical_administrative_policy_index.html to access the diabetes clinical policy update on documentation requirements and evaluation criteria for determination of coverage.

Affiliates

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SignatureValue™ Medical Management Guideline Updates

The following SignatureValue Medical Management Guidelines were recently adopted or revised. A detailed summary of the updates is available at UHCWest.com > Provider Log In > Library > Resource Center > Guidelines & Interpretation Manuals.

The appearance of a service or procedure on this list does not imply that coverage is provided for the service or procedure.

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<th>Effective Date</th>
<th>Update Bulletin</th>
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<td>May 1, 2013</td>
<td>Medical Management Guideline Updates: May 2013</td>
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<td>Chromosome Microarray Testing</td>
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<td>Home Health Care</td>
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<td>Private Duty Nursing Services (PDN)</td>
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### Affiliates

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<td>Ablative Treatment for Spinal Pain</td>
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<td>Apheresis</td>
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<td>June 1, 2013</td>
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<tr>
<td>Breast Imaging for Screening and Diagnosing Cancer</td>
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<tr>
<td>Breast Repair/Reconstruction Not Following Mastectomy</td>
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<td>Medical Management Guideline Updates: May 2013</td>
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<td>Chelation Therapy for Non-Overload Conditions</td>
<td>May 1, 2013</td>
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<td>Chronic Obstructive Pulmonary Disease: Clinical Practice Guideline</td>
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<td>Chronic Stable Angina: Clinical Practice Guideline</td>
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<td>Cochlear Implants</td>
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<td>Gait Analysis</td>
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<td>Intermittent Intravenous Insulin Therapy</td>
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<td>Medical Management Guideline Updates: May 2013</td>
</tr>
<tr>
<td>Mechanical Stretching and Continuous Passive Motion Devices</td>
<td>June 1, 2013</td>
<td>Medical Management Guideline Updates: June 2013</td>
</tr>
<tr>
<td>Glaucoma Surgical Treatments</td>
<td>June 1, 2013</td>
<td>Medical Management Guideline Updates: June 2013</td>
</tr>
<tr>
<td>Gynecomastia</td>
<td>June 1, 2013</td>
<td>Medical Management Guideline Updates: June 2013</td>
</tr>
<tr>
<td>In Utero Fetal Surgery</td>
<td>May 1, 2013</td>
<td>Medical Management Guideline Updates: May 2013</td>
</tr>
<tr>
<td>Intermittent Intravenous Insulin Therapy</td>
<td>May 1, 2013</td>
<td>Medical Management Guideline Updates: May 2013</td>
</tr>
<tr>
<td>Non-Surgical Treatment of Obstructive Sleep Apnea</td>
<td>June 1, 2013</td>
<td>Medical Management Guideline Updates: June 2013</td>
</tr>
<tr>
<td>Occipital Neuralgia</td>
<td>May 1, 2013</td>
<td>Medical Management Guideline Updates: May 2013</td>
</tr>
<tr>
<td>Prolotherapy for Musculoskeletal Indications</td>
<td>June 1, 2013</td>
<td>Medical Management Guideline Updates: June 2013</td>
</tr>
<tr>
<td>Proton Beam Radiation Therapy</td>
<td>May 1, 2013</td>
<td>Medical Management Guideline Updates: May 2013</td>
</tr>
<tr>
<td>Surgical Treatment of Obstructive Sleep Apnea</td>
<td>June 1, 2013</td>
<td>Medical Management Guideline Updates: June 2013</td>
</tr>
<tr>
<td>Thermal Capsulorrhaphy/Thermal Shrinkage Therapy</td>
<td>May 1, 2013</td>
<td>Medical Management Guideline Updates: May 2013</td>
</tr>
<tr>
<td>Thermography</td>
<td>May 1, 2013</td>
<td>Medical Management Guideline Updates: May 2013</td>
</tr>
</tbody>
</table>
**SignatureValue™ Benefit Interpretation Policy Updates**

The following SignatureValue™ Benefit Interpretation Policies were updated or revised effective June 1, 2013. A detailed summary of the updates is available for your reference on UHCWest.com > Provider Log In > Library > Resource Center > Guidelines & Interpretation Manuals > Benefit Interpretation Policy Updates: June 2013.

The appearance of an item or procedure in the table below indicates only that UnitedHealthcare has recently adopted or revised a SignatureValue™ Benefit Interpretation Policy; it does not imply that coverage is provided for the item or procedure listed.

<table>
<thead>
<tr>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UPDATED (FOR ALL STATES)</strong></td>
</tr>
<tr>
<td>• Biofeedback</td>
</tr>
<tr>
<td>• Change in Membership Status While Hospitalized</td>
</tr>
<tr>
<td>• Emergency and Urgent Services</td>
</tr>
<tr>
<td>• Family Planning: Birth Control</td>
</tr>
<tr>
<td>• Family Planning: Infertility Services</td>
</tr>
<tr>
<td>• Foot Care and Podiatry Services</td>
</tr>
<tr>
<td>• Incontinence Control (Adult)</td>
</tr>
<tr>
<td>• Medications (Oral, Infusion, Injectable) and Off-Label Drug Use</td>
</tr>
<tr>
<td>• Ostomy Supplies</td>
</tr>
<tr>
<td>• Rehabilitation: Chemical Dependency/Substance Use Disorder</td>
</tr>
<tr>
<td>• Services While Confined/Incarcerated</td>
</tr>
<tr>
<td>• Shoes and Foot Orthotics</td>
</tr>
<tr>
<td>• Vision Care and Services</td>
</tr>
<tr>
<td><strong>REVISED (FOR STATE OF CALIFORNIA ONLY)</strong></td>
</tr>
<tr>
<td>• Home Health Care &amp; Home Visits</td>
</tr>
<tr>
<td>• Mental Health: Inpatient Mental Health</td>
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<tr>
<td>• Mental Health: Outpatient Mental Health</td>
</tr>
<tr>
<td>• Pervasive Developmental Disorder</td>
</tr>
<tr>
<td>• Preventive Services/Periodic Health Examinations</td>
</tr>
<tr>
<td>• Radiology: Diagnostic and Therapeutic Radiology Services</td>
</tr>
</tbody>
</table>
UnitedHealthcare West EDI Update

Electronic Data Interchange (EDI) modifications for UnitedHealthcare West occurred during the implementation of version 5010 transactions. They include:

• New Payer ID for submitting EDI transactions
• Submission of secondary/coordination of benefits (COB) claims electronically

UnitedHealthcare West EDI Transactions and Payer ID Updates

<table>
<thead>
<tr>
<th>Function</th>
<th>EDI Transaction Number</th>
<th>EDI Payer ID</th>
<th>Former Payer IDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Payable Claims (primary and secondary)</td>
<td>837P</td>
<td>87726</td>
<td>95959, 95962, 95964, 95999</td>
</tr>
<tr>
<td>Institutional Payable Claims (primary and secondary)</td>
<td>837I</td>
<td>87726</td>
<td>95959, 95962, 95964, 95999</td>
</tr>
<tr>
<td>Professional Non-Payable Encounters (primary and secondary)</td>
<td>837P</td>
<td>95958 Enrollment and testing through your clearinghouse are required</td>
<td>No change</td>
</tr>
<tr>
<td>Institutional Non-Payable Encounters (primary and secondary)</td>
<td>837I</td>
<td>95958 Enrollment and testing through your clearinghouse are required</td>
<td>No change</td>
</tr>
<tr>
<td>Health Care Eligibility Benefit Inquiry and Response</td>
<td>270/271</td>
<td>87726</td>
<td>95959, 95962, 95964, 95999</td>
</tr>
<tr>
<td>Health Care Claim Status Request and Response</td>
<td>276/277</td>
<td>87726</td>
<td>95959, 95962, 95964, 95999</td>
</tr>
<tr>
<td>Health Care Claim Payment Advice ERA</td>
<td>835</td>
<td>Check with your clearinghouse</td>
<td>N/A</td>
</tr>
<tr>
<td>Electronic Funds Transfer Authorization Agreement required.</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Check with your software vendor, clearinghouse, or IT department for verification and instructions on performing electronic transactions via your practice management or hospital information system.

Please refer to our Companion Guides for detailed information on the required data elements for each EDI transaction. If you have questions, please contact our EDI Support Team at edisupport@uhc.com, visit our website at UHCWest.com or call 800-203-7729.
**UnitedHealthcare of the River Valley Preauthorization List and Policy Updates**

The following updates apply to UnitedHealthcare of the River Valley commercial and hawk-i plan members only. They do not apply to members enrolled in a River Valley Ohio or South Carolina product. The new and/or revised policies and guidelines in the following table may be viewed at UHCRiverValley.com > Providers > Coverage Policy Library.

The appearance of a service or procedure on this list does not imply that UnitedHealthcare of the River Valley provides coverage for the service or procedure. In the event of an inconsistency or conflict between the information provided in this bulletin and the posted policy, the provisions of the posted policy will prevail.

<table>
<thead>
<tr>
<th>Policy Title</th>
<th>Effective Date</th>
<th>What's Changed</th>
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<tbody>
<tr>
<td><strong>NEW</strong></td>
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</table>
| Custodial and Skilled Care Services               | Sep. 1, 2013   | This policy details benefit considerations, indications for coverage, coverage limitations/exclusions, and applicable CPT and HCPCS codes requiring preauthorization for the following services:  
* Skilled care; including skilled observation and assessment, skilled teaching, skilled rehabilitation and skilled care in an inpatient setting,  
* Custodial care,  
* Non-skilled services, and  
* Respite care  
Refer to the policy for complete details. |
• CPT codes 63650, 63655 and 63685 require preauthorization |
| Outpatient Echocardiogram and Stress Echocardiogram Procedures | July 1, 2013 | For dates of service on or after July 1, 2013, ordering physicians must obtain prior authorization for outpatient stress echocardiogram and echocardiogram. The CPT codes subject to this requirement are:  
* Echocardiogram CPT Codes: 93303, 93304, 93306, 93307, 93308  
* Stress Echo CPT Codes: 93350, 93351  
CareCore National will process preauthorization requests for these procedures and make medical necessity determinations based on evidence-based clinical guidelines.  
Ordering physicians should submit requests by calling 866-889-8054, 7 a.m. -7 p.m. time zone specific or online at UHCRiverValley.com > e-services.  
Additional information regarding these preauthorization requirements are available at UHCRiverValley.com > Preauthorization > Procedures > Diagnostic Catheterizations, Electrophysiology Implant Procedures, Echocardiogram and Stress Echocardiogram Procedures. |

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## Affiliates

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<tr>
<td><strong>REVISED</strong></td>
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</tbody>
</table>
| Ablative Treatment for Spinal Pain                     | Sep. 1, 2013   | • Updated description of services to reflect most current clinical evidence and references  
• Reformatted coverage rationale  
• Revised list of applicable CPT codes; changed coverage status for 64633 - 64636* from "covered" to "requires preauthorization"  
*Although the list of applicable CPT codes in the currently published policy version already reflects this information, this guideline may not have been previously applied due to a system error. |
| Abnormal Uterine Bleeding and Uterine Fibroids          | Sep. 1, 2013   | • Revised coverage rationale; added language to indicate the Mirena® levonorgestrel-releasing intrauterine device (LNG-IUD) is medically necessary for treating menorrhagia in premenopausal women (no other LNG-IUDs have been U.S. Food and Drug Administration (FDA) approved for this indication)  
• Revised list of applicable CPT codes (for uterine fibroids); changed coverage status for 37210 from "covered" to "requires preauthorization" |
| Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes | Sep. 1, 2013 | • Updated description of services to reflect most current clinical evidence and references  
• Revised coverage rationale:  
  • Updated list of medically necessary indications for long-term continuous glucose monitoring, alone or in combination with an external insulin pump; added frequent episodes of hypoglycemia  
• Revised list of applicable CPT/HCPCS codes:  
  • Changed coverage status for 95250, 95251, A9274 and E0784 from "covered" to "requires preauthorization"  
  • Changed coverage status for A9275 from "not covered" to "covered" |
| Corneal Hysteresis and Intraocular Pressure             | Sep. 1, 2013   | • Updated description of services to reflect most current clinical evidence and references  
• Revised coverage rationale; added language to indicate continuous monitoring of intraocular pressure for 24 hours or longer in patients with glaucoma is not considered to be medically necessary  
• Updated list of applicable (not medically necessary) CPT codes to reflect quarterly code updates (effective July 1, 2013); added 0329T |
| Erbitux (Cetuximab)                                     | Aug. 1, 2013   | • Updated description of services to reflect most current CMS information and references; no change to coverage rationale  
• Updated benefit considerations; added language to indicate benefit coverage for an otherwise unproven/not medically necessary service for the treatment of serious rare diseases may occur when certain conditions are met |

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### Affiliates

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<td>REVISED</td>
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</table>
| Gene Expression Tests        | Sep. 1, 2013   | • Updated description of services to reflect most current clinical evidence and references  
• Revised coverage rationale:  
  • Changed coverage status from “not covered” to “requires review”  
• Added language for oncology related services/treatment to indicate:  
  • Multi-panel gene expression tests (e.g., Afirma®) are medically necessary for assessing thyroid nodules that are not clearly benign or malignant based on fine-needle aspiration biopsy results alone  
  • Gene expression tests are not medically necessary for predicting metastatic risk of uveal melanoma (e.g., DecisionDx-UM)  
  • Added list of applicable ICD-9 diagnosis codes  
  • Added list of applicable ICD-10 diagnosis codes (preview draft effective Oct. 1, 2014) |
| Glaucoma Surgical Treatments | Sep. 1, 2013   | • Updated description of services to reflect most current clinical evidence and references  
• Revised coverage rationale for the iStent® Trabecular Micro-Bypass Stent System; changed coverage status from “unproven/not medically necessary” to “medically necessary in certain circumstances”  
  • Added language to indicate the iStent® Trabecular Micro-Bypass Stent System is medically necessary when used in combination with cataract surgery to treat mild to moderate open-angle glaucoma and a cataract in adults currently being treated with ocular hypotensive medication  
  • Added language to indicate the use of aqueous shunts or glaucoma drainage devices with the iStent® Trabecular Micro-Bypass Stent System is medically necessary for treatment of refractory glaucoma when there is intolerance, contraindication, or failure of topical or oral medication  
• Revised list of applicable CPT codes:  
  • Changed coverage status for 0191T and 0253T from “not covered” to “requires preauthorization”  
  • Changed coverage status for 0192T from “covered” to “requires preauthorization” |

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## Affiliates

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<tbody>
<tr>
<td>REVISED</td>
<td></td>
<td><strong>Revised coverage rationale:</strong></td>
</tr>
<tr>
<td>Gynecomastia Treatment</td>
<td>Sep. 1, 2013</td>
<td><strong>Documentation Requirement:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated/replaced reference to &quot;contemporaneous physician office notes&quot; with &quot;physician office notes&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated/replaced requirement for &quot;a well-defined physical and/or physiological abnormality resulting in a medical condition that has required or requires treatment&quot; with &quot;a physical and/or physiological abnormality resulting in a medical condition that has required or requires treatment&quot;</td>
</tr>
<tr>
<td></td>
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<td>• Updated/replaced requirement indicating &quot;the physical and/or physiological abnormality has resulted in a functional impairment&quot; with &quot;the physical and/or physiological abnormality has resulted in a functional/physical impairment&quot;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated/replaced requirement for &quot;frontal and lateral high-quality color photographs of the torso&quot; with &quot;frontal and lateral photographs of the torso&quot;</td>
</tr>
<tr>
<td></td>
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<td>• Removed language indicating the enrollee's identification must be documented on the photograph using either name or health plan identification number</td>
</tr>
</tbody>
</table>
|                              |                | • Updated/replaced requirement for "history of prior medication use (e.g., testosterone for low testosterone level)" with "history of prior and current medication use including prescription, over the counter medications and illicit drugs (some examples include, but are not limited to testosterone, marijuana, asthma drugs, phenothiazines, anabolic steroids, cimetidine and calcium channel blockers)"
|                              |                | • Updated/replaced requirement for "treatment plan that must include the proposed procedures and the expected outcome for the improvement of functional impairment" with "treatment plan that must include the proposed procedures and the expected outcome for the improvement of functional/physical impairment"
|                              |                | **Criteria for a Coverage Determination That Surgery is Reconstructive and Medically Necessary**                                                                 |
|                              |                | Revised guidelines for male patient under age 18; added criteria to indicate:                                                                 |
|                              |                | • The breast enlargement must be present for at least 2 years. If so, lab tests which might include, but are not limited to the following must be performed:
|                              |                | • Thyroid function studies                                                                                                                     |
|                              |                | • Testosterone                                                                                                                                |
|                              |                | • Beta subunit HCG                                                                                                                               |
|                              |                | • If a functional/physical impairment is present, a clinical review is required to determine if it meets reconstructive criteria                  |

(continued on next page)
## Policy Title  | Effective Date  | What's Changed
--- | --- | ---
**REVISED** |  | Revised guidelines for male patient age 18 and up:  
- Updated/replaced criteria indicating “gynecomastia or breast enlargement with moderate to severe chest pain that is causing a functional impairment” with “gynecomastia or breast enlargement with moderate to severe chest pain that is causing a functional/physical impairment”  
- Updated/replaced language indicating “the inability to participate in athletic events, sports or social activities is not considered to be a functional or physiological impairment” with “the inability to participate in athletic events, sports or social activities is not considered to be a functional/physical or physiological impairment”  
- Updated list of tests (examples) performed to rule out certain diseases or other causes of gynecomastia; removed:  
  - Breast ultrasound  
  - Mammogram  
- Added new/additional criterion to indicate if a tumor or neoplasm is suspected then a breast ultrasound and/or mammogram may be performed; as indicated, a breast biopsy may also be performed
|  | Sep. 1, 2013 | Added reference link to related policies titled:  
- Custodial and Skilled Care Services  
- Private Duty Nursing  
- Revised coverage rationale; added indications for coverage and coverage limitations/exclusions  
- Added list of applicable definitions:  
  - Intermittent/part-time home health services  
  - Intermittent visit  
  - Place of residence  
  - Skilled care  
- Added list of applicable CPT and HCPCS codes for home health and home IV infusion (preauthorization required)
| **Immune Globulin (IVIG and SCIG)** | Aug. 1, 2013 | Revised coverage rationale; updated medical necessity criteria for:  
- Bone marrow transplantation (BMT), prevention of acute graft vs. host disease (GVHD) after BMT: Changed IVIG dosing guideline from “500 mg/kg once weekly for the first 90 days of therapy” to “500 mg/kg once weekly for the first 90 days of therapy, then monthly up to day 360 after transplantation”

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# Affiliates

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<table>
<thead>
<tr>
<th>Policy Title</th>
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</table>
| **REVISED**                                      |                | * Bone marrow transplantation (BMT), prevention of infection after BMT: Changed IVIG dosing guideline from “500 mg/kg once weekly for the first 90 days of therapy” to “500 mg/kg once weekly for the first 90 days of therapy, then monthly up to day 360 after transplantation”  
* Fetomaternal alloimmune thrombocytopenia: Changed IVIG dosing guideline from “1,000 mg/kg for 2 days” to “1,000 mg/kg once weekly until delivery” |
| Maximum Dosage Policy                            | Aug. 1, 2013   | * Updated description of services to reflect most current clinical evidence, CMS information and references  
* Revised coverage rationale; updated maximum dosage information to indicate:  
  * Bevacizumab (J9035): Limited to 179 HCPCS units (10 mg per unit) which is a maximum dosage per administration of 15 mg/kg  
  * Infliximab (J1745): Limited to 119 HCPCS units (10 mg per unit) which is a maximum dosage per administration of 10 mg/kg  
  * Pegfilgrastim (J2505): Limited to 1 HCPCS unit (6 mg per unit) which is a maximum dosage per administration of 6 mg total dose  
  * Rituximab (J9310): Limited to 13 HCPCS units (100 mg per unit) which is a maximum dosage per administration of 1,225 mg total dose  
  * Trastuzumab (J9355): Limited to 95 HCPCS units (10 mg per unit) which is a maximum dosage per administration of 8 mg/kg  
  * Zoledronic acid (J3487): Limited to 4 HCPCS units (1 mg per unit) which is a maximum dosage per administration of 4 mg total dose  
* Updated benefit considerations; added language to indicate benefit coverage for an otherwise unproven/not medically necessary service for the treatment of serious rare diseases may occur when certain conditions are met |
| Mechanical Stretching and Continuous Passive Motion Devices | Sep. 1, 2013   | Revised coverage rationale for clarification:  
* Updated coverage statement to indicate:  
  * The use of continuous passive motion (CPM) devices is medically necessary for the prevention of joint contractures of the upper and lower extremities  
  * The use of low-load prolonged-duration stretch devices is medically necessary for the treatment of existing joint contractures of the upper and lower extremities |

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</table>
| **REVISED**                                     |                | • Updated information pertaining to medical necessity review; added language to indicate:  
  • Low-load prolonged duration stretch devices are medically necessary for the treatment of existing joint contractures of the upper and lower extremities  
  • Continuous passive motion devices are medically necessary for patients in the immediate post-operative phase of joint surgery as an adjunct to (and not replacement of) physical therapy to prevent contractures of the joints of the upper and/or lower extremities  
  Revised list of applicable (medically necessary) HCPCS codes; changed coverage status for E1800, E1802, E1805, E1810, E1812, E1815, E1825, E1830 and E1840 from "covered" to "requires preauthorization" |
| Nonsurgical Treatment of Obstructive Sleep Apnea | Sep. 1, 2013   | • Updated description of services to reflect most current clinical evidence and references; no change to coverage rationale  
  • Updated list of applicable ICD-9 diagnosis codes; added 327.27  
  • Updated list of applicable ICD-10 diagnosis codes (preview draft effective Oct. 1, 2014)                                                                                                                                                                                                 |
| Omnibus Codes                                   | Sep. 1, 2013   | Revised coverage rationale (to reflect quarterly code edits); added language to indicate the following services are not medically necessary:  
  • CPT code 0330T: Tear film imaging to monitor or assess tear film disorders  
  • CPT codes 0331T and 0332T: Myocardial sympathetic innervation imaging  
  • CPT code 99174: Instrument-based ocular screening using photoscreening or automated refraction                                                                                                                                               |
| Platelet Derived Growth Factors for Treatment of Wounds | July 1, 2013   | Updated list of applicable (not medically necessary) HCPCS codes to reflect quarterly code edits; added G0460 (effective Aug. 1, 2012)                                                                                                                                                                                        |
| Preterm Labor: Identification and Treatment     | Sep. 1, 2013   | • Updated description of services to reflect most current clinical evidence, FDA information and references  
  • Revised coverage rationale; removed content/language specific to salivary estriol testing  
  • Updated list of applicable HCPCS codes; removed S3652                                                                                                                                                                                             |
<table>
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<tr>
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<tbody>
<tr>
<td>REVISED</td>
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<tr>
<td>Preventive Care Services</td>
<td>Apr. 29, 2013</td>
<td>Revised coverage rationale/claim edit criteria for Cervical Cancer Screening, Pap Smear (effective for dates of service on or after Apr. 1, 2013):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Removed female age limit requirement of 21 to 65 years</td>
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<tr>
<td></td>
<td></td>
<td>• Added language to indicate no age limit applies</td>
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<tr>
<td></td>
<td>July 1, 2013</td>
<td>Updated list of applicable HCPCS codes to reflect quarterly code edits (effective July 1, 2013):</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Preventive Care Services/ Immunizations: Added Q2033</td>
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<tr>
<td></td>
<td></td>
<td>• Expanded Women’s Preventive Health/Contraceptive Methods (Code Group 1, Contraceptive Methods, IUDs): Added Q0090</td>
</tr>
<tr>
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<td>Aug. 1, 2013</td>
<td>Revised list of applicable procedure and diagnosis codes (effective for dates of service on or after Aug. 1, 2013):</td>
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<tr>
<td></td>
<td></td>
<td><strong>Preventive Care</strong></td>
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<td></td>
<td>• Added language to indicate certain codes may not be payable in all circumstances due to other policies or guidelines</td>
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<tr>
<td></td>
<td></td>
<td>• Added lists of applicable ICD-10 diagnosis codes (preview drafts effective Oct. 1, 2014)</td>
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<tr>
<td></td>
<td></td>
<td>• Immunizations:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updated claims edit criteria; added language to clarify noted services are always preventive regardless of diagnosis code for covered preventive immunizations</td>
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<td></td>
<td>• Updated list of applicable CPT codes; added 90686</td>
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<td>• Prostate Cancer Screening: Updated list of applicable diagnosis codes (Code Group 2); removed V84.03</td>
</tr>
<tr>
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<td>• Screening for Intimate Partner Violence: Added new service category indicating this service is included in a preventive care wellness examination</td>
</tr>
<tr>
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<td></td>
<td>• Reformatted and relocated lists of applicable diagnosis codes for atherosclerosis and diabetes</td>
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<td><strong>Expanded Women’s Preventive Health</strong></td>
</tr>
<tr>
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<td></td>
<td>• Added language to indicate certain codes may not be payable in all circumstances due to other policies or guidelines</td>
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<tr>
<td></td>
<td></td>
<td>• Added lists of applicable ICD-10 diagnosis codes (preview drafts effective Oct. 1, 2014)</td>
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<tr>
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<td>• Contraceptive Methods (Including Sterilizations): Updated list of applicable CPT codes (Code Group 3/Anesthesia for Sterilization); added 00851</td>
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<tr>
<td><strong>REVISED</strong></td>
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</tbody>
</table>
| Private Duty Nursing                  | Sep. 1, 2013   | • Added reference link to related policies titled:  
  • Home Health Services  
  • Custodial and Skilled Care Services  
  • Revised coverage rationale; added benefit considerations, indications for coverage (including documentation requirements for requests for service) and coverage limitations/exclusions  
  • Added list of applicable definitions:  
  • Custodial care  
  • Home bound, intermittent/part-time home health services  
  • Intermittent visits  
  • Skilled care  
  • Added list of applicable CPT codes |
| Repository Corticotropin Injection    | Aug. 1, 2013   | • Updated description of services to reflect most current clinical evidence, CMS information and references; no change to coverage rationale  
  • Updated list of applicable ICD-9 codes; added 581.0 - 581.3, 581.81, 581.89 and 581.9  
  • Updated list of applicable ICD-10 diagnosis codes (preview draft effective Oct. 1, 2014) |
| Rituxan (Rituximab)                   | Aug. 1, 2013   | Updated description of services to reflect most current clinical evidence, CMS information and references  
  • Revised coverage rationale:  
  • Replaced references to “idiopathic thrombocytopenic purpura (ITP)” with “immune thrombocytopenic purpura (ITP)”  
  • Added medical necessity criteria for ITP, Wegener’s granulomatosis, microscopic polyangiitis, and rheumatoid arthritis  
  • Updated list of medically necessary diagnoses; added:  
    • Post-transplant B-lymphoproliferative disorder  
    • Neuromyelitis optica  
  • Updated benefit considerations; added language to indicate:  
    • Some Certificates of Coverage allow coverage of experimental/investigational/unproven (not medically necessary) treatments for life-threatening illnesses when certain conditions are met  
    • The enrollee-specific benefit document must be consulted to make coverage decisions for this service |

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| **REVISED**                             |                | • Some states mandate benefit coverage for off-label use of medications for some diagnoses or under some circumstances when certain conditions are met; where such mandates apply, they supersede language in the benefit document or in the medical or drug policy  \  
• Benefit coverage for an otherwise unproven/not medically necessary service for the treatment of serious rare diseases may occur when certain conditions are met  \  
• The state of New Jersey prohibits requiring failed prior therapy or intolerance to therapy as a requirement for coverage  \  
*Updated list of applicable ICD-9 diagnosis codes; added 238.77 and 341.0*  \  
*Updated list of applicable ICD-10 diagnosis codes (preview draft effective Oct. 1, 2014)*                                                                                                                                                                                                                     |
| Sodium Hyaluronate                      | Sep. 1, 2013   | • Updated description of services to reflect most current clinical evidence, FDA information and references  \  
• Clarified language pertaining to treatment with sodium hyaluronate preparations for indications not considered to be medically necessary  \  
• Revised list of applicable HCPCS codes; changed coverage status for J7321* from “covered” to “requires preauthorization”  \  
• Updated list of applicable (medically necessary) ICD-9 codes; added 524.60  \  
• Updated list of applicable ICD-10 diagnosis codes (preview draft effective Oct. 1, 2014)  \  
*Although the list of applicable HCPCS codes in the currently published policy version already reflects this information, this guideline may not have been previously applied due to a system error.*                                                                                                                                                     |
| Transecatheter Heart Valve Procedures   | Sep. 1, 2013   | • Updated description of services to reflect most current clinical evidence, FDA information and references  \  
• Revised coverage rationale for aortic valve; updated coverage criteria:  \  
  • Replaced criterion indicating “patient is not a candidate for conventional, open valve replacement surgery” with “patient requires valve replacement surgery but is at high risk for serious surgical complications or death from open valve replacement surgery”                                                                                                                                                                                                 |
**New Format for UnitedHealthcare of the River Valley Coverage Policies**

**Beginning Sep. 1, 2013**, all coverage policies for UnitedHealthcare of the River Valley will be reorganized and published in a new Adobe Acrobat/PDF template featuring a Table of Contents for improved usability.

There will be no change in policy content as a result of the template reformatting. As always, changes/revisions to policy and/or preauthorization guidelines will continue to be announced prior to implementation.

There will be no change to how you access the Coverage Policy Library. It will continue to be available at UHCRiverValley.com > Providers > Coverage Policy Library.

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**New Policy Update Bulletin for River Valley Coverage Policy Updates**

**Beginning Sep. 1, 2013**, a monthly Policy Update Bulletin summarizing recently approved and/or revised coverage policies will be available for your reference at UHCRiverValley.com.

This communication will provide online notice of coverage policy updates for UnitedHealthcare of the River Valley. A new Policy Update Bulletin will be published on the first calendar day of every month at UHCRiverValley.com > Providers > Coverage Policy Library > Policy Update Bulletin.

The monthly Policy Update Bulletin will replace the bi-monthly Network Bulletin as the official communication vehicle for new and/or revised coverage policies to be effective on or after Oct. 1, 2013. As a result, the Network Bulletin will no longer provide a detailed summary of coverage policy updates. Instead, it will feature a list of recently approved and/or revised coverage policy titles only, as a supplemental reminder to the detailed policy update summaries provided in the monthly Policy Update Bulletin.

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**Policy Title** | **Effective Date** | **What's Changed**
--- | --- | ---
REVISED |  | • Added language to indicate, as of April 2013, only transfemoral and transapical delivery approaches to transcatheter aortic heart valve replacement have received FDA approval; all other delivery approaches (e.g., subaxillary, subclavian, transaortic) are investigational due to lack of FDA approval
• Revised list of applicable CPT codes requiring preauthorization; added 33369

Transthoracic Echocardiography | July 1, 2013 | Added language to indicate policy is applicable to hawk-i plan membership only; for River Valley commercial plan membership, refer to the policy titled Outpatient Echocardiogram and Stress Echocardiogram Procedures (effective July 1, 2013) for applicable coverage guidelines
**Oxford Medical and Administrative Policy Updates**

For complete details on the new and/or revised policies listed in the following table, refer to the monthly Policy Update Bulletin at OxfordHealth.com > Providers > Tools & Resources > Practical Resources > Medical & Administrative Policies > Policy Update Bulletin.

The appearance of a service or procedure on this list does not imply that Oxford provides coverage for the service or procedure. In the event of an inconsistency or conflict between the information provided in this bulletin and the posted policy, the provisions of the posted policy will prevail.

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Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc., Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc.
Accessing EOBs Online

You can reduce the time you spend requesting copies of Explanations of Benefits (EOBs) by using our website. Please see the following table below for information about obtaining UnitedHealthcare and Oxford EOBs online.

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<td><strong>Single EOB Search</strong>&lt;br&gt;• Register or log on to <a href="https://www.UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a>&lt;br&gt;• Select Claims &amp; Payments &gt; Electronic Payments and Statements (EPS) &gt; Single EOB Search.&lt;br&gt;• You may locate EOBs by payment number or status and date.&lt;br&gt;<strong>A Quick Reference Guide</strong> is available.</td>
<td>With additional enrollment in <strong>Electronic Payments &amp; Statements (EPS)</strong> you can:&lt;br&gt;• Search for EOBs using additional options.&lt;br&gt;• View, save or print EOBs and consolidated payment summaries.&lt;br&gt;• Receive payments by direct deposit.&lt;br&gt;Learn more on our website or call 866-842-3278, Option 5, for more information.</td>
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<td><strong>Claim Status</strong>&lt;br&gt;• Register or log on to <a href="https://www.OxfordHealth.com">OxfordHealth.com</a>&lt;br&gt;• Select Claims in the Check column on the Transaction tab.&lt;br&gt;• You may locate claims and EOBs using several search options.&lt;br&gt;<strong>Provider</strong> and <strong>Facility Quick Reference Guides</strong> are available.</td>
<td>With additional enrollment in <strong>PNC Remittance Advantage</strong> you can:&lt;br&gt;• Search for EOBs using additional options.&lt;br&gt;• View, save or print EOBs.&lt;br&gt;• Receive payments by direct deposit.&lt;br&gt;Learn more on our website or call 877-597-5489, Option 1, for more information or to request a demonstration.</td>
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Electronic Inpatient Admission Notifications

Use the Electronic Data Interchange (EDI) 278N to submit notifications from your practice management system for UnitedHealthcare, UnitedHealthcare Medicare Solutions and UnitedHealthcare Community Plan. For more information contact UnitedHealthcare at 888-804-0663 or [278n@uhc.com](mailto:278n@uhc.com); go to [UnitedHealthcareOnline.com > Admission Notification (278N)](https://www.UnitedHealthcareOnline.com); or contact your clearinghouse/vendor.
Odds and Ends

Update to Multiple Procedure Payment Reduction for Therapy Services

Effective April 1, 2013 the Centers for Medicare and Medicaid Services (CMS) initiated an update to the multiple procedure payment reduction policy. The update reduces the practice expense portion of certain physical, occupational and speech/language therapy procedures by 50 percent, when these procedures are the secondary and/or subsequent procedures reported on a single date of service for the same patient.
If you do not contract directly with UnitedHealthcare, or participate in our network through another arrangement some of the information provided in this communication may not be applicable to you and/or may affect you differently. If you have questions or require further information, please contact your local Network Management representative, Physician Advocate or Hospital & Facility Advocate. If you are uncertain who your contact is, please visit UnitedHealthcareOnline.com > Contact Us > Network Contacts.