Physician, Health Care Professional, Facility and Ancillary Provider 2016 Administrative Guide

For Commercial and Medicare Advantage Products
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Important information regarding the use of this Guide

This 2016 Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (this “Guide”) applies to covered services you provide to Customers under a benefit plan insured by or receiving administrative services from UnitedHealthcare and its affiliates*, unless otherwise noted.

Except when indicated, this Guide is effective on April 1, 2016 for physicians, health care professionals, facilities and ancillary providers currently participating in the UnitedHealthcare Network, and effective immediately for physicians, health care professionals, facilities and ancillary providers who join the UnitedHealthcare network on or after January 1, 2016.

Terms used in this Guide include the following:

• “Customer” refers to a person eligible and enrolled to receive coverage from a payer for covered services as defined or referenced in your agreement with us (we sometimes refer to Customers as “members”);
• “Commercial” refers to all UnitedHealthcare medical products that are not Medicare Advantage, Medicare Supplement, Medicaid, CHIP, workers’ compensation, TRICARE, or other governmental programs (except that “Commercial” also applies to benefit plans for the Health Insurance Marketplace, government employees or students at public universities);
• “You,” “your” or “provider” refers to any health care Provider subject to this Guide, including physicians, health care professionals, facilities and ancillary providers; except when indicated all items are applicable to all types of providers subject to this Guide.
• “Us,” “we” or “our” refers to UnitedHealthcare on behalf of itself and its other affiliates for those products and services subject to this Guide.

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

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

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

This entire Guide is subject to change.

UnitedHealthcare and its affiliates own UnitedHealthcareOnline.com, myuhc.com and the websites listed in the “Additional Manuals and Websites” table of this Guide. We do not own the other websites referred to in this Guide, but reference them because they may contain information that is useful or interesting to you. We do not endorse, and are not responsible for, the content and accuracy of websites operated by third parties or any of your dealings with such third parties. You are solely responsible for your dealings with such third parties, and so we encourage you to read the terms of use and privacy policies on such third-party websites.

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

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** The only exception is UnitedHealthcare Senior Options, which is a benefit plan offered only in Massachusetts. For this benefit plan, the logos on the back of the Medicare Advantage Customer health care ID card are “Medicare Community Plan” and “UHC.”
Information regarding certain benefit plans referenced in this Guide

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

Below is a table setting forth information about how to identify the Customers covered under those benefit plans and a general guide to where the Additional Manuals are located and how they apply. You are subject to the Additional Manuals when providing covered services to a Customer covered under one of those benefit plans, to the extent provided in your agreement with us and in the table below. UnitedHealthcare may make changes to the Additional Manuals in accordance with the provisions of your agreement with us that relate to protocol and payment policy changes.

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

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<td>All Savers</td>
<td>Benefit plan issued or administered by All Savers Insurance Company</td>
<td>“All Savers”</td>
<td>All markets</td>
<td>All Savers Supplement to this Guide Myallsaversprovider.com</td>
<td>Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide, except when the Customer is covered under the following benefit plan type: • All Savers products offered on-Exchange</td>
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<td>Harken Health</td>
<td>Benefit plans issued or administered by the following entities: Harken Health Insurance Co.</td>
<td>“Harken Health”</td>
<td>Some counties in GA, IL (Chicago and Atlanta areas)</td>
<td>Harken Health Insurance Co.: harkenhealth.com Member and Provider Assistance: (800) 797-9921</td>
<td>N/A</td>
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<td>MDIPA</td>
<td>Benefit plans issued or administered by MD-Individual Practice Association, Inc.</td>
<td>“MDIPA”</td>
<td>DC, DE, MD, VA, WV, some counties in southeastern PA</td>
<td>Mid-Atlantic Regional Supplement to this Guide. UnitedHealthcareOnline.com</td>
<td>If your agreement specifically references MDIPA protocols or manuals, then the MDIPA Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide.</td>
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<td>Medicare Advantage Capitated Provider Supplement</td>
<td>Medicare Advantage benefit plans offered through the UnitedHealthcare Medicare Solutions business unit</td>
<td>“UHC”</td>
<td>All markets</td>
<td>Medicare Advantage Capitated Provider Supplement to this Guide. UnitedHealthcareOnline.com</td>
<td>The Medicare Advantage Capitated Provider Supplement applies to benefit plans for Customers who have been assigned to, or who have chosen a Provider that receives a capitation payment from UnitedHealthcare for such Customer, and it supersedes conflicting provisions of the rest of this Guide.</td>
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* The Additional Manual for a particular benefit plan also applies and supersedes conflicting provisions in this Guide when you are participating directly with the affiliate that offers that benefit plan.
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<td>NHP</td>
<td>Benefit plans issued or administered by Neighborhood Health Partnership, Inc.</td>
<td>“Neighborhood Health Partnership”*</td>
<td>FL</td>
<td>Neighborhood Health Partnership Supplement to this Guide. UnitedHealthcareOnline.com myNHP.com</td>
<td>If your agreement specifically references NHP protocols or manuals, then the NHP Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide, except when the Customer is covered under one of the following benefit plan types: NHP Flex and outside the service area.</td>
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<td>OCI</td>
<td>Benefit plans issued or administered by Optimum Choice, Inc.</td>
<td>“Optimum Choice” and/or Optimum Choice-HSA</td>
<td>DC, DE, MD, VA, WV, some counties in PA.</td>
<td>Mid-Atlantic Regional Supplement to this Guide. UnitedHealthcareOnline.com</td>
<td>If your agreement specifically references OCI protocols or manuals, then the OCI Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide.</td>
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<td>OneNet</td>
<td>Benefit plans accessing a network administered by OneNet PPO, LLC</td>
<td>PPO Network: &quot;OneNet PPO&quot; Behavioral Health Network: &quot;MAPSI&quot; Workers’ Compensation Network: health care ID cards are normally not utilized</td>
<td>DC, DE, MD, NC, PA, VA, WV. Limited Network in: FL, GA, SC, TN</td>
<td>OneNet PPO Supplement to this Guide. UnitedHealthcareOnline.com or onenetppo.com</td>
<td>If your agreement specifically references OneNet protocols or manuals, then the OneNet Supplement also applies, and it supersedes conflicting provisions throughout the rest of this Guide.</td>
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<td>Oxford</td>
<td>Benefit plans issued or administered by any of the following entities: Oxford Health Plans, LLC Oxford Health Insurance, Inc. Investors Guaranty Life Insurance Company, Inc. Oxford Health Plans (NY), Inc. Oxford Health Plans (NJ), Inc. Oxford Health Plans (CT), Inc.</td>
<td>“Oxford”</td>
<td>CT, NJ, NY (except up-state), some counties in PA.</td>
<td>For Oxford benefit plans: Oxford Commercial Supplement to this Guide. UnitedHealthcareOnline.com For info about Medicare members): OxfordHealth.com (for info about commercial members)</td>
<td>If your agreement specifically references Oxford protocols or manuals, then the applicable Oxford Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide, except as follows: • When the Customer is covered under a NJ Compass Individual Exchange benefit plan (On and Off-Exchange). • For services rendered to Medicare Advantage Customers, this Guide will apply • Medicare Advantage Customers where the &quot;CP&quot; appears on the back of the Customer’s health care ID card.</td>
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* The Additional Manual for a particular benefit plan also applies and supersedes conflicting provisions in this Guide when you are participating directly with the affiliate that offers that benefit plan.
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<th>Additional Manual/ website</th>
<th>When and how does the Additional Manual apply when you are providing services to the Customer of the benefit plan?*</th>
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| River Valley            | Certain benefit plans issued or administered by any of the following entities:  
• UnitedHealthcare Services Company of the River Valley, Inc.  
• UnitedHealthcare Plan of the River Valley, Inc., and  
• UnitedHealthcare Insurance Company of the River Valley | River Valley Customers can be identified by a reference to “uhcrivervalley.com” on the back of their health care ID card | Parts of AR, GA, IA, IL, TN, WI, VA,  
Note: River Valley also offers benefit plans in LA, NC, OH & SC, but the River Valley Additional Manual does not apply to those benefit plans | River Valley Entities Supplement to this Guide.  
UnitedHealthcareOnline.com and uhcrivervalley.com | The River Valley Additional Manual applies to you, and it supersedes this Guide if there is a conflict, if all of the following are true:  
• Your United contract specifically references River Valley or John Deere Health protocols or manuals; and  
• You are located in AR, GA, IA, TN, VA, WI, or the following counties in Illinois: Jo Daviess, Stephenson, Carroll, Ogle, Mercer, Whiteside, Lee, Rock Island, Henry, Bureau, Putnam, Henderson, Warren, Knox, Stark, Marshall, Livingston, Hancock, McDonough, Fulton, Peoria, Tazewell, Woodford, and McLean, and  
• You are providing services to a River Valley Commercial Customer and not a River Valley Medicare Advantage, Medicaid or CHIP Customer. |
| Sierra                  | Benefit plans issued or administered by any of the following entities:  
• Sierra Health and Life Insurance Co., Inc.  
• Health Plan of Nevada, Inc.  
• Sierra Healthcare Options, Inc. | “UnitedHealthcare Choice Plus Network Outside Nevada” or “UnitedHealthcare Options PPO” (As further described in the far right-hand column, these health care ID card references identify Sierra members who access the UnitedHealthcare network outside Nevada). | NV | Benefit plans for Sierra Health and Life Insurance Company, Inc.:  
sierrahealthandlife.com  
Benefit plans for Health Plan of Nevada, Inc.:  
healthplanofnevada.com | The network for services in Nevada is the applicable Sierra network and not the UnitedHealthcare network; if you are in the applicable Sierra network, services you render in Nevada to Sierra Customers are subject to your Sierra agreement, and the applicable Additional Manual, and not to your UnitedHealthcare agreement or this Guide.  
Services rendered outside of Nevada to Sierra Customers with the health care ID card reference described in this row are subject to your UnitedHealthcare agreement and to this Guide, and not to the Additional Manuals described in this row (unless you are in Arizona or Utah and have a contract directly with Sierra). |
| TRICARE                 | Benefit plans for people covered by the Department of Defense’s TRICARE program. | TRICARE West Region (covering roughly the western half of the United States). | UHCMilitaryWest.com | TRICARE benefit plans are not subject to this Guide and are instead subject to the TRICARE Provider Handbook. |

* The Additional Manual for a particular benefit plan also applies and supersedes conflicting provisions in this Guide when you are participating directly with the affiliate that offers that benefit plan.
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<td>UnitedHealthcare Community Plan Medicaid, CHIP and Uninsured</td>
<td>Benefit plans (including Medicaid, CHIP and other non-Commercial state government programs) offered through the UnitedHealthcare Community Plan business unit.</td>
<td>&quot;UnitedHealthcare Community Plan&quot;</td>
<td>UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Administrative Guide for Medicaid, CHIP, or Uninsured. uhccommunityplan.com and UnitedHealthcareOnline.com</td>
<td>If your agreement specifically references UnitedHealthcare Community Plan or Medicaid, CHIP, Uninsured or Other Governmental benefit plans protocols or manuals (including references to “Arizona Physicians IPA”, “APIPA”, or older brand names such as “AmeriChoice”, “Great Lakes Health Plan”, “Unison” or “Evercare”), then the UnitedHealthcare Community Plan Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide.</td>
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<td>UnitedHealthcare Community Plan Medicare Advantage</td>
<td>Medicare Advantage benefit plans offered through the UnitedHealthcare Community Plan business unit.</td>
<td>&quot;CP&quot;</td>
<td>UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Administrative Guide for Medicare uhccommunityplan.com.</td>
<td>If your agreement specifically references UnitedHealthcare Community Plan Medicare Advantage protocols or manuals (including references to older brand names such as “AmeriChoice”, “Great Lakes Health Plan”, “Unison”, “Arizona Physicians IPA” or “APIPA”), then the UnitedHealthcare Community Plan Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide.</td>
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<td>UnitedHealthcare West or UHC West (Benefit plans referenced in this row were formerly referenced in this Guide as (“PacifiCare”))</td>
<td>Benefit plans issued or administered by any of the following entities: UHC of California dba UnitedHealthcare of California (hereinafter referred to as UnitedHealthcare of California) UnitedHealthcare of Oklahoma, Inc. UnitedHealthcare of Oregon, Inc. UnitedHealthcare Benefits of Texas, Inc. UnitedHealthcare of Washington, Inc. PacifiCare of Arizona, Inc.+ PacifiCare of Colorado, Inc.+ PacifiCare of Nevada, Inc.+ These entities offer Medicare Advantage benefit plans only.</td>
<td>&quot;WEST&quot;</td>
<td>UnitedHealthcare West Non-Capitated Supplement to this Guide. UnitedHealthcareOnline.com and uhcwest.com</td>
<td>If your agreement specifically references PacifiCare or UnitedHealthcare West protocols or manuals, then the Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide, except when the Customer is covered under one of the following benefit plan types: • Navigate • Compass • Core • Charter • Any benefit plans offered on-Exchange</td>
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* The Additional Manual for a particular benefit plan also applies and supersedes conflicting provisions in this Guide when you are participating directly with the affiliate that offers that benefit plan.
**Important News and Updates**

Our preferred method to communicate with you is electronically, and any news or updates regarding policy, product, or reimbursement changes are generally posted in the News section of the UnitedHealthcareOnline.com home page and/or in the Network Bulletin (described in the following section of this Guide). Registration is not required to view News or the Network Bulletin.

We also offer Really Simple Syndication (RSS) feeds. In order to receive feeds, you must have an RSS reader which will check subscription data feeds regularly for new content. The content is then downloaded and made viewable to you. Free RSS readers, as well as instructions on how to use them, are available through many popular websites, such as Google and Yahoo! To subscribe to our RSS feeds, copy and paste any or all of the following URLs into your RSS Reader:

**General News Updates:**  https://www.UnitedHealthcareOnline.com/rss/news.xml

**Administrative Guide Updates:**  https://www.UnitedHealthcareOnline.com/rss/adminGuide.xml

**Medical Policy Updates:**  https://www.UnitedHealthcareOnline.com/rss/medical.xml

To the extent that some protocols are applicable only in certain states at the time of printing, we have indicated that in this Guide. Please reference UnitedHealthcareOnline.com to view a complete list of states to which protocols are applicable.

**Health Reform**

The Patient Protection and Affordable Care Act (PPACA) includes several provisions which are designed to expand coverage, control health care costs, and improve the health care delivery system. To find out what these changes are and when they’re scheduled to take effect, visit the United for Reform Resource Center at UHC.com ➔ Providers ➔ Health Reform Information for Providers.

**Free Medicare Education for Your Staff and Patients**

Medicare Made Clear (MMC) is a UnitedHealthcare public service campaign that educates, equips and empowers consumers with the information they need to select the right Medicare plan for their needs. This campaign was created to help consumers easily access important information on topics such as the parts of Medicare, enrollment timing, what’s covered (and what’s not) and what they need to know to make good choices.
Whether your patients are new to their Medicare coverage or are experiencing changes that impact coverage such as moving, delaying retirement or managing a chronic illness, they can find answers on our easy-to-use reference website MedicareMadeClear.com.

Connect with us on social media: Facebook, YouTube, Twitter

**Network Bulletin**

UnitedHealthcare publishes monthly editions of the “Network Bulletin”, a user-friendly online resource that includes notices to our network physicians and facilities of any protocol, policy, or program updates and changes as well as an array of other useful and interesting items. It includes information relevant across our lines of business, including Commercial, Medicaid, and Medicare products. The Network Bulletin is posted and accessible online at UnitedHealthcareOnline.com → Quick Links → Network Bulletin. From the same page, you can also sign up to receive the Network Bulletin via email. The email distribution is not limited to only one person in your office – you can have everyone sign up!

Postcard announcements regarding the availability of the Network Bulletin for the upcoming year are mailed to all providers participating in our network in January, and where required by applicable law, separately for each publication of the Network Bulletin throughout the year. Read the Network Bulletin throughout the year to view important information on protocol and policy changes, administrative information and clinical resources.

In 2016, the Network Bulletin will be available on UnitedHealthcareOnline.com and through email on the following dates:

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<tr>
<th>Network Bulletin Edition</th>
<th>Publication Date</th>
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<td>January</td>
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<td>November</td>
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<td>December</td>
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**Medical Policy Update Bulletin**


**General Information About Updates**

Where required by law, we will provide updates in writing. We may also use additional channels (such as mail, internet, email, phone, and fax) to communicate with you in the event a protocol is modified. We will notify you prior to implementation of a protocol or policy change if specified in your agreement with us or if required by law.

**Information Regarding Our Provider Website Transition**

Our goal is to streamline and simplify the Provider administrative experience by consolidating all UnitedHealthcare transaction capabilities into one location.
Link replaces Optum Cloud Dashboard

In fall 2015, we introduced Link – a new site for UnitedHealthcareOnline.com users. Link is an intuitive self-service experience that can help make your work measurably faster and easier.*

Link is your new gateway to UnitedHealthcare’s online tools. It includes many of the same applications as Optum Cloud Dashboard, but with a new interface that can help you get to the information you need with fewer clicks. Link applications include Claims Management, Claims Reconsideration, Eligibility & Benefits and Provider Data Management.

Available plan information varies for each of the applications, but at this time you can use Link to access information for UnitedHealthcare Commercial, UnitedHealthcare Medicare Solutions, UnitedHealthcare Community Plan (as contracted by state), UnitedHealthcare West, UnitedHealthcare of the River Valley and UnitedHealthcare Oxford members.

We are working to update Link with enhanced features and new applications, so watch for the most current information by email, in the Network Bulletin or on UnitedHealthcareOnline.com.

You need an Optum ID to access Link and UnitedHealthcareOnline.com. To register for an Optum ID, please go to UnitedHealthcareOnline.com → New User. For more information about Link, please visit UnitedHealthcareOnline.com → Tools and Resources → Health Information Technology → Link.

How to Contact Us

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<th>Where to go</th>
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<td>UnitedHealthcare Provider website</td>
<td>Link and UnitedHealthcareOnline.com</td>
<td>Link Enroll in Electronic Payments and Statements (EPS) for direct deposit of payment for covered services and electronic EOBs. Claims Management  • Get the status of your claims quickly and accurately. You can submit a claim for reconsideration directly from the Claims Management app. Claims Reconsideration  • Submit claim reconsiderations with and without supporting documents.  • You will receive a tracking number and can easily check the status of the submission online Eligibility and Benefits  • Submit a referral and check status  • Verify coverage for specific services  • Check the copayment for a visit  • Review a Customer’s eligibility or benefits and current Health Reimbursement Account (HRA) balances.  • Review your network status when checking eligibility.  • Submit referrals and check referral status for gated plans in the Eligibility and Benefits application under My Actions.  • Review the Claims Eligibility Through Date on the Patient Eligibility screen to know when an Individual Exchange Customer is in their 3-month grace period Provider Data Management  • View and update facility/practice data, office locations, specialties, languages spoken, hospital and group affiliations, and more. (except tax identification number (TIN) and Physician Directory indicator</td>
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* Based on ongoing usability studies using keystroke-level modeling when comparing Link to UnitedHealthcareOnline.com and Optum Cloud Dashboard.
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<tr>
<th>Resource</th>
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| **UnitedHealthcare Provider website - continued** | | **UnitedHealthcare Online**  
  - Review/print a current copy of this Guide.
  - View UnitedHealthcare policies.
  - View current and past issues of our Network Bulletin.
  - View Advance Notification List.
  - Access and review clinical program information and patient safety resources.
  - View Patient Personal Health Records.
  - Submit, check status, and update Notifications/Prior Authorizations.
  - View claim pre-determination and bundling logic using Claim Estimator (only for professional claims for Commercial Customers).
  - Submit professional claims (claims for Commercial Customers may be adjudicated in real time).
  - Reprint an explanation of benefits (EOB) using the Single EOB Search.
  - Enroll in Electronic Payments and Statements (EPS) for direct deposit of payment for covered services and electronic EOBs.
  - Submit a Claim Research Project for 20 or more claims.
  - Review the physician directory.
  - Look up your fee schedule, 10 codes at a time.
  - View the Credentialing and Re-credentialing Plan.
  - View and register for webcast seminars, (ICD-10, CME, for example).
  - Submit referrals or check status of referrals.
  - Check claims status.
  - Request a claims adjustment or a Claim Reconsideration when attachments are not needed.
  - Update facility/practice data (except tax identification number (TIN) and Physician Directory indicator).  
| | Help Desks:  
  Link: (855) 819-5909 or linksupport@optum.com  
  UnitedHealthcareOnline.com: (866) 842-3278, Option 1 | • Get help with Link  
• Get help with UnitedHealthcareOnline.com  
| | Website Training  
UnitedHealthcareOnline.com ➔ Quick Links ➔ Training & Education | View and register for webinars about using: UnitedHealthcareOnline.com  
| | Health Reform Resource Center  
UHC ➔ Provider ➔ Health Reform Information for Providers | • View a timeline of provisions, definitions for each provision and frequently asked questions.  
• Learn about health reform through our Health Reform videos.  
• Access the Provider document library to view flyers and quick reference guides designed specifically for you.  
| | Advance Notification, Prior Authorization and Admission Notification (Notification requirements)  
Applies to those Customers whose benefit plans require Prior Authorization and those whose benefit plans do not. | • Notify us about the procedures and services referenced in the Notification requirements section of this Guide.  
• Communicate with us regarding utilization management issues.  
| | Link – Use the Eligibility and Benefits Center Application to notify us about procedures and see whether Notification/ Prior Authorization are required and can be submitted UnitedHealthcareOnline.com ➔ Notifications/Prior Authorizations or: Clinician Resources ➔ Advance & Admission Notification Requirements or  
Phone: Enterprise Voice Portal at (877) UHC-3210 (842-3210).  
See Customer’s health care ID card for Customer Care contact information. |  

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<th>Resource</th>
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<td>Behavioral Health Services</td>
<td>See Customer’s health care ID card for carrier information and contact numbers.</td>
<td>• Inquire about a Customer’s behavioral health benefits.</td>
</tr>
<tr>
<td>Cardiology Notification &amp; Authorization – Submission &amp; Status</td>
<td>UnitedHealthcareOnline.com Phone: (866) 889-8054</td>
<td>• Notify us of certain inpatient, outpatient, and office-based cardiology procedures as described in the Cardiology Notification/Prior Authorization Protocol for Commercial Customers and the Cardiology Prior Authorization Protocol for Covered Services to Medicare Advantage Customers sections of this Guide.</td>
</tr>
</tbody>
</table>
| Chemotherapy (Injectable) Prior Authorization Program | UnitedHealthcareOnline.com Phone: (866) 889-8054                             | • Learn about UnitedHealthcare’s outpatient chemotherapy (injectable) prior authorization requirements.  
• Request a Prior Authorization.  
• View authorization submission and status. |
| Chiropractic, Physical Therapy, Occupational Therapy, and Speech Therapy Providers contracted with OptumHealth Physical Health, a UnitedHealth Group company | myoptumhealthphysicalhealth.com Phone: (800) 873-4575                          | • Verify benefits and eligibility.  
• Check Utilization Review process requirements. |
| Customer Care                                     | UnitedHealthcare Commercial and Medicare Advantage Phone: (877) 842: 3210     | • Obtain information for benefit services as indicated in this Guide.                  |
| Electronic Payments and Statements (EPS)          | Information and Enrollment: UnitedHealthcareOnline.com → Quick Links → Electronic Payments & Statements or WelcometoEPS.com Logon: Optumhealthfinancial.com → Customer Login → Health Care Professional → Log in Helpdesk: (866) 842-3278, Option 5 | • Learn about EPS.  
• Sign up for EPS.  
• Access online explanation of benefits (EOBs/remittance advice), 835 files and information about direct deposit payments.  
• Call for questions about EPS. |
| Electronic Data Interchange (EDI)                 | Online Information: UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions. EDI Support: Phone: (800) 842-1109 or UnitedHealthcareOnline.com → Contact Us → Electronic Data Interchange (EDI) Claims → Transaction Support Form. | • Learn about electronic transactions and submission options:  
› Admission Notification (278N)  
› Claim Submission (837)  
› Claim Status Request & Response (276/277)  
› Authorization and Notification Inquiries (278I)  
› Pre-Authorization and Advance Notifications (278A)  
› Electronic Remittance Advice (835)  
› Eligibility Benefit Inquiry & Response (270/271)  
• Obtain Payer IDs for UnitedHealthcare, Affiliates, and Strategic Alliances.  
• Access companion guides  
• View a list of EDI transaction and code sets  
• Call or submit online form for questions |
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<th>Resource</th>
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<tr>
<td>Enterprise Voice Portal</td>
<td>Phone: (877) UHC-3210 (842-3210) For a Quick Reference Guide, go to UnitedHealthcareOnline.com → Contact Us → click on the quick reference link under UnitedHealthcare for Health Care Professionals (Enterprise Voice Portal).</td>
<td>• Inquire about a Customer’s eligibility or benefits (including copayments, deductibles, past/current coverage, coinsurance, and out-of-pocket information) and obtain a faxed confirmation. • Check claim status, reason code explanation and claims pending and mailing addresses. • Update facility/practice demographic data (except TIN). • Check credentialing status or request for participation inquiries. • Check appeal or claim project submission process information. • Check care notification process information. • Check privacy practice information.</td>
</tr>
<tr>
<td>Erickson Advantage® (A UnitedHealthcare Medicare Advantage product for residents of Erickson Retirement Communities).</td>
<td>See Customer’s health care ID card for Customer Care contact information.</td>
<td>• Inquire about benefits and services as indicated in this Guide, including Notification requirements.</td>
</tr>
<tr>
<td>Fraud, Waste and Abuse (Report Potential Non-Compliance or Suspected Issues)</td>
<td>Phone: Enterprise Voice Portal at (877) UHC-3210 (842-3210)</td>
<td>• If you identify potential compliance issues and/or suspected fraud, waste, or abuse, please report it to us immediately so that we can investigate and respond appropriately. UnitedHealthcare expressly prohibits retaliation if a report is made in good faith. • For more information on Medicare fraud, waste, and abuse prevention efforts, please go to Medicare Compliance Expectations and Fraud, Waste and Abuse Training section of this Guide.</td>
</tr>
<tr>
<td>Outpatient Radiology Notification &amp; Authorization – Submission and Status</td>
<td>UnitedHealthcareOnline.com Phone: (866) 889-8054</td>
<td>• Notify us of certain advanced outpatient imaging procedures, as described in the Outpatient Radiology Notification/Prior Authorization Protocol for Commercial Customers and the Outpatient Radiology Prior Authorization Protocol for Medicare Advantage Customers sections of this Guide.</td>
</tr>
<tr>
<td>Pharmacy Services (For services to Commercial Customers only).</td>
<td>UnitedHealthcareOnline.com → Tools &amp; Resources → Pharmacy Resources OptumRx: OptumRx Phone: (800) 711-4555 OptumRx Fax (non-specialty meds): (800) 527-0531 OptumRx Fax (specialty meds): (800) 853-3844</td>
<td>• View and search the Prescription Drug List (PDL) and a current list of participating specialty pharmacy provider(s) that apply to the use of certain pharmaceuticals. • Learn about pharmaceutical management procedures for Prior Authorization requirements, supply limits and step therapy protocols. • Call for medications requiring Notification/Prior Authorization. • Fax for medications requiring Notification/Prior Authorization.</td>
</tr>
<tr>
<td>Pharmacy Services (For services to Medicare Advantage Customers only)</td>
<td>UnitedHealthcareOnline.com → Tools &amp; Resources → Pharmacy Resources → UnitedHealthcareOnline.com OptumRx: OptumRx Phone: (800) 711-4555 OptumRx Fax (non-specialty meds): (800) 527-0531 OptumRx Fax (specialty meds): (800) 853-3844</td>
<td>• View the UnitedHealthcare Medicare Solutions Part D (MAPD) Formulary or request a copy. • Request a Prior Authorization. • Submit request for oral medications. • Submit request for injectable medications. • Request information on the Medicare Medication Management Program. • View incentives that apply to the use of certain pharmaceuticals.</td>
</tr>
<tr>
<td>Provider Relations (For Hospital, Physician, Ancillary)</td>
<td>UnitedHealthcareOnline.com → Contact Us → Network Contacts.</td>
<td>• Locate your Physician or Hospital Advocate. • Advocates are local market and field representatives who are (1) Navigational Specialists who assist participating providers with services, product offerings and specific issues and (2) trusted advisors on industry best practices.</td>
</tr>
<tr>
<td>Resource</td>
<td>Where to go</td>
<td>What you can do there</td>
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<tr>
<td>Provider Relations (For Free-Standing Skilled Nursing Facility)</td>
<td>UnitedHealthcareOnline.com → Tools &amp; Resources → Products &amp; Services → Skilled Nursing Facilities Phone: 877-842-3210.</td>
<td>Locate your Skilled Nursing Facility Advocate. To reach Provider Service or to be directed to your local Optum Skilled Nursing Facility Network Team.</td>
</tr>
<tr>
<td>Referral Submission and Status Verification-Commercial</td>
<td>Link → Eligibility and Benefits Center where you can submit a referral and check the status UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Referral Submission or Referral Status Electronic Data Interchange (EDI)</td>
<td>Notify us of a procedure and/or service (See Referrals and Notification requirements - Navigate, Charter, Compass and Core section of this Guide). Confirm a status of a referral. Note: Submitted referrals are effective immediately and are viewable within 24 hours.</td>
</tr>
<tr>
<td>Provider Directory</td>
<td>UnitedHealthcareOnline.com → Physician Directory → General Physician Directory</td>
<td>Locate a participating physician, hospital, laboratory, or other health care professional.</td>
</tr>
<tr>
<td>Therapeutic Radiation Prior Authorization (IMRT, SRS, and SBRT) For program information: UnitedHealthcareOnline.com → Clinical Resources → Oncology → Medicare Advantage Therapeutic Radiation (IMRT, SRS, and SBRT) To request an authorization online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Oncology Authorization Submission &amp; Status Phone: (866) 889-8054</td>
<td>Learn about the UnitedHealthcare Medicare Advantage Therapeutic Radiation authorization program requirements. Request a Prior Authorization. View authorization submission and status.</td>
<td></td>
</tr>
<tr>
<td>Transplant Services</td>
<td>See Customer’s health care ID card for carrier information and contact numbers.</td>
<td>Inquire about a Customer’s transplant benefits.</td>
</tr>
<tr>
<td>Urgent Appeal Submission (Commercial Customers only)</td>
<td>Fax: (801) 994-1083</td>
<td>An expedited appeal may be available to you if the Customer’s medical conditions are such that the time needed to complete a standard appeal could seriously jeopardize the Customer’s life, health or ability to regain maximum function.</td>
</tr>
<tr>
<td>Vision Services</td>
<td>See Customer’s health care ID card for carrier information and contact numbers The health care ID card is available in the Patient and Eligibility functions and Benefits Center application on Link</td>
<td>Inquire about a Customer’s vision benefits.</td>
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**Health care identification (ID) cards**

UnitedHealthcare Customers receive health care ID cards containing information needed for you to submit claims. Information may vary in appearance or location on the card due to payer or other unique requirements. However, all cards display essentially the same information (such as claims address, copayment information, phone numbers such as those for Customer Care, Advance Notification and Prior Authorization) and are viewable in the Eligibility and Benefits Center application on Link.

Please check the Customer’s health care ID card at each visit, and keep a copy of both sides of the health care ID card for your records. Additionally it is important that you verify eligibility and benefits before or at the point of service for each office visit. Please refer to the Checking eligibility, benefits, and your participation status section of this Guide.
Using the bar code health care ID card

UnitedHealthcare uses bar codes on health care ID cards. The bar code format allows for pharmacy information (Rx Bin, PCN and Group) to be included and can be scanned/photocopied successfully keeping the functionality of the bar code intact. This also allows for electronic technology, such as smart phones, to include a graphic of the health care ID card bar code which can be read at the point of service.

A 2D bar code scanner is required to use these cards. The scanner can be used in conjunction with UnitedHealthcareOnline.com to access the Customer’s Personal Health Record, verify eligibility, submit a claim and perform other administrative transactions. UnitedHealthcare uses the national WEDI (Workgroup for Electronic Data Interchange) card standards for our Customer health care ID cards.

For more information, visit UnitedHealthcareOnline.com → Tools & Resources → Health Information Technology → Health Care ID Card Technology.

Commercial health care ID card

Sample Commercial ID card and Legend

Note: Sample health care ID cards are for illustration only; information on health care ID cards may vary

1. UnitedHealthcare commercial logo; Examples include AllSavers, Golden Rule, UnitedHealthcare, UnitedHealthOne.
2. Customer Plan Identifier: This is a customized field to capture more specific details about a customer’s plan as needed. Some examples include Individual Exchange, Tiered Benefits, UnitedHealth Premium, and other customer specific plan names.
3. PCP name and phone number: Please note the PCP address information can be found in the Eligibility and Benefits Center application on Link. For Individual Exchange Customers, ‘PCP required’ will be noted in place of the PCP name and number in most states. This section may also include ‘Laboratory’ (LAB) and ‘Radiology’ (RAD) participant codes.
4. Copay information; if this area is blank, no co-payment is required at the time of service.
5. The Benefit Plan Name: Examples of some commercial UHC plans include, but are not limited to:

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Option</th>
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<tr>
<td>Charter Network</td>
<td>Choice</td>
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<tr>
<td>Choice Plus</td>
<td>Compass</td>
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<tr>
<td>Compass Plus</td>
<td>Compass Balanced</td>
</tr>
<tr>
<td>Dual Complete (PPO)</td>
<td>Navigate</td>
</tr>
<tr>
<td>Navigate Plus</td>
<td>Neighborhood HMO</td>
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<tr>
<td>Optimum Choice</td>
<td>Signature Value</td>
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</table>

6. Referral requirements identifier: Referral requirements may be noted on the front (6a), or occasionally on the back of the card (6b), depending upon the benefit plan.

7. Prescription information: This will include the prescription plan name, prescription bin, PCN and Group code.

8. For Customers/Insureds benefit plan contact information (website, phone numbers) for the Customer/Insured, and if applicable may include critical information on referrals and notifications.

9. For Providers; benefit plan and pharmacy contact information for providers (websites, phone numbers). May also include critical information regarding referrals and may point to some customized benefit plans participation such as the W500.

**Medicare Advantage health care ID card**

In order to help identify Customers associated with our Medicare Advantage products, please go to UnitedHealthcareOnline.com → Tools & Resources → Medicare → HMO, POS & PPO or Special Needs Plans (SNP) → Scroll to “Benefit Plan Name Overviews” in the Reference Materials section.

**Medicare Advantage ID Legend card**

Front:
- **AARP MedicareComplete**
- Health Plan (80840): 911-87726-04
- Member ID: 999999999-99
- Member: SUBSCRIBER BROWN
- PCP Name: PROVIDER BROWN
- PCP Phone: (999) 999-9999
- Medical Network Name: UnitedHealthcare
- Copay: PCP $10
- Spec $40
- ER $75
- H0151 PBP# 001
- Referral Required: AARP MedicareComplete Plan 1 (HMO)

Back:
- Customer Service Hours: 8 a.m. - 8 p.m. local time, 7 days a week
- For Members:
  - Website: www.myAARPMedicare.com
  - Customer Service: 1-800-643-4845 TTY 711
  - NurseLine: 1-877-365-7949 TTY 711
  - Behavioral Health: 1-800-985-2596 TTY 711
  - Dental: 1-800-643-4845 TTY 711
- For Providers:
  - www.unitedhealthcareonline.com
  - Medical Claim Address: PO Box 31362 Salt Lake City, UT 84131-0362
  - PCP to send electronic referrals
  - Dental Providers: www.dtb.com
  - Medicare Solutions
  - Part B RX Claims: OptumRx PO Box 29045, Hot Springs, AR 71903
- For Pharmacists: 1-877-889-6510

Printed: 09/28/15
Health care Medicare Advantage ID card legend:

1. Member Name

2. Dental Benefits: Shows “Dental Benefits Included” if there are routine dental benefits embedded in the plan and/or if the member purchased an optional supplemental dental benefit (rider).

3. PCP name and phone number: Please note the PCP address information can be found in the Eligibility and Benefits Center application on Link.

4. Prescription information: If the plan has integrated Part D prescription drug coverage, this will show the pharmacy information: Rx Bin, PCN and Group code. If the plan does not have Part D coverage, this area will show information for Medicare Part B Drugs.

5. Copay information. PCP, Specialist, and ER copays are shown. Some Special Needs Plans do not list the copay information. In addition, select HMO plans in FL and NC have tiered copayments. FL and NC have two copayments for PCPs; NC also has two copayments for Specialist.

6. Referral requirements identifier:
   a. If a plan requires referrals, it will be noted on the front of the card
   b. If no referral is required, it will be noted on the back of the card

7. The Benefit Plan Name: Examples of some UHC plans include, but are not limited to:
   a. AARP Medicare Complete plans
   b. Care Improvement Plus plans
   c. UnitedHealthcare Dual Complete plans
   d. UnitedHealthcare MedicareComplete plans
   e. UnitedHealthcare Nursing Home Plans

8. For Customer/Insureds; benefit plan contact information (website, phone numbers) for the Customer/Insured

9. For Providers; benefit plan contact information for the Provider

Although most of UnitedHealthcare’s ID cards follow the format above, there are some exceptions. Most notably Harken Health ID cards will display as follows:

Checking eligibility, benefits, and your participation status:

As our product portfolio evolves and new products are introduced, it’s important for you to verify eligibility and benefits before or at the point of service for each office visit. A customer’s eligibility and benefits can differ based on your participation for the Customer’s plan and whether the Customer’s plan offers tiered benefits. Some benefits may be tiered based on the United Health Premium Program, services performed with or without referrals for gated plans, a provider’s taxonomy, or plans that are built around an ACO group. If you are not participating in the Customer’s benefit plan or are outside the service area for the benefit plan (i.e., Compass) the Customer may have higher cost share or no coverage.
There are 3 ways you can verify eligibility and benefits:

- Online using the Eligibility and Benefits Center application on Link
- Electronic Data Interchange (EDI)
- By calling Enterprise Voice Portal at (877) UHC-3210 (842-3210)

**Participation Status**
When confirming eligibility, you will need to know if you are considered a network Provider for the Customer's plan. You can confirm your network participation and tier status for the Customer’s benefit plan using the Eligibility and Benefits Center application on Link.

**Tiered Benefit Plans**
Customers with tiered benefit plans will have an identifier on the front of the healthcare ID card stating UnitedHealth Premium, Tiered Benefits, or ACO Tiered under the group number field. You can determine your tiered status by reviewing the Customer’s benefit plan using the Eligibility and Benefits application on Link.

**Three month grace period for Individual Exchange Customers**
The Patient Protection and Affordable Care Act (PPACA) requires health insurance plans to provide a three-month grace period before terminating coverage for certain individuals enrolled in a health plan purchased through the Individual Health Insurance Marketplace (also known as Individual Exchange). The grace period applies to those who receive federal subsidy assistance in the form of an advanced premium tax credit and who have paid at least one full month’s premium within the benefit year.

There are 3 ways to verify online if a Customer is within their grace period:

- When checking eligibility on UnitedHealthcareOnline.com, we have added an “exchange participant claim eligible through date” at the bottom-right of the Eligibility and Benefits screen to indicate the date in which premiums are paid through by the Customer.
- When checking eligibility on Link, we have added “Premium Paid Through Date” on the Eligibility and Benefits app.
- For EDI 271 Response Transactions, we will return the following information:
  1. Premium Paid to Date
  2. Coverage Status
     a. 1st month: Active
     b. 2nd month: Active - Pending Investigation
     c. 3rd month: Active - Pending Investigation
  3. Period Start – First day of the first month of the grace period
  4. Period End - Last day of the third month of the grace period
  5. MSG - Individual Exchange Grace Period

If the date of service is scheduled to occur after the ‘through date’, then the Customer is in the grace period and is at risk of retroactive termination of coverage if the premium is not paid in full at the end of the three month period.

For more information on how the grace period works and asked questions, visit uhc.com

For Physicians ➔ United for Reform Resource Center.
Our Products:

This section provides information about some of the most common UnitedHealthcare products (your agreement with us may use “benefit contract types”, “benefit plan types” or a similar term to refer to our products).

Visit UnitedHealthcareOnline.com → Tools & Resources → Products & Services for more information about our Products and Individual Exchange plans offered by state. If a Customer presents a health care ID card with a product name with which you are not familiar, please contact Customer Care at (877) 842-3210. This product list is provided for your convenience and is subject to change from time to time.

Understanding your network participation status

As a UnitedHealthcare provider, you are contracted to see all Commercial, (including Exchange), and Medicare Advantage Customers, unless you are excluded from participation as listed in your participation agreement. This includes new benefit plans that are introduced into your market after the effective date of your agreement. Additionally, UnitedHealthcare Compass requires providers to be located in a limited geographic market (network service area).

Participation can be verified for each Customer’s benefit plan in the Eligibility and Benefits Center application on Link.

Commercial products:

UnitedHealthcare is creating new Commercial Products and network configurations to meet Customer needs around affordability and access to quality care. We have a variety of Commercial Products for individuals, small groups, and large groups on a fully insured and self-funded basis. These products vary by their network size and composition, gated or non-gated requirements, and benefit structure.

Health Insurance Marketplaces (Exchanges)

Exchanges are another way for Customers to participate in our existing Commercial Products. UnitedHealthcare offers one or more of our Commercial Products on the Individual or SHOP Exchange (Small Business Health Options Program) in certain states. Commercial Products offered through the Individual and SHOP Exchange will follow the same policies and protocols as outlined within this Guide, except as otherwise required by your agreement.

Commercial product overview grid:

<table>
<thead>
<tr>
<th>Product Name</th>
<th>How do Customers access physicians and health care professionals?</th>
<th>Is a Specialist referral required?</th>
<th>Is the treating physician and/or facility required to give notification when providing certain services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Choice and Choice Plus</td>
<td>Customers can choose any network physician or health care professional without a referral and without designating a primary physician. UnitedHealthcare Choice Plus provides out-of-network benefits. UnitedHealthcare Choice Plus does not cover out-of-network services (except for emergency services).</td>
<td>No. Customers have open access to a national network of care providers.</td>
<td>Yes, on selected procedures, see guidelines in the Notification requirements section of this Guide.</td>
</tr>
<tr>
<td>UnitedHealthcare Select and Select Plus</td>
<td>Customers choose, or are assigned, a (PCP) for each family member from the network of participating physicians. The Customer is encouraged to see their PCP to coordinate their care, but is not required to obtain PCP referral when accessing a Specialist or facility for care. UnitedHealthcare Select Plus provides out-of-network benefits. UnitedHealthcare Select does not cover out-of-network services (except for emergency services).</td>
<td>No. Customers have open access to a national network of limited care providers.</td>
<td>Yes, on selected procedures, see guidelines in the Notification requirements section of this Guide.</td>
</tr>
<tr>
<td>Product Name1</td>
<td>How do Customers access physicians and health care professionals?</td>
<td>Is a Specialist referral required?</td>
<td>Is the treating physician and/or facility required to give notification when providing certain services?</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------------------</td>
<td>----------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>UnitedHealthcare Options PPO</td>
<td>Customers can choose any network physician or health care professional without a referral and without designating a primary physician. Options PPO also provides, out-of-network benefits2</td>
<td>No, Customers have open access to a national network of care providers.</td>
<td>In all states other than Colorado, no. Customers are responsible for notifying us at the phone number on their health care ID card, as described under the Customer’s benefit plan. Please refer Customers to Customer Care for questions about their responsibilities. In Colorado: Yes, for selected procedures, see guidelines in the Notification requirements section of this Guide</td>
</tr>
<tr>
<td>UnitedHealthcare Indemnity</td>
<td>Customers can choose any physician or health care professional.2</td>
<td>No, Customers have open access to a national network of care providers.</td>
<td>No. Customers are responsible for notifying us at the phone number on their health care ID card. Please refer Customers to Customer Care for questions about their responsibilities.</td>
</tr>
<tr>
<td>UnitedHealthcare CORE and CORE Essential</td>
<td>Customers can choose any network physician or health care professional without a referral and without designating a primary physician. CORE provides out-of-network benefits.2 CORE Essential does not (except for emergency services).</td>
<td>No, Customers have open access to a national network of care providers.</td>
<td>Yes, on selected procedures See guidelines in the Notification requirements section of this Guide</td>
</tr>
<tr>
<td>UnitedHealthcare Navigate®, Navigate Balanced®, Navigate Plus®</td>
<td>For each covered family member, Customers choose a network primary care physician, or are assigned a PCP. If they do not select one, to manage the Customer’s care and generate electronic online referrals to network Specialists when required. Navigate Plus provides out-of-network benefits.2 Navigate and Navigate Balanced do not (except for emergency services).</td>
<td>Yes, on selected procedures, see guidelines in the Referrals and Notification requirements-Navigate, Charter, Compass and Core section of this Guide.</td>
<td>Yes, on selected procedures, see guidelines in the Notification requirements section of this Guide</td>
</tr>
<tr>
<td>UnitedHealthcare Charter®, Charter® Balanced, Charter® Plus</td>
<td>For each covered family member, Customers choose a network primary care physician, or are assigned a PCP. If they do not select one, to manage the Customer’s care and generate referrals to network Specialists when required. Charter Plus provides out-of-network benefits.2 Charter and Charter Balanced do not (except for emergency services).</td>
<td>Yes, on selected procedures, see guidelines in the Referrals and Notification requirements-Navigate, Charter, Compass and Core section of this Guide.</td>
<td>Yes, on selected procedures, see guidelines in the Notification requirements section of this Guide</td>
</tr>
<tr>
<td>UnitedHealthcare Compass, Compass Balanced, Compass Plus</td>
<td>For each covered family member, Customers choose a network primary care physician, or are assigned a PCP, to manage the Customer’s care and generate referrals to network Specialists within the Compass network service area.4 Compass Plus provides out-of-network benefits.3 Compass and Compass Balanced do not (except for emergency services).</td>
<td>Yes, on selected procedures, see guidelines in the Referrals and Notification requirements-Navigate, Charter, Compass and Core section of this Guide.</td>
<td>Yes, on selected procedures, see guidelines in the Notification requirements section of this Guide</td>
</tr>
</tbody>
</table>

1 The UnitedHealthcare Network may be different among Commercial Products in your local market. Please refer to your contract to determine whether you are part of that local network.

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

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

4 For more information the Compass service area, please go to UnitedHealthcareOnline.com  Tools & Resources  Products & Services  UnitedHealthcare Compass.
Commercial networks
Each product has a distinct network of care providers with whom we can collaborate more closely to have a positive impact for our Customers. The following Commercial Products include a subset of our commercial network providers: Navigate, Charter, Core, and Compass. Providers are encouraged to coordinate care with other providers that participate for the Customer’s plan. You may find a list of participating providers by each plan at UnitedHealthcareOnline.com ➔ Physician Directory ➔ General Physician Directory.

W500 Additional Network
• Some benefit plans include Additional Network Benefits (referred to as W500), for certain services to be provided by an additional network of providers, (this may also be referred to as the ‘Wrap Network’). These services include:
  ◦ Emergency services and related admissions;
  ◦ Urgent care services; and
  ◦ Pre-approved services by UnitedHealthcare when services are not available from a network provider
• Providers that have been excluded from participation in narrow networks may be contracted to provide coverage for Customers with the W500 Additional Network Benefit Plans.
• The W500 Additional Network Benefit Plan is comprised of providers excluded from participation in that plan as well as UnitedHealthcare’s network of providers outside of the Compass network service area.

Medical Policies, Drug Policies and Coverage Determination Guidelines for Commercial Customers
General information
UnitedHealthcare has developed Medical Policies, Drug Policies, and Coverage Determination Guidelines to assist us in administering health benefits. These policies and guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and health care providers are solely responsible for determining what care to provide to their patients. Enrollees should always consult their physician before making any decisions about medical care.

• Our Medical and Drug Policies express our determination of whether a health service (e.g., test, drug, device or procedure) is proven to be effective based on the published clinical evidence. They are also used to decide whether a given health service is medically necessary. Services determined to be experimental, investigational, unproven, or not medically necessary by the clinical evidence are typically not covered.
• Coverage Determination Guidelines are used to determine whether a service falls within a benefit category or is excluded from coverage. Coverage Determination Guidelines may address such matters as whether services are skilled versus custodial, or reconstructive versus cosmetic.

Benefit coverage for health services is determined by the enrollee’s specific benefit plan document, such as a Certificate of Coverage, Schedule of Benefits, or Summary Plan Description, and applicable laws that may require coverage for a specific service. The enrollee’s benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the enrollee’s specific benefit document supersedes these policies and guidelines.

Medical Policies, Drug Policies and Coverage Determination Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. The information presented in these policies and guidelines is believed to be accurate and current as of the date of publication, and is provided on an “as is” basis. Additionally, UnitedHealthcare may use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified Health Care Provider and do not constitute the practice of medicine or medical advice.

Access to policies
Policy updates

Product requirements for Navigate, Charter and Compass

Primary Care Physicians (PCP) selection
• Customers are required to select a network PCP or we will assign one. A PCP is defined as a physician specializing in family practice, internal medicine, pediatrics, or general practice. Other providers will be included as primary physicians as required by state mandates.
• Some PCPs have multiple TINs but may not participate under each of those TINs for the Customer’s benefit plan. Therefore, Customers are required to see their PCP or a covering physician at the address location that shares the same TIN listed on the Patient Eligibility screen. Prior to scheduling appointments, it is important to verify that you are the Customer’s assigned PCP and the TIN listed on the Patient Eligibility screen is the same TIN for the address location where the Customer will be seen. You may submit Provider address corrections through the Provider Data Management application on Link, or call the phone number on the back of the Customer’s health care ID card prior to seeing the Customer.
• PCPs are responsible for monitoring their office capacity based on Customer assignment and for notifying UnitedHealthcare if you have reached your maximum capacity. A self-reporting tool is available for you to generate a PCP roster report at UnitedHealthcareOnline.com → Tools & Resources → Reports.
• Customers may elect to change their PCP at any time by calling the number on the back of the Customer’s ID card.

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

Specialist Referrals
The Customer’s PCP coordinates the Customer’s care and initiates online electronic referrals to other network Specialists prior to the Customer seeking care. A referral to the network Specialist is required for the associated inpatient or outpatient facility claim to be eligible or receive the highest benefit, based on the Customer’s benefit plan. Failure to follow referral requirements results in financial penalties to the Customer. Referrals are valid for any physician within the same TIN as the Specialist included on the referral and cover eligible services performed in all settings, including inpatient and outpatient.

Managing Referrals
• Specialists are required to confirm the status of referrals before each visit. Customers will have significantly reduced benefits or no coverage for care provided without a referral.
• The referral is considered expired when the authorized number of visits or the referral end date has been reached, whichever occurs first.
• If a referral has expired, but additional care is needed, the Customer must contact their PCP to request a new referral. The Specialist is also encouraged to contact the PCP to inform him or her of the care that has been provided and to request a new referral.
• If a network Specialist identifies the need for a Customer to see another Specialist, the Specialist must ask the Customer’s PCP, who decides whether or not to issue an additional referral.

• Facilities are required to confirm the existence of a referral to the admitting physician (unless the admitting physician is the Customer’s PCP) for planned services. Customers have significantly reduced benefits or no coverage for care provided without a referral.

• A list of existing referrals can be viewed on UnitedHealthcareOnline.com, on the Eligibility and Benefits application on Link, including information about the network Specialist to whom the referral is made, the number of visits authorized and the number of visits remaining.

**Services Not Requiring a Referral**

• Referrals are not required for the following services:
  
  › Services from a network Obstetrician/Gynecologist, including any type of OB/GYN (e.g., general OB/GYN, perinatologist, GYN/oncology, nurse midwife, nurse practitioner, physician assistant).
  
  › Services from a pathologist, radiologist or anesthesiologist physician.
  
  › Services from a physician practicing under the same TIN* as the primary physician.
  
  › A routine refractive eye exam from a network provider.
  
  › Mental health/substance use disorder services with network behavioral health clinicians.
  
  › Services rendered in any emergency room, network urgent care center, or network convenience clinic, or network online virtual visit provider, or services for emergency ambulance transport.
  
  › Physician services for emergency/unscheduled admissions.
  
  Services from facility-based inpatient/outpatient network consulting physicians, network assisting surgeons, network co-surgeons, or network team surgeons.
  
  › Any other services for which applicable law does not allow us to impose a referral requirement.

• If not billed by a network physician, referrals are not required for any non-physician type of network services which include but are not limited to:
  
  › Outpatient lab, x-ray, or diagnostics.
  
  › Physical therapy, DME, home health, prosthetic devices, hearing aids, national specialty pharmacy providers.
  
  › Rehab services.

Note that manipulative treatment and vision therapy are physician services and require referrals.

**Referral Submission Requirements**

• Referrals must be submitted by the Customer’s PCP on our secure website at UnitedHealthcareOnline.com → Notification/Prior Authorizations → Referral Submission or Link Eligibility & Benefits application.

• Referrals cannot be accepted via phone, fax or paper, unless required by law in certain states.

• Referral submissions may be backdated up to five calendar days prior to the date of submission.

• Users must have the Referral Submission functional role selected on their user profile to be granted security rights to submit and verify the status of referrals. For more information on access and roles, refer to the Roles Function Quick Reference Guide at UnitedHealthcareOnline.com → Help → Quick Reference → User ID & Password Management → Roles Function Quick Reference.

• Only the Customer’s PCP or other PCP practicing under the same TIN can submit referrals to us for the Customer to see a network Specialist. A Specialist cannot enter a referral.

**Referral Impacts to notification requirements**

Customer’s must have referrals to see another network Specialist to receive the highest network benefit level. When the Specialist needs to perform a service that also requires a notification, then the Specialist must follow the notification requirements as outlined within this Guide. The referral is no substitution for notifications.

* Referrals should be submitted if the Specialist TIN is not known
For planned admissions, if a referral is not on file for the Customer to see the admitting Specialist, then the hospital admission will be denied or have significantly reduced benefits because of the lack of a referral. When this occurs, a Customer whose benefit plan does not offer coverage for services provided without a referral, will be held financially responsible for services provided without a referral. Customers with network benefits that do not require referrals (Balanced and Plus plans for Navigate, Charter, and Compass) will have their admissions approved without referrals, but at a higher cost share for the Customer.

**Maximum Referral Visits**

Customers with network coverage benefits for no referrals (Navigate, Charter, Compass Balanced and Plus plans for Navigate, Charter, and Compass) will have their admissions approved without referrals at a higher cost share for the Customer.

Each referral may include up to 6 visits and any unused visits will expire after 6 months. At any time after the 6 visits have been used or if any unused visits expire after 6 months, an additional referral to that network Specialist with up to 6 visits may be entered by the Customer’s PCP. For Customers with chronic conditions, the online referral screen will allow Standing Referrals for 99 visits to be entered for up to 6 months.

At any time after the 99 visits have been used or if any unused visits expire after 6 months, a new referral can be issued. Conditions eligible for Standing Referrals of up to 99 visits are:

- AIDS/HIV
- Anemia
- Cancer
- Cystic Fibrosis
- Schizoaffective disorders/schizophrenia
- Parkinson’s Disease
- Amyotrophic Lateral Sclerosis
- Multiple Sclerosis
- Epileptic Seizure
- Myasthenia Gravis
- Glaucoma
- Thrombotic Microangiopathy
- Allergies
- Renal Failure (acute)
- Seizure
- Fracture Care

**Plan requirements for all Commercial Plans**

**Using Non-Participating Providers**

When services are not available from a network physician, the Customer’s PCP, direct access Provider or referred network Specialist can submit a request for an out-of-network review. If approved, services rendered by the nonparticipating Provider will be covered at the network benefit level. The physician request can be submitted by calling the number on the back of the Customer’s health care ID card. UnitedHealthcare will review the request and determine whether or not a Provider in the Customer’s network is available to treat their condition and, as a result, whether the request will be approved to cover eligible services at the network level.

UnitedHealthcare will send a written confirmation with the final decision to the requesting physician and the Customer.
Before submitting a request for services from a non-participating provider:
1. Confirm there is no network Provider available by performing a search on the Provider directory.
2. If there is not a network Provider available, then determine if the Customer has the W500 Additional Network Benefit by reviewing the back of the Customer’s health care ID card.
   a. If W500 is indicated on the back of the Customer’s health care ID card, then search for a network Provider for the W500 Additional Network directory. To access the W500 Additional Network directory:
      i. Select Physician Directory ➔ General Physician Directory
      ii. Select Additional Network benefit Plan/W500 Directory
      iii. If a network Provider is found, then request for an out-of-network review for the Customer to see the network Provider participating for the W500 Additional Network.
   b. If W500 is not indicated on the back of the Customer’s health care ID card or if a network Provider is not found in the W500 Additional Network directory, then proceed with submitting a request by calling in a notification request for the Customer to see a nonparticipating Provider outside of the W500 network.
3. All services are still subject to Advance Notification and Prior Authorization as referenced in the Notification requirements section of this Guide.

Consumer-driven health plans
UnitedHealthcare offers consumer-driven health plans that may be identified via the health care ID card or by looking up your patient’s information in the Eligibility and Benefits Center on Link.

Each of these products includes 3 major components:
1. Traditional medical insurance that includes preventive care. Preventive care is not charged against the deductible;
2. A Health Reimbursement Account (HRA) or Health Savings Account (HSA) for routine health care expenses, and
3. Educational tools and other helpful support resources designed to influence consumer behavior and health care choices.

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

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

This table provides information about some of the most common UnitedHealthcare Medicare Advantage products for Medicare eligible individuals and employer group retirees. Visit: UnitedHealthcareOnline.com; AARPMedicarePlans.com, UHCMedicareSolutions.com, uhcwest.com; or UHCCommunityPlan.com for more information about our Medicare Advantage products in your area. If a Customer presents a health care ID card with a product name with which you are not familiar, please contact the Enterprise Voice Portal at (877) 842-3210 for a product list. That product list is provided for your convenience and is subject to change at any time.

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

## Medicare Advantage – Products for Individuals

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Medicare Customer’s Eligibility</th>
<th>How do Customers access physicians and health care professionals?</th>
<th>Does a primary physician have to make a referral to a Specialist?</th>
<th>Is the treating physician and/or facility required to give notification when providing certain services?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HMO and HMO-POS plans under the UnitedHealthcare or AARP brands:</strong></td>
<td>Customers who are Medicare eligible</td>
<td>Customers choose a primary physician from the network of physicians who can help coordinate their care.</td>
<td>A referral may or may not be required to see a Specialist, depending on the plan ** For further information, see Medicare Advantage Referral Required Plans, or call (877) 842-3210. Please have the health care ID and your TIN available. Primary care physicians should coordinate care with the appropriate network Specialists.</td>
<td>Yes, see guidelines in the Notification requirements section of this Guide.</td>
</tr>
<tr>
<td>• MedicareComplete</td>
<td></td>
<td>HMO-POS plans provide out-of-network coverage for some covered benefits.*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MedicareComplete Essential</td>
<td></td>
<td>HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MedicareComplete Plus</td>
<td></td>
<td>A referral may or may not be required to see a Specialist, depending on the plan ** For further information, see Medicare Advantage Referral Required Plans, or call (877) 842-3210. Please have the health care ID and your TIN available. Primary care physicians should coordinate care with the appropriate network Specialists.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Local PPO and Regional PPO (RPO) plans under the UnitedHealthcare or AARP brands:</strong></td>
<td>Customers who are Medicare eligible</td>
<td>Customers choose a primary physician from the network of physicians who can help coordinate their care.</td>
<td>No, a referral is not needed.</td>
<td>Yes, see guidelines in the Notification requirements section of this Guide.</td>
</tr>
<tr>
<td>• MedicareComplete Choice</td>
<td></td>
<td>PPO plans provide out-of-network coverage for all benefits also covered in-network.*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MedicareComplete Choice Essential</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Local PPO and RPO plans under the Care Improvement Plus name:</strong></td>
<td>Customers who are Medicare eligible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Care Improvement Plus Medicare Advantage</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Institutional Special Needs Plans (HMO, HMO-POS, PPO)</strong></td>
<td>Customers reside in a contracted institutional setting or live in the community but require an equivalent level of care to those residing in a long-term care facility.</td>
<td>Customers choose a primary physician from the network of physicians to coordinate their care.</td>
<td>No, a referral is not needed.</td>
<td>Yes, see guidelines in the Notification requirements section of this Guide.</td>
</tr>
<tr>
<td>• UnitedHealthcare Nursing Home Plan</td>
<td></td>
<td>PPO and HMO-POS plans provide out-of-network coverage.*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• UnitedHealthcare Assisted Living Plan</td>
<td></td>
<td>HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

** Most services rendered to customers enrolled in gatekeeper plans require referrals and/or authorizations from the PCP or Physician Hospital Organization, dependent upon contractual arrangement See Medicare Advantage Referral Required Plans for more information.
<table>
<thead>
<tr>
<th>Product Name</th>
<th>Medicare Customer’s Eligibility</th>
<th>How do Customers access physicians and health care professionals?</th>
<th>Does a primary physician have to make a referral to a Specialist?</th>
<th>Is the treating physician and/or facility required to give notification when providing certain services?</th>
</tr>
</thead>
</table>
| **Dual Special Needs Plans (HMO, PPO and Regional PPO)**  
- UnitedHealthcare Dual Complete  
- UnitedHealthcare Senior Care Options  
- Care Improvement Plus Dual Advantage | Customers both are Medicare and Medicaid eligible. | Customers choose a primary physician from the network of physicians, to coordinate their care. POS and PPO plans provide out-of-network coverage. HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis. | A referral may or may not be required to see a Specialist, depending on the plan. For further information, see Medicare Advantage Referral Required Plans, or call (877) 842-3210. Please have the health care ID card and your TIN available. PCPs should coordinate care with the appropriate network Specialists. | Yes, see guidelines in the Notification requirements section of this Guide. |
| **Chronic Special Needs Plans (PPO and Regional PPO)**  
- Care Improvement Plus Gold Rx  
- Care Improvement Plus Silver Rx | Customers who have one or more of the following qualifying chronic conditions: diabetes, chronic heart failure, and/or cardiovascular disorders. | Customers choose a primary physician from the network of physicians who can help coordinate their care. PPO plans provide out-of-network coverage for all benefits also covered in-network. | No. a referral is not needed. | Yes, see guidelines in the Notification requirements section of this Guide. |
| **Erickson Advantage Plans** | Customers who reside in an Erickson Retirement Community. | Customers are assigned a primary physician from the Erickson Health Medical Group network of physicians. The primary physician coordinates their care. Erickson Advantage provides out-of-network coverage. | No, a referral is not needed. | Yes, see guidelines in the Notification requirements section of this Guide. |

* The benefit level for non-emergency services from non-network physicians and other providers will generally be less than that for services from network physicians and other providers.
# Medicare Advantage – Products for Groups

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Customer’s Eligibility</th>
<th>How do Customers access physicians and health care professionals?</th>
<th>Does a primary physician have to make a referral to a Specialist?</th>
<th>Is the treating physician and or facility required to give notice when providing certain services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Group Medicare Advantage (HMO/MCO)</td>
<td>Customers meet employer’s requirements.</td>
<td>Customers choose a primary physician from the network of physicians. The primary physician coordinates their care. HMO-POS plans provide out-of-network coverage for some covered benefits.* HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.</td>
<td>A referral may or may not be required to see a Specialist based on the plan. ** For further information, see Medicare Advantage Referral Required Plans, or call the number on the back of the health care ID card. Please have the health care ID and your TIN available. Primary care physicians should coordinate care with the appropriate network Specialists.</td>
<td>Yes, see guidelines in the Notification requirements section of this Guide.</td>
</tr>
<tr>
<td>UnitedHealthcare Group Medicare Advantage Plans (Regional PPO).</td>
<td>Customers meet employer’s requirements.</td>
<td>Customers may choose a primary physician from the network of physicians. If a primary physician is chosen, the primary physician coordinates their care. Regional PPO plans provide out-of-network coverage *</td>
<td>No, a referral is not needed.</td>
<td>Yes, see guidelines in the Notification requirements section of this Guide.</td>
</tr>
<tr>
<td>UnitedHealthcare Group Medicare Advantage Plans (PPO)</td>
<td>Customers meet employer’s requirements.</td>
<td>Customers are encouraged but not required to see a primary physician from the network of physicians to help coordinate their care.</td>
<td>No, a referral is not needed.</td>
<td>Yes, see guidelines in the Notification requirements section of this Guide.</td>
</tr>
</tbody>
</table>

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

** Most services rendered to customers enrolled in gatekeeper plans require referrals and/or authorizations from the PCP or Physician Hospital Organization, dependent upon contractual arrangement. See Medicare Advantage Referral Required Plans for more information.

## Medicare Advantage Referral Required Plans

The referral required plans are gated plans that focus on coordination of care through the PCP with referrals to Specialists. The Plan names are on the Customer’s health care ID cards. Referral required products also require Prior Authorization by UnitedHealthcare or delegated entity for selected services as referenced in the Notification requirements section in this Guide.

## 2016 Medicare Advantage Referral Required Plans

<table>
<thead>
<tr>
<th>Alabama</th>
<th>Florida</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0151 PBP#001 AARP® MedicareComplete® Plan 1</td>
<td>H1045 PBP#028 AARP® MedicareComplete®</td>
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<tr>
<td>H0151 PBP#015 UnitedHealthcare Dual Complete®</td>
<td>H1045 PBP#029 AARP® MedicareComplete®</td>
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<td>H0151 PBP#025 AARP® MedicareComplete® Plan 2</td>
<td>H1045 PBP#030 AARP® MedicareComplete®</td>
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<td>H0151 PBP#027 AARP® MedicareComplete® Plan 3</td>
<td>H1045 PBP#031 AARP® MedicareComplete®</td>
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<td>Arizona</td>
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<td>H5253 PBP#036 AARP® MedicareComplete®</td>
<td>H1045 PBP#033 AARP® MedicareComplete®</td>
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<tr>
<td>Connecticut</td>
<td></td>
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<tr>
<td>H0755 PBP#033 UnitedHealthcare MedicareComplete® Plan 3</td>
<td>H1045 PBP#034 AARP® MedicareComplete® Plan 2</td>
</tr>
<tr>
<td></td>
<td>H1045 PBP#035 AARP® MedicareComplete®</td>
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<td></td>
<td>H1045 PBP#039 UnitedHealthcare Dual Complete® LP</td>
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<td>H1045 PBP#040 UnitedHealthcare Dual Complete® LP</td>
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<tr>
<td>State</td>
<td>Plans</td>
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<tr>
<td>--------------</td>
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<tr>
<td>Georgia</td>
<td>H1111 PBP#006 AARP® MedicareComplete® Plan 1, H1111 PBP#007 AARP® MedicareComplete® Plan 2</td>
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<tr>
<td>Illinois</td>
<td>H2654 PBP#033 AARP® MedicareComplete® Focus, H2654 PBP#034 AARP® MedicareComplete® Plan 1, H2654 PBP#035 AARP® MedicareComplete® Plan 2, H2654 PBP#036 AARP® MedicareComplete® Access</td>
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<td>Kentucky</td>
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<tr>
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<td>New York</td>
<td>H3379 PBP#001 AARP® MedicareComplete® Plan 2</td>
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<td>Virginia</td>
<td>H5253 PBP#047 AARP® MedicareComplete® Plan 1</td>
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<td>Washington</td>
<td>H1286 PBP#002 AARP® MedicareComplete® Plan 1, H1286 PBP#003 AARP® MedicareComplete® Essential</td>
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</tbody>
</table>
Health care ID card
Customers receive health care ID cards containing information that helps identify the type of benefit plan, Customer’s PCP, and benefit plans that require referrals. Please note the referral language displayed on the front of the health care ID cards.

Note: For more detailed information on ID cards and to see a sample health care ID card, please refer to the Health care identification (ID) cards section of this guide. Sample health care ID cards are for illustration only; information on health care ID cards may vary.

Confirming eligibility and benefits
Checking your patient’s eligibility and benefits prior to rendering services will allow you to verify PCP assignment, collect copayments and know when the Customer has reached their maximum out of pocket limits, determine if a referral is required, and reduce denials for non-coverage. To check eligibility and benefits, use any of the following methods:

- The Eligibility and Benefits Center application on Link, or the delegated entity’s portal, as applicable, shown on the back of the Customer’s health care ID card;
- Electronic Data Interchange (EDI) – where applicable.
- UnitedHealthcareOnline.com
- Phone number on the back of the Customer’s health care ID card;

Medicare Advantage Referral Required Plan Details
The plan rules identified below only apply to the referral required plans listed above.

Referral Required Plans
A network-only product where Customers must have a referral from their PCP to receive network benefits for services from any specialty Provider who is not practicing under the same TIN as their PCP. If Customers seek care from a specialty Provider without a referral, there is no payment for the services and the claim will deny Provider liability. The Customer cannot be billed for such services.

Primary care physicians (PCP) selection
Customers are required to select a network PCP or one is automatically assigned in order for the Customer to receive the highest level of benefits. A PCP is defined as a physician specializing in family practice, internal medicine, or general practice. Other providers may be included as primary physicians such as nurse practitioners and physician assistants as allowed by state mandates.

Prior to scheduling appointments, it is important to verify that you are the Customer’s assigned PCP on the Patient Eligibility screen. If you are not the assigned PCP, please have the Customer contact the customer service number on the back of their health care ID card.

Changing PCP
Customers may elect to change their PCP at any time. Changes submitted to UnitedHealthcare will generally be effective on the 1st day of the following month. Referrals previously submitted by the Customer’s PCP will not be affected by the change in PCP.

Specialist Referrals
The Customer’s PCP coordinates the Customer’s care and generates electronic referrals to network Specialists prior to the Customer seeking care. Referrals are valid for any Provider within the same TIN as the Specialist included on the referral and cover eligible services performed in all settings including inpatient and outpatient. Referrals match on TIN only; there is no referral matching on diagnosis, type of service, or place of service. Referrals are made to the Specialist rendering the service, not to the facility where the services are performed.

If a network Specialist to whom the Customer has been referred identifies the need for a Customer to see another Specialist, the Specialist must contact the PCP. Only the Customer’s PCP or a PCP practicing under the same TIN can write a referral to a network Specialist. A Specialist cannot enter a referral.
Services Not Requiring a Referral*

Referrals are not required for the following services:

- Any service provided by a network PCP or a network physician practicing under the same tax ID as the Customer’s PCP
- Any service from a network obstetrician/gynecologist, chiropractor, optometrist, ophthalmologist, optician or podiatrist
- Allergy immunotherapy
- Mental health/substance abuse services with behavioral health clinicians
- Any service from a pathologist or anesthesiologist (excludes office-based or pain management services), and any inpatient consulting physicians including hospitalists
- Services rendered in an emergency room, emergency ambulance, or a network urgent care center or convenience clinic
- Medicare-covered preventive services, kidney disease education or diabetes self-management training
- Routine annual physical exams, vision or hearing exams
- Any lab services and radiological testing service, excluding radiation therapy
- Durable medical equipment, home health, prosthetic/orthotic devices, medical supplies, diabetic testing supplies and Medicare Part B drugs
- Services that may be covered by some Medicare Advantage plans but are not covered by Medicare, such as hearing aids, routine eyewear, fitness benefits that may include a gym membership, or outpatient prescription drugs
- Services obtained under the UnitedHealth Passport® Program, which allows for services while traveling

Referral Submission Requirements:

- Referrals must be submitted electronically by the Customer’s PCP using the Eligibility and Benefits Center Application on Link, or to the delegated entity’s portal shown on the back of the Customer health care ID card.

Failure to follow referral requirements results in Provider claim denial. Customers cannot be billed for services performed without a valid referral.

Maximum Referral Visits

The PCP will determine the number of visits necessary for each referral with a timeframe limit of up to 6 months. After the initial visits are used (or if unused visits expire), the PCP may submit another referral to the network Specialist.

Referral Status

Specialists are expected to confirm the existence of a referral (specific to the Specialist’s TIN) before seeing the Customer. A list of existing referrals can be viewed in the Eligibility and Benefits Center application on Link, including information on the network Specialist to whom the referral is made, number of visits authorized and number of visits remaining.

Referrals and Notification requirements-Medicare Advantage Referral Required Plans

The physician performing a service that requires Notification, (see Notification requirements section in this Guide) has the responsibility to follow the Advance Notification or Prior Authorization process. The Advance Notification and Prior Authorization process is in addition to the referral submission process. If a referral has not been obtained, then coverage will be denied for no referral on file. All other protocols and guidelines outlined in this manual apply to the Medicare Advantage Referral Required Plans.

* Delegated plans may follow a separate referral exclusion list. For Missouri benefit plans, there is no change to referral rules.
Medicare Select (AARP Health)

What Is Medicare Select?
Medicare Select is a Medicare Supplement product available only to AARP Customers who reside within the service area of a hospital that participates in our Medicare Select network. The network aspect of Medicare Select allows lower premiums than those for non-Select plans.

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

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

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

UnitedHealthcare Claim Division
P.O. Box 740819
Atlanta, GA 30374-0819

Note: Medicare Part B claims billed to a Medicare carrier are, in most cases, received electronically from the Medicare carrier. To promote timely processing on all claim submissions, follow standardized Medicare billing practices.

Be sure to include the insured’s 11 digit AARP membership number on the standard CMS billing form.

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

Medicare Select Plans C & F
- In-Hospital Part A coinsurance for days 61 through 90 in a Medicare Benefit Period.
- In-Hospital Part A coinsurance for days in which Lifetime Reserve days are used.
- Medicare Part A eligible expenses for a Lifetime Maximum of 365 days after all Medicare Part A benefits are exhausted.
- Medicare Part B coinsurance (generally 20% of Medicare’s approved amount).
- Medicare Part B deductible amount applied each calendar year.
- Skilled Nursing Facility stays - the daily coinsurance amount for days 21 to 100 for stays eligible under Medicare.
- Medicare Parts A and B Blood deductible: Charge incurred for the first 3 pints of un-replaced blood furnished in a calendar year.
- Foreign Travel Emergency.
- Hospice - the Medicare copayments and coinsurance for Hospice Care and Respite Care.

Select Plan F only
- Medicare Part B Excess Charges for Medicare approved services.

Medicare Select benefit design
Medicare Select Customers must go to a participating hospital. Only participating hospitals will be included in AARP Medicare Select Plan marketing materials within their service area.

- Under the AARP Medicare Select Plans C and F, neither inpatient hospital stays, nor outpatient hospital services, will be covered unless they are received at a participating hospital. The participating hospital agrees to a reduced reimbursement of Medicare’s Part A deductible. UnitedHealthcare reimburses all other Medicare Part A eligible
expenses up to the 365-day limit, which are not paid for by Medicare, as well as all Medicare Part B eligible expenses not paid for by Medicare. If a non-participating hospital provides inpatient or outpatient services to a Medicare Select insured Customer the services will not be covered.

- Hospitals can expect to receive claim payment in a timely fashion, as more than 90% of all claims are processed within 10 business days, which reduces hospital collection efforts.

- Note that all Medicare Select Plans meet “Safe Harbor” requirements under Federal Anti-Kickback legislation. For more information on Medicare Select and other AARP Medicare Supplement product offerings, contact Customer Service at (800) 523-5800, (para Español (800) 822-0246). For TTY/TDD hearing impaired, use your TTY machine and call 711 or you can access services through the National Relay Center at (800) 828-1120.

**Coverage Summaries for Medicare Advantage Customers**

**Hierarchy of References/Resources**
UnitedHealthcare Coverage Summaries are developed and written using the following references/resources:


2. Local Coverage Determination (LCD) and Local Policy Articles (A/B MAC & DME MAC)

3. UnitedHealthcare Medical Policies/Coverage Determination Guidelines

**General information**
Covered benefits, limitations and exclusions are specified in the UnitedHealthcare Medicare Advantage Plan Evidence of Coverage (EOC) and Summary of Benefits (SOB). UnitedHealthcare Medicare Advantage Coverage Summaries are policies based on existing current Medicare National Coverage Determinations, Local Coverage Determinations, UnitedHealthcare Medical Policies, and applicable UnitedHealthcare Medicare Advantage Plans EOCs and SOBs intended to provide benefit coverage information and guidelines specific to UnitedHealthcare Medicare Advantage Plans. Benefit interpretations for UnitedHealthcare Medicare Advantage Plan Members are made on a case-by-case basis using the guidelines in this Manual. The Coverage Summaries are subject to change based upon changes in Medicare’s coverage requirements, changes in scientific knowledge and technology and evolving practice patterns. Providers are responsible for reviewing the CMS Medicare Coverage Center guidance and in the event that there is a conflict between this Manual and the CMS Medicare Coverage Center guidance, the CMS Medicare Coverage Center guidance will control. A complete library of UnitedHealthcare Medicare Advantage Coverage Summaries and additional information about Coverage Summaries is available at UnitedHealthcareOnline.com ➔ Tools & Resources ➔ Policies, Protocols and Guides ➔ UnitedHealthcare Medicare Advantage Coverage Summaries.

**Coverage summary updates**
UnitedHealthcare publishes monthly editions of the “Medicare Advantage Coverage Summary Update Bulletin”, an online resource that provides notice to our network physicians and facilities of any changes to our Medicare Advantage Coverage Summaries. The Medicare Advantage Coverage Summary Update Bulletin is posted on the first calendar day of every month and is accessible online at UnitedHealthcareOnline.com ➔ Tools & Resources ➔ Policies, Protocols and Guides ➔ UnitedHealthcare Medicare Advantage Coverage Summaries ➔ Update Bulletin. As a supplemental reminder to the detailed policy update summaries announced in the Medicare Advantage Coverage Summary Update Bulletin, a list of recently approved, revised and/or retired Coverage Summaries is also provided in the monthly Network Bulletin available at UnitedHealthcareOnline.com ➔ Quick Links ➔ Network Bulletin.

**Notification requirements**

**Notification requirements at a glance:**
To view the most current and complete Advance Notification List, including procedure codes and associated services, go to UnitedHealthcareOnline.com ➔ Clinician Resources ➔ Advance and Admission Notification Requirements.

- Physicians, health care professionals and ancillary providers are responsible for providing Advance Notification for services referenced in the Advance Notification List.
• Physicians, health care professionals and ancillary providers are responsible for directing Customers to care within the Customer’s UnitedHealthcare network.
• Customers may be required to obtain Prior Authorization of out-of-network services.
• Facilities are responsible, prior to the date of services, for confirming the coverage approval is on file.
• Facilities are responsible for Admission Notification for inpatient services even if the coverage approval is on file.
• Failure to comply with the requirements described in greater detail below may result in claims being denied in whole or in part and, as required under your agreement with us, the Customer being held harmless.

Standard Advance Notification requirements for physicians, health care professionals and ancillary providers

Why is Advance Notification required?
Advance Notification is the first step in the process of making a coverage determination and for referrals to case and condition management programs. Information received about planned medical services, supports the pre-service clinical coverage review process, where applicable, and the care coordination process, which allows us to support our Customers throughout their course of treatment, including pre-service planning and coordination of home care and other discharge plans.

Is the Advance Notification process different for different Customers?
No. The list of services for which you must give Advance Notification, and the process for giving Advance Notification, is the same with regard to all Customers in benefit plans that are subject to this Advance Notification protocol.

What is the difference between Advance Notification and Prior Authorization?
The list of services that require Advance Notification and Prior Authorization is the same. Certain services require Prior Authorization which will result in a request for clinical information, a clinical coverage review based on medical necessity, and a coverage determination. Regardless of whether Prior Authorization is required, the list of services that require submission of Advance Notification and the process for submitting Advance Notification is the same.

Who is responsible for Advance Notification?
• Physicians, health care professionals and ancillary providers are responsible for Advance Notification for those planned services on the Advance Notification List.
• Customers may be required to obtain Prior Authorization of out-of-network services.

What services require Advance Notification?
• Advance Notification is required only for those services on the Advance Notification List. In some cases, Prior Authorization is required to determine whether the services will be covered.
• Certain services may not be covered by an individual Customer’s benefit plan, regardless of whether Advance Notification/Prior Authorization is required by this Guide.
• The Advance Notification requirements outlined in this Protocol do not apply to services that are subject to the following Protocols, each of which are addressed in separate sections later in this Guide:
  › The Cardiology Notification/Prior Authorization Protocol for Commercial Customers.
  › The Cardiology Prior Authorization Protocol for covered services to Medicare Advantage Customers.
  › The Outpatient Injectable Chemotherapy Prior Authorization Protocol for Commercial Customers.
  › The Outpatient Radiology Notification/Prior Authorization Protocol for Commercial Customers.
  › The Outpatient Radiology Prior Authorization Protocol for Medicare Advantage Customers.
  › Laboratory Services protocol.
  › The Outpatient Therapeutic Radiation (IMRT, SRS, SBRT) Prior Authorization Program for Medicare Advantage Customers.
  › UnitedHealthcare Laboratory Benefit Management Program Administered by Beacon Lab Benefit Solutions (BLBS).
When is Advance Notification Required?

- Advance Notification should be submitted as far in advance as possible, but is required to be submitted at least 5 business days prior to the planned service date (unless otherwise specified with the Advance Notification List) with supporting clinical documentation, to allow enough time for coverage review. Advance Notification for home health services and durable medical equipment is required within 48 hours after the start of service.

- It may take up to 15 calendar days to render a decision (14 calendar days for Medicare Advantage). Prioritization of case review is based on the specifics of the case, the completeness of the information received, CMS requirements, or other state or federal requirements. Time may be extended if additional information is needed.

- For services requiring expedited review, please call the telephone number on the Customer’s health care ID card (unless specified differently below). Expedited review for benefits that require Advance Notification or a benefit determination prior to receiving medical care is available where:
  - a delay in treatment could seriously jeopardize the Customer’s life or health, or
  - the ability to regain maximum function, or
  - in the opinion of a physician with knowledge of the Customer’s medical condition, could cause severe pain.

- You must explain the clinical urgency when requesting an expedited review. When you submit a request for an expedited review, you are responsible for providing required clinical information in the same calendar day.

What happens after the Provider gives Advance Notification?

- In certain cases, services on the Advance Notification List require Prior Authorization through a pre-service clinical coverage review that will result in either a coverage approval or adverse coverage determination.

- Once you inform us of a planned service on the Advance Notification List, we will inform you if Prior Authorization is required. We will advise you of the required information necessary to complete the review and you will be notified of the coverage decision within the time required by law.

- It is important that you and the Customer are fully aware of coverage decisions before services are rendered.

- If you provide the service before a coverage decision is rendered, and we ultimately determine that the service was not covered, we may deny the claim and you must not bill the Customer. By proceeding prior to the final coverage determination, it is not possible for the Customer to make an informed decision about whether to pay for and receive the non-covered services.

- Subject to state and federal regulations, including regulations pertaining to a provider’s inclusion in a sanction and excluded list and non-inclusion in the Medicare Provider Enrollment Chain and Ownership System (PECOS)* list, and Medicare Advantage guidelines, the provision of Advance Notification or receipt of a Prior Authorization approval does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual Customer’s benefit plan, the Provider being eligible for payment, any claim processing requirements, and the Provider participation agreement with UnitedHealthcare. See Coverage Determinations and Utilization Management Decisions section for additional details.

When can I update an Advance Notification or Prior Authorization?

- You may update or provide additional information related to an Advance Notification submission or Prior Authorization request until a coverage decision is made regarding the service. Once an approval has been rendered, you may update the Advance Notification or Prior Authorization with a change in date of service only (as long as the original date of service has not passed). You may update the date of service on UnitedHealthcareOnline.com or by phone.

Is there an expiration date on the Advance Notification or Prior Authorization of approved service(s)?

- Advance Notification or Prior Authorization is valid only for the date of service or date range designated on the notification. If the designated date of service or date range has passed and the service(s) has not been rendered, a new Advance Notification or Prior Authorization must be obtained.

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* PECOS is the CMS online enrollment system where providers and healthcare entities are required to register so they can manage their Medicare Provider file & establish their Medicare specialty as eligible to order & refer services/items.
May I change the Advance Notification or Prior Authorization after the service has been delivered?

• No updates can be made to an existing Advance Notification or Prior Authorization AFTER the service has been delivered. If during the service, you performed an additional or different service than was originally approved, you must submit the supporting clinical information for the service at the time of claim submission.

What information must be included in the Advance Notification or Prior Authorization?

Advance Notification or Prior Authorization must contain the following information about the planned service:

• Customer name and Customer health care ID number.
• Ordering physician, health care professional or ancillary Provider name and TIN or National Provider Identification (NPI).
• Rendering physician or health care professional name and TIN or NPI.
• ICD-10-CM diagnosis code for the diagnosis for which the service is requested.
• All applicable procedure codes.
• Anticipated date(s) of service.
• Type of service (primary and secondary) procedure code(s) and volume of service (when applicable).
• Service setting (e.g., inpatient, outpatient hospital, ambulatory surgical center, physician office, home).
• Facility name and TIN or NPI where service will be performed (when applicable).
• Original start date of dialysis (End Stage Renal Disease (ESRD) only).

Please refer to the individual services listed in the Advance Notification/Prior Authorization List. Where a clinical coverage review is provided for in the Customer’s benefit plan, we may request additional information in order to make the necessary determination, as described in more detail in the Clinical coverage review: Clinical information section below.

Note: Certain services may not be covered within an individual Customer’s benefit plan, regardless of whether Advance Notification or Prior Authorization is required.

In the event of a conflict or inconsistency between applicable regulations and the Notification requirements in this Guide, the notification process will be administered in accordance with applicable regulations.

Clinical coverage review: Clinical information

• Your cooperation is required with all UnitedHealthcare requests for information, documents or discussions for purposes of a clinical coverage review including, but not limited to, all applicable procedure codes, pertinent medical records and imaging studies/reports. Please refer to UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Medical Records Requirement for Pre-Service for a list of individual services and specific, additional required information.

• You are responsible to return calls from our care management team and/or medical director. You must provide complete clinical information as required within 4 hours if request is received before 1:00 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1:00 p.m. local time (but no later than 12:00 p.m. local time the next business day).

• UnitedHealthcare also may use tools developed by third parties, such as the MCG™ Care Guidelines, (formerly known as Milliman Care Guidelines®) or other guidelines, to assist us in administering health benefits and to assist clinicians in making informed decisions in many health care settings. These tools are intended to be used in connection with the independent professional medical judgment of a qualified Health Care Provider and do not constitute the practice of medicine or medical advice. You may request a copy of the clinical criteria by calling Care Management at (877) 842-3210.

• You can obtain copies of the Pharmacy Policies we use for Commercial products online at UnitedHealthcareOnline.com → Tools & Resources → Pharmacy Resources → Clinical & Specialty Programs → Clinical Programs.

• For Medicare Advantage Customers, we use CMS guidelines and coverage documents (e.g., Medical Policies, or coverage determination documents (CDGs)), to determine coverage. If MCG™ guidelines, or any other Medical
Policies or CDGs contradict CMS guidance, including National Coverage Determinations and Local Coverage Determinations, then UnitedHealthcare will follow CMS guidance. You may request a copy of the clinical criteria by calling Care Management at (877) 842-3210.

- In some cases for Medicare Advantage Customers, if a pre-service clinical coverage review is not performed, Medicare guidelines, including National Coverage Determination and Local Coverage Determination guidelines may be utilized to perform a clinical review when the claim is received.
- You can obtain copies of the Coverage Determination Guidelines (CDGs) and Medical Policies we use for Commercial products and the UnitedHealthcare Medicare Advantage Coverage Summaries used for Medicare Advantage products online at UnitedHealthcareOnline.com ➔ Tools & Resources ➔ Policies, Protocols, and Guides.

**How to submit Advance Notification or Admission Notifications and requests for Prior Authorizations**

Multiple options are available to submit Advance or Admission Notifications and requests for Prior Authorizations to UnitedHealthcare, including electronic methods. To avoid duplication, once an Advance or Admission Notification or Prior Authorization is submitted and confirmation is received, please do not resubmit.

- Notify us in the Eligibility and Benefits Center application on Link or using UnitedHealthcareOnline.com ➔ Notifications/Prior Authorizations ➔ Notification/Prior Authorization Submission. We will accept daily composite census logs for inpatient admissions with complete and relevant information via fax (see fax numbers below).
- If you do not have electronic access, please call us at the number on the Customer’s health care ID card.

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<th>EDI 278 Transactions</th>
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<tr>
<td>Method</td>
<td>Electronic</td>
<td>Electronic</td>
<td>Non-Electronic</td>
<td>Non-Electronic</td>
</tr>
<tr>
<td>Description</td>
<td>X12 EDI submissions directly to UnitedHealthcare or through a clearinghouse.</td>
<td>Website submission directly to UnitedHealthcare through Link or UnitedHealthcareOnline.com.</td>
<td>Phone submission directly to UnitedHealthcare through (877) 842-3210 (Option 3) OR dial the number provided on Customer’s health care ID card. For Erickson Advantage, call Erickson Campus Customer Service number on the Customer’s health care ID card.</td>
<td>Phone submission through assigned 800 number specific to facility.</td>
</tr>
</tbody>
</table>
Advance Notification List

To view the most current and complete Advance Notification List, including procedure codes and associated services, go to: UnitedHealthcareOnline.com → Clinician Resources → Advance and Admission Notification Requirements.

The Advance Notification requirements for physicians, other health care professionals and ancillary providers do not indicate or imply coverage. Coverage is determined in accordance with the Customer’s benefit plan.

- For additional product information in your area, visit UnitedHealthcareOnline.com, or refer to the Our Products section of this Guide. Medicare Advantage and/or Medicaid products are offered in select markets; your agreement with us will determine if you are participating in our network for these products. This product list is provided for your convenience and is subject to change over time.

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

- The Advance Notification List is provided online for your convenience and is subject to change over time. Written notice of any changes to the Advance Notification List will be made via the Network Bulletin which is published and distributed throughout the year.

- We will notify you prior to implementation of a protocol change if specified in your agreement with us, or if required by law. Where required by law, updates will be provided in writing. We may also use additional channels (such as mail, internet, email, phone, and fax) to communicate with you in the event a protocol is modified. Upon your request, UnitedHealthcare will provide a paper copy of the Advance Notification/Prior Authorization List. Please contact your Network Management representative, Physician Advocate, or Hospital & Facility Advocate to request a paper copy of the Advance Notification/Prior Authorization List.
Excluded Plans (benefit plans not subject to the requirements set forth in the protocol)*

- UnitedHealthcare Options PPO (Providers are not required to follow this protocol for Options PPO benefit plans because Customers enrolled in these benefit plans are responsible for providing Notification/requesting Prior Authorization. However, Providers are required to follow this protocol for Options PPO benefit plans for Customers in Colorado because Colorado Customers are not responsible for providing Notification/requesting Prior Authorization).
- UnitedHealthcare Indemnity
- UnitedHealthOne - Golden Rule Insurance Company (“GRIC” group number 705214)
- All Savers products offered off-Exchange
- M.D.IPA, Optimum Choice or OneNet

- NHP
- Oxford Commercial
- Benefit plans subject to the River Valley Entities Supplement.
- UnitedHealthcare West or UHC West
- UnitedHealthcare Community Plan Medicare Advantage benefit plans subject to an Additional Manual (see the benefit plans section of this Guide.) As explained in the in the benefit plans section of this Guide, some UnitedHealthcare Community Plan Medicare Advantage benefit plans are not subject to an Additional Manual and, therefore, are subject to this Guide and this Notification Program.
- Other benefit plans such as Medicaid, CHIP and Uninsured that are neither Commercial nor Medicare Advantage.

Standard Notification requirements for facilities (for most states*)

Confirming coverage approvals:

- For any inpatient or outpatient service on the Advance Notification/Prior Authorization List (except when those services are provided to Customers under benefit plans identified as Excluded Plans below) the facility must confirm, prior to rendering the service that the coverage approval is on file. The purpose of this protocol is to enable the facility and the Customer to have an informed pre-service conversation; in cases where it is determined that the service will not be covered the Customer can then decide whether to receive and pay for the service.

- If the facility fails to confirm that the coverage approval is on file and instead performs the service on the Advance Notification/Prior Authorization requirements the Customer’s benefit plan, UnitedHealthcare will not deny the facility’s claim despite the facility's non-compliance with UnitedHealthcare's notification protocols.

- If the service is ultimately determined not to have been covered under the Customer’s benefit plan, then UnitedHealthcare may deny the facility’s claim for the non-covered service and, as provided under the facility’s agreement with us, the facility must not bill the Customer or accept payment from the Customer, in light of the facility’s non-compliance with UnitedHealthcare’s notification protocols.

- If a coverage review is in process on the date of service as a result of the Advance Notification or Prior Authorization request AND that coverage review ultimately determines the service to have been a covered service under the Customer’s benefit plan, UnitedHealthcare will not deny the facility’s claim despite the facility’s failure to take specific action to confirm the coverage approval.

Admission Notification:

Excluded Plans (benefit plans not subject to the requirements set forth in the protocol)*

- UnitedHealthcare Option PPO (Providers are not required to follow this protocol for Options PPO benefit plans because Customers enrolled in these benefit plans are responsible for providing Notification/requesting Prior Authorization. However, Providers are required to follow this protocol for Options PPO benefit plans for Customers in Colorado because Colorado Customers are not responsible for providing Notification/requesting Prior Authorization).
- UnitedHealthcare Indemnity
- UnitedHealthOne - Golden Rule Insurance Company (“GRIC” group number 705214)
- All Savers products offered off-Exchange
- M.D.IPA, Optimum Choice or OneNet

- NHP
- Oxford Commercial
- Benefit plans subject to the River Valley Entities Supplement.
- UnitedHealthcare West or UHC West
- Erickson Advantage
- UnitedHealthcare Community Plan Medicare Advantage Benefit plans subject to an Additional Manual (please refer to the benefit plans section of this Guide.) Some UnitedHealthcare Community Plan Medicare Advantage benefit plans are not subject to an Additional Manual and, therefore, are subject to this Guide including these Admission Notification Requirements.

- Other benefit plans such as Medicaid, CHIP and Uninsured that are neither Commercial nor Medicare Advantage.

* The Admission Notification requirements will not apply to these listed benefit plans. However, these benefit plans may have separate notification or prior-authorization requirements. Please refer to the applicable Additional Manual in the benefit plans table of this Guide for additional details. Please see the Supplements of this Guide for the plans listed.

* For state specific variations, please refer to UnitedHealthcareOnline.com → Tools and Resources → Policies, Protocols, and Guides → Advance and Admission Notification.
• Facilities are responsible for Admission Notification for the following types of inpatient admissions:
  › All planned/elective admissions for acute care
  › All unplanned admissions for acute care
  › All Skilled Nursing Facility (SNF) admissions
  › All admissions following outpatient surgery
  › All admissions following observation
  › All newborns admitted to Neonatal Intensive Care Unit (NICU)
  › All newborns who remain hospitalized after the mother is discharged (notice required within 24 hours of the mother’s discharge)

• Unless otherwise indicated, Admission Notification must be received within 24 hours after actual weekday admission (or by 5:00 p.m. local time on the next business day if 24 hour notification would require notification on a weekend or holiday). For weekend and holiday admissions, notification must be received by 5:00 p.m. local time on the next business day.

• Admission Notification by the facility is required even if Advance Notification was supplied by the physician and a pre-service coverage approval is on file.

• Receipt of an Admission Notification does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual Customer’s benefit plan, the facility being eligible for payment, any claim processing requirements, and the facility’s participation agreement with UnitedHealthcare.

• Admission Notifications must contain the following details regarding the admission:
  › Customer name, Customer health care ID number, and date of birth
  › Facility name and TIN or NPI
  › Admitting/attending physician name and TIN or NPI
  › Description for admitting diagnosis or ICD-10-CM diagnosis code
  › Actual admission date

• For emergency admissions where a Customer is unstable and not capable of providing coverage information, the facility should notify UnitedHealthcare via phone or fax within 24 hours (or the next business day, for weekend or holiday admissions) from the time the information is known, and communicate the extenuating circumstances. We will not apply any notification-related reimbursement deductions.

• All Skilled Nursing Facility admissions (Customers receiving Part A skilled services) for UnitedHealthcare Nursing Home and Assisted Living Plan Customers must be authorized by an Optum CarePlus Nurse Practitioner or Physician’s Assistant. Failure to coordinate authorizations through the Optum clinician may result in full or partial denial of claims.

Reimbursement reductions for failure to provide timely Admission Notification
If a facility does not provide timely Admission Notification as described above, reimbursement reductions will apply as follows:

<table>
<thead>
<tr>
<th>Notification Timeframe</th>
<th>Reimbursement Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission Notification received after it was due, but not more than 72 hours after admission.</td>
<td>100% of the average daily contract rate1 for the days preceding notification.2</td>
</tr>
<tr>
<td>Admission Notification received after it was due, and more than 72 hours after admission.</td>
<td>100% of the contract rate (entire stay).</td>
</tr>
<tr>
<td>No Admission Notification received.</td>
<td>100% of the contract rate (entire stay).</td>
</tr>
</tbody>
</table>

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

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

Note: Reimbursement reductions will not be applied for maternity admissions.
Inpatient Concurrent Review: Clinical Information

- Your cooperation is required with all UnitedHealthcare requests for information, documents or discussions for purposes of concurrent review and discharge planning including, but not limited to: primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information via access to Electronic Medical Records (EMR).

- Your cooperation is required with all UnitedHealthcare requests from the inpatient care management team and/or medical director to support requirements to engage our Customers directly face-to-face or telephonically.

- You must return/respond to inquiries from our inpatient care management team and/or medical director. You must provide complete clinical information and/or documents as required within 4 hours if our request is received before 1:00 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1:00 p.m. local time (but no later than 12:00 p.m. local time the next business day).

- UnitedHealthcare uses MCG™ Care Guidelines, CMS guidelines, or other guidelines, which are nationally recognized guidelines, to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, long term acute care, acute rehabilitation, skilled nursing facilities, home health care, and ambulatory facilities. You may request a copy of the clinical criteria by calling Care Management at (877) 842-3210.

Coverage Determinations and Utilization Management Decisions

At UnitedHealthcare, and all of its affiliated companies, and delegates, all applicable coverage decisions on health care services are based on the Customer’s benefit documents and applicable state and federal requirements. For Commercial Customers, this includes the contract the Customer’s employer plan sponsor has with UnitedHealthcare. For Medicare Advantage Customers, this includes but is not limited to, National Coverage Determinations, Local Coverage Determinations, Medicare Benefit Policy Manual (CMS publication 100-02), and general Medicare guidelines.

UnitedHealthcare employees, contractors, or delegates involved in making these coverage decisions are not compensated or otherwise rewarded for issuing non-coverage decisions. UnitedHealthcare and its delegates do not offer incentives to physicians or utilization management decision makers to encourage underutilization of care or services or to encourage barriers to care and service. Hiring, promoting or terminating employees or contractors is not based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.

State-Specific Variations from the Standard Notification Requirements for Maryland Facilities:

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

1. The information submitted to UnitedHealthcare regarding the service to be delivered to the Customer was fraudulent or intentionally misrepresented;

2. Critical information requested by UnitedHealthcare regarding the service to be delivered to the Customer was omitted such that UnitedHealthcare’s determination would have been different had it known the critical information;

3. A planned course of treatment for the patient that was approved by UnitedHealthcare was not substantially followed by the provider; or

4. On the date the service was authorized or approved service issued through Advance Notification was delivered the Customer was not covered by UnitedHealthcare and the Provider could have verified the Customer eligibility status by utilizing the Eligibility and Benefits Center application on Link, if registered, UnitedHealthcareOnline.com or UnitedHealthcare’s Enterprise Voice Portal at (877) 842-3210 or by accessing UnitedHealthcareOnline.com 24 hours a day, 7 days a week. Note that the online verification must indicate that the Customer is not covered by UnitedHealthcare.

If Advance Notification or Prior Authorization is obtained and Admission Notification is not made by the facility in a timely manner, payment reductions will be limited to hospital room and board charges when applicable.
Cardiology Notification/Prior Authorization Protocol for Commercial Customers

The UnitedHealthcare Cardiology Notification/Prior Authorization protocol for Commercial Customers does not apply to the following benefit plans. However, these benefit plans may have separate Cardiology Notification or Prior Authorization requirements. Please refer to the applicable benefit plans table of this Guide for additional details.

Excluded Plans (benefit plans not subject to the requirements set forth in the protocol)

- UnitedHealthcare Options PPO (Providers are not required to follow this protocol for Options PPO benefit plans because Customers enrolled in these benefit plans are responsible for providing Notification/requesting Prior Authorization. Exception: Providers are required to follow this protocol for Options PPO benefit plans for Customers in Colorado because Colorado Customers are not responsible for providing Notification/requesting Prior Authorization).
- UnitedHealthOne– Golden Rule Insurance Company (“GRIC”) group number 705214 only
- All Savers products offered off Exchange
- M.D.IPA, Optimum Choice, or OneNet
- Oxford (USA, New Jersey Small Group, NJ Individual, certain NJ public Sector groups, CT public Sector, Brooks Brothers (BB1627) and Weil, Gotshal and Manages (WG00101), any Customer at VAMC facility.)
- UnitedHealthcare Indemnity / Managed Indemnity
- Sierra
- Benefit plans sponsored or issued by certain self-funded employer groups

Other Excluded Plans

The UnitedHealthcare Cardiology Notification/Prior Authorization protocol does not apply to non-Commercial benefit plans such as Medicare Advantage Medicaid, CHIP and Uninsured. The Admission Notification requirements will not apply to these listed benefit plans. However, these benefit plans may have separate notification or prior-authorization requirements. Please refer to the applicable . Additional Manual in the benefit plans table of this Guide for additional details. Please see the Supplements of this Guide for the plans listed.

The Cardiology Notification/Prior Authorization Protocol for Commercial Customers applies to all participating physicians who perform diagnostic catheterizations, electrophysiology implant procedures, echocardiograms, and stress echocardiograms (herein referred to as “Cardiac Procedures”) on UnitedHealthcare Commercial Customers (other than those in the Excluded Plans above).

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

Once notification of a Cardiac Procedure is received and if the Customer’s benefit plan requires health services to be medically necessary in order to be covered, we will conduct a clinical coverage review to determine whether the service is medically necessary. Providers do not need to determine whether a clinical coverage review is required in a given case or for a given Customer because once we receive notification, we will let the Provider know whether a clinical coverage review is required pursuant to our Prior Authorization process.

- If the entire process described below is not completed before the Cardiac Procedure is rendered, an administrative claim reimbursement reduction, in part or in whole, will occur.

For the most current listing of CPT codes for Cardiac Procedures, please refer to UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Cardiology Notification & Prior Authorization.

How to submit Advanced Notifications and request for Prior Authorizations for Cardiac Procedures

To receive payment for services rendered, prior to performing the stated Cardiac Procedure, Providers must provide notification by contacting us:

- Online:
  - UnitedHealthcare, UnitedHealthcare West and UnitedHealthOne Commercial Benefit Plans subject to this Protocol: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Cardiology Notification & Authorization - Submission & Status.
Notification Requirements

- Neighborhood Health Partnership and UnitedHealthcare of the River Valley Commercial Benefit Plans: carecorenational.com
- Phone: (866) 889-8054

The information listed below may be requested at the time notification is provided:

Customer/procedure information
- Customer’s name and Customer’s health care ID number
- Customer’s address and phone number
- Customer’s group number
- Customer’s date of birth
- The examination(s) or type of service(s) being requested, with the CPT code(s)
- The working diagnosis with the appropriate ICD code(s)

Provider information
- Provider’s name, TIN/NPI, specialty, address, and phone number
- Provider to whom the Customer is being referred, if specified, address and phone number
- Rendering Provider’s name and TIN/NPI (if different)

Clinical information
- The Customer’s clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.
- Dates of prior imaging studies performed.
- Any other information the ordering Provider believes would be useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports.
- Once notification of a planned Cardiac Procedure is received, if the Customer’s benefit plan requires health services to be medically necessary in order to be covered, we will conduct a clinical coverage review to determine whether the service is medically necessary pursuant to our Prior Authorization process.
- A Prior Authorization number will be issued to the ordering Provider if the service is medically necessary. A clinical denial will be issued, and a Prior Authorization number will not be issued, if it is determined during the Prior Authorization process or the Retrospective Review Process that the service is not medically necessary.
- Once notification of a planned Cardiac Procedure is received, if the Customer’s benefit plan does not require health services to be medical necessary in order to be covered, and if the service is consistent with evidence-based clinical guidelines, a notification number will be issued to the ordering Provider. If the service is not consistent with evidence-based clinical guidelines, or if additional information is needed to assess the request, we will let the ordering Provider know whether he or she must engage in a physician-to-physician discussion to explain the request, to provide additional clinical information, and to discuss alternative approaches. Upon completion of the discussion, the Provider will confirm the procedure ordered and a notification number will be issued. If a physician-to-physician is required, that process must be completed in order to ensure payment.
- The purpose of the physician-to-physician discussion is to facilitate the provision of evidence-based health care through an open dialogue based on evidence-based clinical guidelines. This discussion is not a Prior Authorization, pre-certification or medical necessity determination unless applicable state law dictates otherwise.
- A Notification number will be issued to the ordering Provider when the process is completed. The Notification number will be communicated by fax, phone, or online, consistent with how the request was initiated. To help promote proper payment, the Notification number must be communicated by the ordering Provider to the rendering Provider scheduled to perform the Cardiac Procedure.
- Subject to state regulation, receipt of a Notification number or Prior Authorization number does not guarantee or authorization payment. Payment for covered services is contingent upon the following: coverage with an individual
Customer’s benefit plan, the Provider being eligible for payment, any claims processing requirements, and the Provider’s participation with UnitedHealthcare.

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

**Urgent requests during regular business hours**
The Provider may request a Notification number or Prior Authorization number on an “urgent” basis if the Provider determines it to be medically required. Urgent requests should be requested via telephone by calling (866) 889-8054. The Provider must state that the case is clinically urgent and explain the clinical urgency. We will respond to urgent requests within 3 hours of our receipt of all required information. If you feel you cannot wait for a decision in 3 hours, a Notification number or Prior Authorization number must be requested retrospectively following the Retrospective Review Process.

**Retrospective review process for urgent requests outside of regular business hours**
If the Provider determines that care is medically required on an urgent basis, or a Notification number or Prior Authorization number cannot be requested because it is outside of UnitedHealthcare’s normal business hours, the Notification number or Prior Authorization number must be requested retrospectively. Retrospective Notification number and Prior Authorization number requests must be made within 15 calendar days following diagnostic catheterizations and electrophysiology implants, and within 2 business days following echocardiograms and stress echocardiograms after the cardiac procedure is rendered. The retrospective review request must be made by calling (866) 889-8054 and following the phone prompts, according to the process described below:

- Documentation must include an explanation as to why the procedure was required on an urgent basis and why a Notification number or Prior Authorization number could not have been requested during UnitedHealthcare’s normal business hours.

- Once notification is received on a retrospective basis, and if the Customer’s benefit plan requires services to be medically necessary in order to be covered, we will conduct a clinical coverage review to determine whether the service is medically necessary. A Prior Authorization number will be issued to the ordering Provider if the service is medically necessary. A clinical denial will be issued, and a Prior Authorization number will not be issued, if it is determined that the service is not medically necessary; the Customer cannot be billed for the service.

- Once notification is received on a retrospective basis, if the Customer’s benefit plan does not require services to be medically necessary in order to be covered, and if the service is consistent with evidence-based clinical guidelines, a Notification number will be issued to the ordering provider. If the service is not consistent with evidence-based clinical guidelines, or if additional information is needed to assess the request, we will let the ordering Provider know whether he or she must engage in a physician-to-physician discussion to explain the request, to provide additional clinical information, and to discuss alternative approaches. Upon completion of the discussion, the ordering Provider will confirm the procedure ordered and a Notification number will be issued.

- Failure to obtain a Notification number or Prior Authorization number either prospectively or retrospectively will result in denial of the claim(s).

**Rendering Provider (if different than the Ordering Provider)**
To be eligible to receive payment for covered services rendered, (a) the rendering Provider must validate with us prior to performing a Cardiac Procedure that a notification number is on file and, (b) if the Customer’s benefit plan requires that health services be medically necessary in order to be covered, the rendering Provider must validate with us prior to performing a Cardiac Procedure that the Prior Authorization process has been completed and a coverage decision has been issued before rendering the service. This must be done by contacting us as follows:


- By phone: (866) 889-8054 (follow the prompts provided).
If the Customer’s benefit plan does not require that services be medically necessary in order to be covered:

- If a Cardiac Procedure is rendered and a claim for the service is submitted without a Notification number, an administrative claim reimbursement reduction, in part or in whole, will occur. The Customer cannot be billed for the service.
- If the rendering Provider determines there is no Notification number on file, and the ordering Provider participates in UnitedHealthcare’s network, we will use reasonable efforts to work with the rendering Provider to obtain the Notification number from the participating ordering Provider prior to the rendering of services.
- If the rendering Provider determines there is no Notification number on file, and the ordering Provider does not participate in UnitedHealthcare’s network, and is unwilling to obtain a Notification number, the rendering Provider is required to obtain a Notification number.
- If the rendering Provider does not obtain a Notification number for Cardiac Procedures ordered by a nonparticipating Provider, the rendering Provider’s claim will be denied administratively, in part or in whole, for failure to provide notification, and the Customer cannot be billed for the service.

If the Customer’s benefit plan does require services to be medically necessary in order to be covered:

- If the rendering Provider determines a coverage determination has not been issued, and the ordering Provider participates in UnitedHealthcare’s network, we will use reasonable efforts to work with the rendering Provider to urge the ordering Provider to complete the Prior Authorization process and obtain a coverage decision prior to the rendering of services.
- If the rendering Provider determines a coverage determination has not been issued, and the ordering Provider does not participate in UnitedHealthcare’s network, and is unwilling to complete the Prior Authorization process, the rendering Provider is required to complete the Prior Authorization process and verify that a coverage decision has been issued prior to rendering the service.
- If the rendering Provider provides the service before a coverage decision is issued, the rendering Provider’s claim will be denied administratively, in part or in whole, and the Customer cannot be billed for the service.

**Note:** Non-participating Providers can provide notification and complete the Prior Authorization process if applicable either through UnitedHealthcareOnline.com, if they are registered, or by calling (866) 889-8054.

**Cardiology Crosswalk Table**

Under the CPT Code Crosswalk Table, for certain specified CPT code combinations, Providers are not required to follow the Commercial Cardiology Prior Authorization protocol to modify the existing Prior Authorization record. A complete listing of applicable CPT code combinations is available at UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Cardiology Notification/Prior Authorization. However, for code combinations not listed on the CPT Code Crosswalk Table, Providers must follow the Cardiology Prior Authorization protocol process set forth above for additional procedures.
Cardiology Prior Authorization Protocol for Covered Services to Medicare Advantage Customers

The Cardiology Prior Authorization Protocol for Covered Services to Medicare Advantage Customers does not apply to the following benefit plans. However, these benefit plans may have separate Cardiology Notification or Prior Authorization requirements. Please refer to the applicable benefit plans table for additional details.

Excluded Plans (benefit plans not subject to the requirements set forth in the protocol)

- **Hawaii**: AARP MedicareComplete Choice Plan 1 - Group 77000 & 77007 and AARP MedicareComplete Choice Essential - Group 77003 & 77008
- **New York**: AARP MedicareComplete Plan 1 - Group 66074, AARP MedicareComplete Plan 2 - Group 13012, AARP MedicareComplete Essential - Group 66075, AARP MedicareComplete Mosaic - Group 66076. Existing process of obtaining authorization from Montefiore Care Management Organization (CMO) will continue.
- **Utah**: AARP MedicareComplete Plan 1 - Group 42000, AARP MedicareComplete Essential - Group 42004, UnitedHealthcare Group Medicare Advantage - Group 42020, AARP MedicareComplete Plan 2 - Group 42022
- UnitedHealthcare Community Plan Medicare Advantage benefit plans subject to an Additional Manual, as further described in the benefit plans section of the UnitedHealthcare Provider Administrative Guide.
- Erickson Advantage Plans
- UnitedHealthcare Assisted Living Plan
- UnitedHealthcare Nursing Home Plan (HMO SNP), (HMO-POS SNP), (PPO SNP)
- UnitedHealthcare Senior Care Options (HMO SNP)
- Senior Dimensions Medicare Advantage plans

Other Excluded Plans

The Medicare Advantage Cardiology Prior Authorization protocol does not apply to Commercial benefit plans or to other benefit plans, such as Medicaid, CHIP and Uninsured that are not Medicare Advantage. The Admission Notification requirements will not apply to these listed benefit plans. However, these benefit plans may have separate notification or prior-authorization requirements.

The Cardiology Prior Authorization Protocol for Covered Services to Medicare Advantage Customers applies to all participating physicians ("Providers") who perform diagnostic catheterizations, electrophysiology implant procedures, echocardiograms, and stress echocardiograms (herein referred to as “Cardiac Procedures”).

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. Cardiac Procedures rendered in and appropriately billed with any of the following places of service do not require Prior Authorization: emergency room visits, observation unit, urgent care, or inpatient stay (except for electrophysiology implants).

Failure to complete the Medicare Advantage Cardiology Prior Authorization process will result in administrative denial, and claims denied for failure to request Prior Authorization may not be billed to the Customer.

Upon request for Prior Authorization, a failure to meet clinical criteria will result in a denial for lack of medical necessity because services that are not medically necessary are not covered under Medicare Advantage plans. Upon issuance of the denial for lack of medical necessity, the Customer and Provider will receive a denial notice with the appeal process outlined. Providers who render cardiac procedures within the scope of the protocol must confirm that Prior Authorization has been obtained, or payment for their services may be denied.

To obtain the latest information on this protocol, please refer to: UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Medicare Advantage Cardiology Prior Authorization Program

Process for Provider:

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

- **Online**: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Cardiology Notification & Authorization - Submission & Status;
- **Phone**: (866) 889-8054

The information listed below may be requested at the time of the Prior Authorization request:
Customer/procedure information

• Customer’s name and Customer’s health care ID number
• Customer’s address and phone number
• Customer’s group number
• Customer’s date of birth
• The examination(s) or type of service(s) being requested, with the CPT code(s)
• The working diagnosis with the appropriate ICD-10 code(s)

Provider information

• Ordering Provider’s name, TIN/NPI, specialty, address, and phone number
• Provider to whom the Customer is being referred, if specified, address and phone number
• Rendering Provider’s name and TIN/NPI

Clinical information

• The Customer’s clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.
• Dates of prior imaging studies performed.
• Any other information the ordering Provider believes would be useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports.

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

Note: Receipt of an authorization for Medicare services means that the service was medically necessary. It does not guarantee or authorize payment.

Subject to state and federal regulations, including regulations pertaining to a provider’s inclusion in a sanction and excluded list and non-inclusion in the Medicare Provider Enrollment Chain and Ownership System (PECOS) * list, and Medicare Advantage guidelines, the provision of a Prior Authorization approval does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual Customer’s benefit plan, the Provider being eligible for payment, any claim processing requirements, and the Provider participation agreement with UnitedHealthcare. See Coverage Determinations and Utilization Management Decisions section for additional details.

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

Urgent requests during regular business hours

The ordering Provider may request a Prior Authorization number on an “urgent” basis if the Provider determines it to be medically required. Urgent requests should be requested via telephone by calling (866) 889-8054. The Provider must state that the case is clinically urgent and explain the clinical urgency. We will respond to urgent requests within 3 hours after our receipt of all required information and no later than federal requirements. If you feel you cannot wait for a decision, a Prior Authorization number must be requested retrospectively following the Retrospective Review Process described below.

Retrospective review process for urgent requests outside of regular business hours

If the Provider determines that care is medically required on an urgent basis, or a Prior Authorization number cannot be requested because it is outside of UnitedHealthcare’s normal business hours, the service may be rendered and the Prior Authorization number must be requested retrospectively following the Retrospective Review Process described below.

* PECOS is the CMS online enrollment system where providers and healthcare entities are required to register so they can manage their Medicare Provider file & establish their Medicare specialty as eligible to order & refer services/items.
Authorization number must be requested retrospectively. Retrospective Prior Authorization number requests must be made within 15 calendar days following diagnostic catheterizations and electrophysiology implants, and 2 business days following for echocardiograms and stress echocardiograms after the cardiac procedure is rendered. The retrospective review request can be made by calling (866) 889-8054 and following the phone prompts, according to the process described below:

- Documentation must include an explanation as to why the procedure was required on an urgent basis and why Prior Authorization could not have been requested during UnitedHealthcare’s normal business hours.
- Once notification of a Cardiac Procedure is received on a retrospective basis, we will conduct a clinical coverage review to determine whether the service is medically necessary. Prior Authorization number will be issued to the ordering Provider if the service is medically necessary. A clinical denial will be issued, and a Prior Authorization number will not be issued, if it is determined that the service is not medically necessary; the Customer cannot be billed for the service.
- Failure to obtain a Prior Authorization number either prospectively or retrospectively will result in administrative denial of the claim(s).

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

- Phone: (866) 889-8054 (follow the phone prompts provided).

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

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

Note: Non-participating Providers can submit Prior Authorization requests either through UnitedHealthcareOnline.com, if they are registered, or by calling (866) 889-8054 and follow the prompts provided.

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

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

Outpatient Radiology Notification/Prior Authorization Protocol for Commercial Customers
The UnitedHealthcare Outpatient Radiology Notification/Prior Authorization Protocol for Commercial Customers does not apply to the following benefit plans. However, these benefit plans may have separate Radiology Notification or Prior Authorization requirements. Please refer to the applicable in the benefit plans table of this Guide for additional details.
### Excluded Plans (benefit plans not subject to requirements set forth in the protocol)

- UnitedHealthcare Options PPO Exception: Providers are required to follow this protocol for Options PPO benefit plans for Customers in Colorado because Colorado Customers are not responsible for providing Notification/requesting Prior Authorization.
- UnitedHealthOne– Golden Rule Insurance Company (“GRIC”) group number 705214 only
- All Savers products offered off Exchange
- M.D.IPA, Optimum Choice, or OneNet
- Oxford (USA, New Jersey Small Group, NJ Individual, certain NJ public Sector groups, CT public Sector, Brooks Brothers (BB1627) and Weil, Gotshal and Manages (WG00101), any Customer at VAMC facility)
- UnitedHealthcare Indemnity / Managed Indemnity
- Sierra
- Benefit plans sponsored or issued by certain self-funded employer groups

### Other Excluded Plans

The UnitedHealthcare Radiology Notification/Prior Authorization protocol does not apply to non-Commercial benefit plans such as Medicare Advantage Medicaid, CHIP and Uninsured. The Admission Notification requirements will not apply to these listed benefit plans. However, these benefit plans may have separate notification or prior-authorization requirements. Please refer to the applicable Additional Manual in the benefit plans table of this Guide for additional details. Please see the Supplements of this Guide for the plans listed.

The Outpatient Radiology Notification/Prior Authorization protocol requirements apply to all participating providers that order or render any of the following advanced imaging procedures: Computerized Tomography (CT), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron-Emission Tomography (PET), Nuclear Medicine or Nuclear Cardiology. Please note that Notification is required under this protocol for only certain of these advanced imaging procedures. An advanced imaging procedure for which Notification is required is referred to herein as an “Advanced Outpatient Imaging Procedures.”

Notification under this protocol is required for outpatient services only. Imaging procedures rendered in, and appropriately billed with, any of the following places of service do not require notification: emergency room visits, observation unit, urgent care, or inpatient stay.

In general, once UnitedHealthcare receives Notification of an Advanced Outpatient Imaging Procedure and if the Customer’s benefit plan requires health services to be medically necessary in order to be covered, we will conduct a clinical coverage review to determine whether the service is medically necessary pursuant to our Prior Authorization process.

Providers do not need to determine whether a Prior Authorization is required in a given case or for a given Customer because, once we receive Notification, we will let the Provider know whether a clinical coverage review is required pursuant to our Prior Authorization process.

Compliance with this protocol is required and will be monitored through physician data sharing reports.

Failure to comply with the requirements described in this protocol will result in claims being administratively denied in whole or in part and, as required under the Provider’s agreement with us, the Customer being held harmless.

For the most current listing of CPT codes for which Notification is required pursuant to this protocol, please refer to UnitedHealthcareOnline.com → Clinician Resources → Radiology → Radiology Notification & Prior Authorization.

### Ordering Provider

The Provider ordering the Advanced Outpatient Imaging Procedure is responsible for providing notification prior to scheduling any Advanced Outpatient Imaging Procedure. The process required by this protocol for ordering Providers is as follows:

Provide notification by contacting us:

- Online:
  - Neighborhood Health Partnership and UnitedHealthcare of the River Valley Commercial Benefit Plans: carecorenational.com
- Phone: (866) 889-8054
The information listed below may be requested at the time notification is provided.

**Customer/procedure information**
- Customer’s name and Customer’s health care ID number
- Customer’s address and phone number
- Customer’s group number
- Customer’s date of birth
- The examination(s) or type of service(s) being requested, with the CPT code(s)
- The working diagnosis with the appropriate ICD-10 code(s)

**Provider information**
- Ordering Provider’s name, TIN/NPI, specialty, address, and phone number.
- Provider, to whom the Customer is being referred, if specified, addresses and phone number.
- Rendering Provider’s name and TIN/NPI.

**Clinical information**
- The Customer’s clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.
- Dates of prior imaging studies performed.
- Any other information the ordering Provider believes would be useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports.

Once UnitedHealthcare receives notification of a planned Advanced Outpatient Imaging Procedure, if the Customer’s benefit plan requires services to be medically necessary in order to be covered, we will conduct a clinical coverage review to determine whether the service is medically necessary pursuant to our Prior Authorization process. Services that are not medically necessary are not covered under the Customer’s benefit plan. Upon issuance of the denial for lack of medical necessity, the Customer and Provider will receive a denial notice with the appeal process outlined. A clinical denial will be issued, and a Prior Authorization number will not be issued, if it is determined during the Prior Authorization process that the service is not medically necessary. The Prior Authorization number will be communicated by fax, phone or online, consistent with how the request was initiated. To help promote proper payment, the Prior Authorization number must be communicated by the ordering Provider to the rendering Provider scheduled to perform the Advanced Outpatient Imaging Procedure.

The ordering Provider does not need to determine whether Prior Authorization is required in a given case or for a given Customer because once we are notified of a planned Advanced Outpatient Imaging Procedure we will let the Provider know whether a clinical coverage review will be conducted pursuant to the Prior Authorization process.

Once UnitedHealthcare receives notification of a planned Advanced Outpatient Imaging Procedure, if the Customer’s benefit plan does not require services to be medical necessary in order to be covered, and if the service is consistent with evidence-based clinical guidelines, a Notification number will be issued to the ordering Provider. If the service is not consistent with evidence-based clinical guidelines, or if additional information is needed to assess the request, we will let the ordering Provider know whether he or she must engage in a physician-to-physician discussion to explain the request, to provide additional clinical information, and to discuss alternative approaches. Upon completion of the discussion, the ordering Provider will confirm the procedure ordered and a Notification number will be issued.

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

A Notification number will be issued to the ordering Provider when the Notification process is completed. The Notification number will be communicated by fax, phone, or online, consistent with how the request was initiated. To help promote proper payment, the Notification number must be communicated by the ordering Provider to the rendering Provider scheduled to perform the Advanced Outpatient Imaging Procedure.
Subject to state regulation, receipt of a Notification number or Prior Authorization number does not guarantee or authorize payment. Payment for covered services is contingent upon the following: coverage with an individual Customer’s benefit plan, the Provider being eligible for payment, any claims processing requirements, and the Provider’s participation with UnitedHealthcare.

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

**Urgent requests during regular business hours**

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

**Retrospective review process for urgent requests outside of regular business hours**

If the ordering Provider determines that an Advanced Outpatient Imaging Procedure is medically required on an urgent basis, and a Notification number or Prior Authorization number cannot be requested because it is outside of UnitedHealthcare’s normal business hours, the Notification number or Prior Authorization number must be requested retrospectively within two business days after the date of service. The retrospective review request must be made by calling (866) 889-8054 and following the phone prompts, according to the process described below:

- Documentation must include an explanation as to why the procedure was required on an urgent basis and why a Notification number or Prior Authorization number could not have been requested during UnitedHealthcare’s normal business hours.

- Once UnitedHealthcare receives Notification of an Advanced Outpatient Imaging Procedure on a retrospective basis, and if the Customer’s benefit plan requires services to be medically necessary in order to be covered, we will conduct a clinical coverage review to determine whether the service is medically necessary. A Prior Authorization number will be issued to the ordering Provider if the service is medically necessary. A clinical denial will be issued, and a Prior Authorization number will not be issued, if it is determined that the service is not medically necessary; the Customer cannot be billed for the service.

- Once UnitedHealthcare receives Notification of an Advanced Outpatient Imaging Procedure on a retrospective basis, if the Customer’s benefit plan does not require services to be medically necessary in order to be covered, and if the service is consistent with evidence-based clinical guidelines, a Notification number will be issued to the ordering Provider. If the service is not consistent with evidence-based clinical guidelines, or if additional information is needed to assess the request, we will let the ordering Provider know whether he or she must engage in a physician-to-physician discussion to explain the request, to provide additional clinical information, and to discuss alternative approaches. Upon completion of the discussion, the ordering Provider will confirm the procedure ordered and a Notification number will be issued.

Failure to obtain a Notification number or Prior Authorization number either prospectively or retrospectively will result in administrative denial of the claim(s).

**Rendering Provider**

To be eligible to receive payment for covered services rendered, the rendering Provider must validate with us prior to performing an Advanced Outpatient Imaging Procedure that a Notification number is on file, and if the Customer’s benefit plan requires that health services be medically necessary in order to be covered, the rendering Provider must validate that the Prior Authorization process has been completed and a coverage decision has been issued before rendering the service. This must be done by contacting us as follows:


- Phone: (866) 889-8054 - (follow the phone prompts provided)
If the Customer’s benefit plan does not require that services be medically necessary in order to be covered:

- If an Advanced Outpatient Imaging Procedure is rendered and a claim for the service is submitted without a Notification number, an administrative claim reimbursement reduction, in part or in whole, will occur. The Customer cannot be billed for the service.

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

- If the rendering Provider determines there is no Notification number on file, and the ordering Provider does not participate in UnitedHealthcare’s network, and is unwilling to obtain a Notification number, the rendering Provider is required to obtain a Notification number.

- If the rendering Provider does not obtain a Notification number for Advanced Outpatient Imaging Procedures ordered by a non-participating Provider, the rendering Provider’s claim will be denied administratively, in part or in whole, for failure to provide Notification, and the Customer cannot be billed for the service.

If the Customer’s benefit plan does require services to be medically necessary in order to be covered:

- If the rendering Provider determines a coverage determination has not been issued, and the ordering Provider is a participating Provider, we will use reasonable efforts to work with the rendering Provider to urge the ordering Provider to complete the Prior Authorization process and obtain a coverage decision prior to the rendering of services.

- If the rendering Provider determines a coverage determination has not been issued, and the ordering Provider is not a participating Provider, and is unwilling to complete the Prior Authorization process, the rendering Provider is required to complete the Prior Authorization process and verify that a coverage decision has been issued prior to rendering the service.

- If the rendering Provider provides the service before a coverage decision is issued, the rendering Provider’s claim will be denied administratively, in part or in whole, and the Customer cannot be billed for the service.

Services that are not medically necessary are not covered under the Customer’s benefit plan. Upon issuance of the denial for lack of medical necessity, the Customer and rendering Provider will receive a denial notice with the appeal process outlined. A clinical denial will be issued, and a Prior Authorization number will not be issued, if it is determined during the Prior Authorization process or Retrospective Review Process that the service is not medically necessary. A Prior Authorization number will be issued to the rendering Provider if the service is medically necessary.

Note: Non-participating Providers can provide notification and complete the Prior Authorization process if applicable either through UnitedHealthcareOnline.com, if they are registered, or by calling (866) 889-8054.

Provision of an additional or modified Advanced Outpatient Imaging Procedure

If during the delivery of an Advanced Outpatient Imaging Procedure, the rendering Provider determines that an additional Advanced Outpatient Imaging Procedure should be delivered above and beyond the service(s) for which a Notification number or Prior Authorization number has already been obtained, the Provider must request a new Notification number prior to rendering the additional service, or if applicable request a new Prior Authorization number and be sure a coverage decision has been issued prior to rendering the additional service, in accordance with this Protocol.

If during the delivery of an Advanced Outpatient Imaging Procedure for which the Provider completed the Notification/ Prior Authorization process set forth in this Protocol, the physician modifies the Advanced Outpatient Imaging Procedure, and if the CPT code combination is not listed on the CPT Code Crosswalk Table available at UnitedHealthcareOnline.com → Clinician Resources → Radiology → Radiology Notification & Prior Authorization, the process below must be followed:

- Contiguous body part – if the procedure being performed is for a contiguous body part, the ordering or rendering Provider must modify the original Notification number request, or if applicable the original Prior Authorization number request online or by calling within 2 business days after the procedure is ordered or rendered.

- Non-contiguous body part – if the procedure being performed is not for a contiguous body part, the ordering Provider must submit a new Notification number request, or if applicable a new Prior Authorization number request, and a coverage determination must be issued, in accordance with this Protocol prior to rendering the procedure.
For certain specified CPT code combinations, as set forth in the CPT Code Crosswalk Table (available at the link specified above), providers are not required to modify the original, or request a new notification number or if applicable a Prior Authorization number.

**Outpatient Radiology Prior Authorization Protocol for Medicare Advantage Customers**

The UnitedHealthcare Outpatient Radiology Prior Authorization Protocol for Medicare Advantage Customers does not apply to the following benefit plans. However, these benefit plans may have separate radiology Notification or Prior Authorization requirements. Please refer to the applicable benefit plans table of this Guide for additional details.

### Excluded Plans (benefit plans not subject to the requirements set forth in the protocol)

- **Hawaii:** AARP MedicareComplete Choice Plan 1 - Group 77000 & 77007 and AARP MedicareComplete Choice Essential - Group 77003 & 77008
- **New York:** AARP MedicareComplete Plan 1 - Group 66074, AARP MedicareComplete Plan 2 - Group 13012, AARP MedicareComplete Essential - Group 66075, AARP MedicareComplete Mosaic - Group 66076. Existing process of obtaining authorization from Montefiore Care Management Organization (CMO) will continue.
- **Utah:** AARP MedicareComplete Plan 1 - Group 77000, AARP MedicareComplete Plan 2 - Group 77004, AARP MedicareComplete Plan 2 - Group 42020, AARP MedicareComplete Plan 2 - Group 42022
- UnitedHealthcare Community Plan Medicare Advantage benefit plans subject to an Additional Manual, as further described in the benefit plans section of the UnitedHealthcare Provider Administrative Guide.
- Erickson Advantage Plans
- UnitedHealthcare Assisted Living Plan
- UnitedHealthcare Nursing Home Plan (HMO SNP), (HMO-POS SNP), (PPO SNP)
- UnitedHealthcare Senior Care Options (HMO SNP)
- Senior Dimensions Medicare Advantage plans

### Other Excluded Plans

The Medicare Advantage Radiology Prior Authorization protocol does not apply to Commercial benefit plans or to other benefit plans, such as Medicaid, CHIP and Uninsured that are not Medicare Advantage. The Admission Notification requirements will not apply to these listed benefit plans. However, these benefit plans may have separate notification or prior-authorization requirements.

- Erickson Advantage Plans
- UnitedHealthcare Assisted Living Plan
- UnitedHealthcare Nursing Home Plan (HMO SNP), (HMO-POS SNP), (PPO SNP)
- UnitedHealthcare Senior Care Options (HMO SNP)
- Senior Dimensions Medicare Advantage plans

The Medicare Advantage Radiology Prior Authorization protocol requirements apply to all Providers that order or render any of the following advanced imaging procedures; Computerized Tomography (CT), Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron-Emission Tomography (PET), Nuclear Medicine, or Nuclear Cardiology.

Please note Prior Authorization is required for only certain of these advanced imaging procedures. An advanced imaging procedure for which Prior Authorization is required is referred to herein as an “Advanced Outpatient Imaging Procedure.”

Prior Authorization under this protocol is required for outpatient services only. Imaging procedures rendered in, and appropriately billed with, any of the following places of service do not require notification: emergency room visits; urgent care, or inpatient stay.

Failure to comply with the requirements described in this protocol will result in claims being administratively denied in whole or in part and, as required under the Provider's agreement with us, the Customer being held harmless.

This protocol applies in all states. For a complete list of CPT Codes for which Prior Authorization is required, please visit UnitedHealthcareOnline.com ➔ Clinician Resources ➔ Radiology ➔ Medicare Advantage Radiology Prior Authorization Program.

### Ordering Provider:

The ordering Provider is responsible for obtaining a Prior Authorization number prior to scheduling any Advanced Outpatient Imaging Procedure. The process required by this protocol for ordering Providers is as follows:

Request a Prior Authorization number by contacting us:

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

**Customer/procedure information**
- Customer’s name and Customer’s health care ID number
- Customer’s address and phone number
- Customer’s group number
- Customer’s date of birth
- The examination(s) or type of service(s) being requested, with the CPT code(s)
- The working diagnosis the appropriate ICD code(s)

**Provider information**
- Ordering Provider’s name, TIN/NPI, specialty, address, and phone number.
- Provider, to whom the Customer is being referred, if specified, address and phone number.
- Rendering Provider’s name and TIN/NPI.

**Clinical information**
- The Customer’s clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.
- Dates of prior imaging studies performed.
- Any other information the ordering Provider believes would be useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports.

Once we receive a Prior Authorization request, we will conduct a clinical coverage review to determine whether the service is medically necessary. Services that are not medically necessary are not covered under the Customer’s benefit plan. Upon issuance of the denial for lack of medical necessity, the Customer and Provider will receive a denial notice with the appeal process outlined.

A Prior Authorization number will be issued to the ordering Provider when the Prior Authorization process is completed regardless of whether the service is medically necessary. The Prior Authorization number will be communicated by fax, phone or online, consistent with how the request was initiated.

To help promote proper payment, the Prior Authorization number must be communicated by the ordering Provider to the rendering Provider scheduled to perform the Advanced Outpatient Imaging Procedure. Subject to federal laws and regulations and Medicare Advantage guidelines, the issuance of a Prior Authorization number does not guarantee or authorize payment. Payment for covered services is contingent upon coverage within an individual Customer’s benefit plan, the Provider being eligible for payment, (including, but not limited to, a provider’s inclusion on a sanction or exclusion list or a provider’s failure to register with the Medicare Provider Enrollment Chain and Ownership System (PECOS) *), any claim processing requirements, and the Provider’s participation agreement with UnitedHealthcare.

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

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* PECOS is the CMS online enrollment system where providers and healthcare entities are required to register so they can manage their Medicare Provider file & establish their Medicare specialty as eligible to order & refer services/items.
Urgent requests during regular business hours
The ordering Provider may request a Prior Authorization number on an “urgent” basis if the Provider determines that rendering the services urgently is medically required. Urgent requests should be requested via the phone by calling (866) 889-8054 and then selecting the option for Outpatient Diagnostic Imaging. The ordering Provider must state that the case is clinically urgent and explain the clinical urgency. We will respond to urgent requests within 3 hours of our receipt of all required information and no later than federal requirements.

Retrospective review process for urgent requests outside of regular business hours
If the ordering Provider determines that an Advanced Outpatient Imaging Procedure is medically required on an urgent basis, and a Prior Authorization number cannot be requested because it is outside of UnitedHealthcare’s normal business hours, Prior Authorization number must be requested retrospectively within two business days after the date of service. The retrospective review request can be made by calling (866) 889-8054 and following the phone prompts, according to the process described below.

Documentation must include an explanation as to why the procedure was required on an urgent basis and why a Prior Authorization number could not have been requested during UnitedHealthcare’s normal business hours.

Once UnitedHealthcare receives the Prior Authorization number request for an Advanced Outpatient Imaging Procedure on a retrospective basis, we will conduct a clinical coverage review to determine whether the service is medically necessary.

A clinical denial will be issued if it is determined that the service is not medically necessary; the Customer cannot be billed for the service.

Failure to obtain a Prior Authorization number either prospectively or retrospectively will result in administrative denial of the claim(s).

Rendering Provider
To be eligible to receive payment for covered services rendered the rendering Provider must validate with us prior to performing an Advanced Outpatient Imaging Procedure that the Prior Authorization process has been completed and a coverage decision has been issued before rendering the service. This must be done by contacting us as follows:

- Phone: (866) 889-8054 (follow the phone prompts provided).

If the rendering Provider determines a coverage determination has not been issued, and the ordering Provider participates in UnitedHealthcare’s network, we will use reasonable efforts to work with the rendering Provider to urge the ordering Provider to complete the Prior Authorization process and obtain a coverage decision prior to the rendering of services.

If the rendering Provider determines a coverage determination has not been issued, and the ordering Provider does not participate in UnitedHealthcare’s network, and is unwilling to complete the Prior Authorization process, the rendering Provider is required to complete the Prior Authorization process and verify that a coverage decision has been issued prior to rendering the service. If the rendering Provider provides the service before a coverage decision is issued, the rendering Provider’s claim will be denied administratively, in part or in whole, and the Customer cannot be billed for the service. Services that are not medically necessary are not covered under the Customer’s benefit plan. Upon issuance of the denial for lack of medical necessity, the Customer and rendering Provider will receive a denial notice with the appeal process outlined. A clinical denial will be issued if it is determined during the Prior Authorization process or Retrospective Review Process that the service is not medically necessary. A Prior Authorization number will be issued once the rendering Provider completes the Prior Authorization process regardless of whether services are medically necessary. The Prior Authorization number will be communicated by fax, phone or online, consistent with how the request was initiated.

Note: Non-participating Providers can submit Prior Authorization requests either through UnitedHealthcareOnline.com, if they are registered, or by calling (866) 889-8054.
Provision of an additional or modified Advanced Outpatient Imaging Procedure

If, during the delivery of an Advanced Outpatient Imaging Procedure, the rendering Provider determines that an additional Advanced Outpatient Imaging Procedure should be delivered above and beyond the service(s) for which a Prior Authorization number has already been obtained, the Provider must complete the Prior Authorization process and be sure a coverage decision has been issued prior to rendering the additional service, in accordance with this Protocol.

If during the delivery of an Advanced Outpatient Imaging Procedure for which the Provider completed the Prior Authorization process set forth in this Protocol, the physician modifies the Advanced Outpatient Imaging Procedure, and if the CPT code combination is not listed on the CPT Code Crosswalk Table available at UnitedHealthcareOnline.com → Clinician Resources → Radiology → Medicare Advantage Radiology Prior Authorization Program, the process below must be followed:

- Contiguous body part – if the procedure being performed is for a contiguous body part, the ordering or rendering Provider must modify the original Prior Authorization number request online or by calling within 2 business days after the procedure is rendered.

- Non-contiguous body part – if the procedure being performed is not for a contiguous body part, the ordering Provider must submit a new Prior Authorization number request, and a coverage determination must be issued prior to rendering the procedure, in accordance with this Protocol.

For certain specified CPT code combinations, as set forth in the CPT Code Crosswalk Table, providers are not required to modify the original Prior Authorization number request or request a new Prior Authorization number.

Outpatient Therapeutic Radiation (IMRT, SRS, SBRT) Prior Authorization Program for Medicare Advantage Customers

The UnitedHealthcare Medicare Advantage Outpatient Therapeutic Radiation Prior Authorization Program will not apply to the following benefit plans. However, these benefit plans may have separate Notification/Prior Authorization requirements. Please refer to the applicable benefit plans table of this Guide for additional details.

Excluded Plans (benefit plans not subject to the requirements set forth in the protocol)

- **Hawaii**: AARP® MedicareComplete Choice Plan 1 - Group 77000 & 77007 and AARP MedicareComplete Choice Essential - Group 77003 & 77008
- **New York**: AARP MedicareComplete Plan 1 - Group 66074, AARP MedicareComplete Plan 2 - Group 13012, AARP MedicareComplete Essential - Group 66075, AARP MedicareComplete Mosaic - Group 66076 Existing process of obtaining authorization from Montefiore Care Management Organization (CMO) will continue.
- **Utah**: AARP® MedicareComplete Plan 1 - Group 42000, AARP® MedicareComplete Essential - Group 42004, UnitedHealthcare Group Medicare Advantage - Group 42020, AARP® MedicareComplete Plan 2 - Group 42022
- UnitedHealthcare Community Plan Medicare Advantage benefit plans subject to an Additional Manual, as further described in the benefit plans section of this Guide.
- Erickson Advantage Plans
- UnitedHealthcare Senior Care Options (HMO SNP)
- Senior Dimensions Medicare Advantage plans
- Additionally, this Medicare Advantage Outpatient Therapeutic Radiation Prior Authorization protocol does not apply to Commercial benefit plans or to other benefit plans, such as Medicaid, CHIP and Uninsured that are not Medicare Advantage.

The UnitedHealthcare Medicare Advantage Outpatient Therapeutic Radiation Prior Authorization requirements in this Program apply to all participating Providers that provide therapeutic radiation services of intensity modulated radiotherapy (IMRT), stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT). (Collectively, “Therapeutic Radiation Services”).

Prior Authorization is required for outpatient services only. Compliance with this Program is required.

Failure to complete the therapeutic radiation prior authorization requirement will result in administrative denial. Claims denied for failure to complete Prior Authorization may not be billed to the Customer. If we receive a Prior Authorization request and determine that the services do not meet clinical coverage criteria, the claim will be denied for lack of medical necessity and thus not covered under Medicare Advantage plans. Upon issuance of the denial for lack of medical necessity, the Customer and Provider will receive a denial notice with the appeal process outlined. Providers who render Therapeutic Radiation Services within the scope of the Program must confirm that Prior Authorization has been obtained, or payment for their services may be denied.
Subject to federal laws and regulations and Medicare Advantage guidelines, the issuance of a Prior Authorization number does not guarantee or authorize payment. Payment for covered services is contingent upon coverage within an individual Customer’s benefit plan, the Provider being eligible for payment (including, but not limited to, a provider’s inclusion on a sanction or exclusion list or a provider’s failure to register with the Medicare PECOS), any claim processing requirements, and the Provider’s participation agreement with UnitedHealthcare.

For additional information about the Outpatient Therapeutic Radiation (IMRT, SRS, and SBRT) Prior Authorization program for Medicare Advantage Customers go to: UnitedHealthcareOnline.com → Clinician Resource → Oncology → Medicare Advantage Therapeutic Radiation (IMRT, SRS, and SBRT).

A Provider may obtain the required Prior Authorization number by contacting us via:

- Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Oncology Authorization Submission and Status.
- Phone: (866) 889-8054

## Important Protocol Information

### Non-Participating Providers Consent Form Protocol

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<th>Excluded Plans (benefit plans not subject to the following requirements)</th>
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<td>• All Savers products offered off-Exchange</td>
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<td>• M.D.IPA, Optimum Choice, or OneNet</td>
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<td>• Benefit plans subject to the River Valley Entities Supplement</td>
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<tr>
<td>• UnitedHealthcare West or UHC West</td>
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</tbody>
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In order to allow Customers to make informed choices regarding their healthcare providers, any time, except in emergent situations where a participating Provider is recommending, referring, including or utilizing one of the following types of non-participating providers/services, the requirements within this protocol apply.

### Impacted Provider/Service Types:

- Ambulatory Surgical Centers – free-standing and hospital outpatient non-emergent
- Assistant Surgeon - a physician or other health care professional who is assisting the physician performing a surgical procedure, where the participating surgeon selects the assistant surgeon
- Home Health
- Air Ambulance, fixed-wing non-emergency transport
- Laboratory Services – for specimens collected in the physician’s office and sent out to a non-participating laboratory for processing
- For Oxford Members on New York Products – refer to the Oxford New York Participating Provider Laboratory & Pathology Protocol for specific requirements and instructions on nonparticipating laboratory and pathology services.
- Outpatient Dialysis
- Specialty Drug vendor

**In advance of any services being rendered, you must:**

1. Verbally discuss Provider options and financial impacts with the Member:
   - Review this policy and the Member Advance Notice Form with the Member
   - Provide participating alternatives and explain the reason for the nonparticipating provider
   - Discuss the financial impact of utilizing a nonparticipating provider
      - If the Member has out-of-network benefits, they may utilize those benefits to receive services from a nonparticipating provider. However, they may have higher out-of-pocket costs when using a non-participating provider.
Members that do not have out-of-network benefits may be responsible for the entire cost of the service(s) provided by the nonparticipating provider.

2. Complete the Member Advance Notice Form: If the Member has elected to use the non-participating Provider, fill in the required information on the Member Advance Notice Form and obtain the Member’s signature on the completed form.
   - A copy of the signed Member Advance Notice Form must be kept on file by the participating Provider to give to us upon request.
   - A separate Member Advance Notice Form is required for each nonparticipating provider/service
   - A copy of the Member Advance Notice Form can be found at UnitedHealthcareOnline.com → Tools & Resources → Policies & Protocols.

This Protocol does not apply in emergent situations. Or instances where the Provider or Customer has obtained an in-network exception to utilize a non-participating physician, facility or other healthcare provider.

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

Administrative Actions for Non-Compliance
We will monitor the involvement of the non-participating Provider types and services outlined above in our ER’s care and may request a copy of the completed Member Advance Notice Form at any time. Compliance with this Protocol will be reviewed by UnitedHealthcare, in accordance with relevant state and federal laws and regulations, and failure to comply with the Protocol may result in appropriate action under your participation agreement, which may include, but is not limited to, ineligibility for performance based compensation, or termination of your participation agreement.

Notes: (1) This protocol was previously titled, “Protocol for Providing Advance Notice to Commercial Customers when Involving Non-Participating Providers in Commercial Customers’ Care” (2) This protocol is effective for Commercial Members (Oxford and UnitedHealthcare) in New York State beginning on 4/1/2016 (previously effective for all other states 4/1/2012). (3) This protocol is effective for Medicare Advantage Customers beginning on 4/1/2016.

Air Ambulance, fixed-wing non-emergency transport protocol
This protocol applies to all participating physicians and health care professionals, and it applies to all non-emergency fixed-wing air ambulance transports, ordered by physicians and health care professionals.

We maintain a network of air ambulance transportation providers. These participating air ambulance providers deliver fixed-wing air ambulance transportation to meet the needs our members, and of the facilities and physicians participating in the UnitedHealthcare network. It is important to note that in many benefit plans, Customers receiving services for out-of-network non-emergency air ambulance services may incur increased financial liability and therefore higher out-of-pocket expenses.

You are required to refer non-emergency fixed-wing air ambulance services to a participating air ambulance provider, except as otherwise authorized by us or a payer. Participating non-emergency fixed-wing air ambulance providers can be found in the UnitedHealthcare Physician Directory online at UnitedHealthcareOnline.com. If you need assistance in locating or using a participating non-emergency fixed-wing air ambulance Provider or believe no participating air ambulance service is available, please contact UnitedHealthcare. We will work with you to assure that required non-emergency fixed-wing air ambulance services are received, even if that means the use of a non-participating air ambulance Provider if necessary.

Administrative actions for referral to out-of-network fixed-wing Air Ambulance Providers
We anticipate that will be able to easily find, a participating fixed-wing air ambulance Provider that will meet the physicians, health care professionals, facilities and ancillary provider’s needs. If we identify an ongoing and material practice of referrals to out-of-network fixed-wing air ambulance providers, we will inform the responsible participating physicians, health care professionals, facilities and/or ancillary providers in the UnitedHealthcare network of the issue and remind them that they are required to refer Customers to participating providers. While it is our expectation that these actions will rarely be necessary, please note compliance with this Protocol will be reviewed by UnitedHealthcare, in accordance with relevant state and federal laws and regulations, and failure to comply with the Protocol may result
Important Protocol Information

**Laboratory services protocol**

**Clinical Information Submission**

UnitedHealthcare requests clinical data from care providers to comply with state and federal data collection and reporting requirements. Additionally, this clinical data helps us to measure quality care for UnitedHealthcare Customers and collaborate with care providers to address gaps in care. As such, care providers must submit to UnitedHealthcare all clinical data including, but not limited to, laboratory testing results by any available means including electronic data interchange, fax, telephone and/or physical data collection methods. All clinical data must be made available to UnitedHealthcare within 30 days of the date of service or within the time specified by applicable law.

Clinical data must be provided to UnitedHealthcare consistent with state and federal law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the American Recovery and Reinvestment Act of 2009 (ARRA) and the Clinical Laboratory Improvement Act (CLIA). Evidence of data provenance will be provided upon request by UnitedHealthcare to satisfy National Committee for Quality Assurance (NCQA) audits or other compliance requirements. Care providers must ensure the data submitted is accurate and complete, meaning all clinical data will represent the information received from the ordering physician and all results from the rendering provider.

UnitedHealthcare will verify that security measures, protocols, and practices are compliant with HIPAA regulation and UnitedHealthcare data usage, governance, and security policies, and will be used for the lawful receipt of clinical data from care providers. Any clinical data received will be used only as allowed under applicable state and federal law. UnitedHealthcare will use this data to perform treatment, payment or health care operations – as defined in HIPAA – for its members.

Health care operations may include the following:

1. Compliance with state and federal data collection and reporting requirements, including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS), Health Outcomes Survey (HOS), NCQA accreditation, Centers for Medicare & Medicaid Services’ (CMS) Star Ratings, and CMS Hierarchical Condition Category Risk Adjustment System

2. Care coordination and other care management and quality improvement programs including physician performance, pharmaceutical safety, customer health risks using predictive modeling and the subsequent development of disease management programs used by UnitedHealthcare and other member and care Provider health awareness programs

3. Quality assessment and benchmarking data sets

4. Any other lawful health care operations

UnitedHealthcare will work collaboratively with the care Provider to help ensure all clinical data values are being transmitted effectively to allow for lawful identification and use of the clinical data.

HIPAA minimum necessary data requirements will be defined in specific documents related to the method of clinical data acquisition, including HL7 companion guide(s) and process documentation related to proprietary file exchange, fax submissions, paper data submission and/or manual data collection by UnitedHealthcare authorized personnel. The companion guides are available at unitedhealthcareonline, numbers 11 and 12.

**Requirement to use participating laboratories**

This protocol applies to all participating physicians and health care professionals, and it applies to all laboratory services, clinical and anatomic, ordered by physicians and health care professionals except as indicated in the following:

- This protocol does not apply where the physician bears financial risk of laboratory services.
- This protocol does not apply where the physician provides laboratory services in their offices.

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

You are required to refer laboratory services to a participating laboratory provider in our network, except as otherwise authorized by us or a Payer. Participating laboratory providers can be found in the UnitedHealthcare Physician Directory online at UnitedHealthcareOnline.com. If you need assistance in locating or using a participating laboratory Provider, or you believe no participating laboratory is available, please contact UnitedHealthcare in advance to confirm that the specific laboratory test is covered. We will work with you to assure that those covered tests are performed, even if that means the use of a non-participating laboratory. Some plans are capitated for Laboratory services and only the capitated laboratory Provider can be utilized for services.

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

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

If we identify a material practice of referrals to out-of-network laboratory service providers, we will inform the responsible participating physicians of the issue and remind them of the general requirements to refer their patients to other network providers. While it is our expectation that these actions will rarely be necessary, please note that continued referrals to non-participating laboratories may, after appropriate notice, subject the referring physician to one or more of the following administrative actions for failure to comply with this protocol:

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

**Self-Referral and Anti-Kickback**

This protocol applies to all participating physicians and health care professionals, and it applies to all laboratory services, clinical and anatomic, ordered by physicians and health care professionals. Referrals for laboratory services that results in the physician earning a profit, including, but not limited to the following, are not allowed:

- Profits resulting from an investment in an entity for which the referring physician or health care professional generates business; or
- Profits resulting from collection, processing and/or transport of specimens,

Failure to comply with this protocol may result in:

- A decreased fee schedule; or
- Termination of network participation, as provided in your agreement with us.

**UnitedHealthcare Laboratory Benefit Management Program Administered by BeaconLBS™**

The UnitedHealthcare Laboratory Benefit Management Program applies to fully insured Customers who live in Florida. If you order laboratory services and your practice is located outside of Florida, this program does not apply to you. This Program will provide physicians and laboratories with point of order support for test selection and laboratory selection. Certain Laboratory Services are subject to additional protocols, including but not limited to, Advance Notification and Laboratory Point of Performance Requirements. Claims for Laboratory Services are subject to additional complete claim requirements.

For more information on requirements and implementation, please visit UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → UnitedHealthcare Laboratory Benefit Management Program.

**Protocols for UnitedHealthcare Nursing Home Plans**

Applicability – This protocol is only applicable to primary care physicians, nurse practitioners, and physician assistants who participate in the network for the UnitedHealthcare Nursing Home Plan (i.e., Medicare Advantage Institutional Special Needs Plans).
Definitions – Capitalized terms used in this protocol but not otherwise defined will have the same meaning as in your agreement with us.

**UnitedHealthcare Nursing Home Plan:** A Medicare Advantage Institutional Special Needs Plan benefit plans that;

a. exclusively enrolls special needs individuals who for 90 calendar days or longer, have had or are expected to need the level of service requiring an institutional level of care (as such term is defined in 42 CFR 422.2);

b. is issued by UnitedHealthcare Insurance Company or by one of UnitedHealthcare’s affiliates; and (c) is offered through our UnitedHealthcare Medicare Solutions business unit, as indicated by a reference to Nursing Home Plan or Erickson Advantage in the plan name listed on the face of the valid health care ID card of any UnitedHealthcare Nursing Home Plan Institutional Customer eligible for and enrolled in such benefit plan.

**UnitedHealthcare Nursing Home Plan Customer:** A Medicare beneficiary who for 90 calendar days or longer has had or is receiving an institutional level of care is enrolled in a UnitedHealthcare Nursing Home Plan.

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

**Physician Assistant:** A health care professional licensed to practice medicine with physician supervision. Physician assistants are trained in intensive education programs accredited by the Commission on Accreditation of Allied Health Education Programs.

**PCP:** For purpose of this section a PCP is a professional who meets all of the following criteria: (a) a Doctor of Medicine or a Doctor of Osteopathy or another health care professional as authorized under state law, Skilled Nursing Facility bylaws and the applicable benefit plan to admit or refer patients to Skilled Nursing Facility for covered services; (b) who has been selected by or assigned to a UnitedHealthcare Nursing Home Plan Customer to provide and/or coordinate the UnitedHealthcare Nursing Home Plan Customer’s covered services; (c) whose practice includes internal medicine, family or general practice; and (d) who participates in UnitedHealthcare’s network.

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

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

**UnitedHealthcare Nursing Home Plan PCP protocols**

If these PCP protocols differ from or conflict with other protocols in connection with any matter pertaining to UnitedHealthcare Nursing Home Plan Customers, these PCP protocols will govern unless statutes and regulations dictate otherwise.

The PCP will cooperate with and be bound by these additional protocols:

1. Attend PCP orientation session and annual PCP meetings thereafter.

2. Conduct face-to-face initial and ongoing assessments of the medical needs of UnitedHealthcare Nursing Home Plan Customers, including all assessments mandated by regulatory requirements.

3. Deliver health care to UnitedHealthcare Nursing Home Plan Customers at their place of residence in collaboration with the Primary Care Team.

4. Participate in formal and informal Family Care Conferences with responsible parties, family and/or legal guardian of the UnitedHealthcare Nursing Home Plan Customer to discuss the UnitedHealthcare Nursing Home Plan Customer’s condition, care needs, overall plan of care and goals of care, including advance care planning.

5. Primary Care Team collaboration and coordination - Collaborate with other Customers of the Primary Care Team designated by UnitedHealthcare and any other treating professionals to provide and arrange for the provision of covered services to UnitedHealthcare Nursing Home Plan Customers. This includes, but is not limited to, making joint visits with other Primary Care Team members to UnitedHealthcare Nursing Home Plan Customers and participating in formal and informal conferences with Primary Care Team Customers and/or other treating professionals following a scheduled UnitedHealthcare Nursing Home Plan Customer reassessment, significant change in plan of care and/or condition.

6. Collaborate with UnitedHealthcare when a change in the Primary Care Team is necessary.
7. Provide UnitedHealthcare a minimum of 45 calendar days' prior notice when discontinuing delivery of covered services at any facility where UnitedHealthcare Nursing Home Plan Customers reside.

8. When admitting a UnitedHealthcare Customer to a hospital, immediately notify the PCP and UnitedHealthcare Nursing Home Plan or Payer of the admission and reasons for such admission (i.e., if the admission is for an emergency or for observation).

**UnitedHealthcare Nursing Home Plan Nurse Practitioner and Physician Assistant protocols**

If these Nurse Practitioner and Physician Assistant protocols differ from or conflict with other protocols in connection with any matter pertaining to UnitedHealthcare Nursing Home Plan Customers, these Nurse Practitioner and Physician Assistant protocols will govern unless statutes and regulations dictate otherwise.

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

1. Attend training and orientation meetings as scheduled by UnitedHealthcare Nursing Home Plan.

2. Deliver health care to UnitedHealthcare Nursing Home Plan Customers at their place of residence in collaboration with a Primary Care Physician, including making joint visits to UnitedHealthcare Nursing Home Plan Customers in the facility on a regular basis.

3. Family Care Conferences - Communicate with the UnitedHealthcare Nursing Home Plan Customer's responsible parties, family and/or legal guardian on a regular basis. Participate in formal and informal conferences with responsible parties, family and/or legal guardian of the UnitedHealthcare Nursing Home Plan Customer to discuss the UnitedHealthcare Nursing Home Plan Customer's condition, care needs, overall plan of care and goals of care, including advance care planning.

4. Primary Care Team collaboration and coordination - Collaborate with other Customers of the Primary Care Team designated by UnitedHealthcare and any other treating professionals to provide and arrange for the provision of covered services for UnitedHealthcare Nursing Home Plan Customers. This includes, but is not limited to, making joint visits with other Primary Care Team Customers to UnitedHealthcare Nursing Home Plan Customers and participating in formal and informal conferences with Primary Care Team Customers and/or other treating professionals following a scheduled UnitedHealthcare Nursing Home Plan Customer reassessment, significant change in plan of care and/or condition.

5. Collaborate and communicate with UnitedHealthcare Nursing Home Plan's designated Director of Clinical Operations to coordinate all inpatient, outpatient and facility care delivered to UnitedHealthcare Nursing Home Plan Customers. Forward copies of the required documentation to UnitedHealthcare's office. Work with the Director to develop a network of providers cognizant of the special needs of the frail elderly.

6. Initial Assessment - Conduct a comprehensive initial assessment for all UnitedHealthcare Nursing Home Plan Customers within 30 calendar days of enrollment that includes:
   a. History and physical examination, including mini-mental status (MMS) and functional assessment.
   b. Review previous medical records.
   c. Prepare problem list.
   d. Review medications and treatments.
   e. Review lab and x-ray procedures.
   f. Review current therapies (Physical Therapy, Occupational Therapy, and Speech Therapy).
   g. Update treatment plan.
   h. Review advance directive documentation including Do Not Resuscitate: Do Not Intervene (DNR/DNI) and use of other life-sustaining techniques.
   i. Contact the family/responsible party within 30 calendar days of enrollment to:
      i. Schedule a meeting at the facility, if possible;
      ii. Obtain further history;
      iii. Agree on type and frequency of future contacts; and
iv. Discuss advance directives.

j. Perform clinical and quality initiative documentation as directed.

7. Provide care management services to coordinate the full range of covered services outlined in the UnitedHealthcare Nursing Home Plan Customer’s benefit plan including, but not limited to:
   • All medically necessary and appropriate facility services
   • Outpatient procedures and consultations
   • Inpatient care management
   • Podiatry, audiology, vision care and mental health care provided in the facility. When a UnitedHealthcare Nursing Home Plan Customer requires a hospitalization, notify PCP and UnitedHealthcare Nursing Home Plan or Payer immediately if the admission is for an emergency or for observation. If contact information is not available, please contact the local office or coordinate communication through the local nursing facility clinical staff.

8. Provide UnitedHealthcare a minimum of 45 calendar days prior notice when discontinuing delivery of covered services at any facility where UnitedHealthcare Nursing Home Plan Customers reside.

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

This protocol applies to the following specialty medications identified below. This protocol does not apply when Medicare or another health plan is the primary payer and UnitedHealthcare is the secondary payer.

• Botox® (botulinum toxin type A)
• Dysport® (botulinum toxin type A)
• Gel-One® (sodium hyaluronate)
• Hyalgan® (Sodium hyaluronate and hyaluronan cross-linked preparations. For consistency, these preparations will be referred to as sodium hyaluronate preparations).
• Monovisc® (sodium hyaluronate)
• Myobloc® (botulinum toxin type B)
• Orthovisc® (sodium hyaluronate)
• Supartz® (sodium hyaluronate)
• Synagis® (palivizumab)
• Xeomin® (botulinum toxin type A)
• Xolair® (omalizumab)

Note: This protocol does not apply to Euflexxa®, Synvisc® and Synvisc-One®. Euflexxa, Synvisc and Synvisc-One may continue to be purchased and directly billed to UnitedHealthcare. Health care providers may continue to “buy and bill” Euflexxa, Synvisc and Synvisc-One.

Requirement to use a participating Specialty Pharmacy Provider for certain medications:

UnitedHealthcare has contracted for the national distribution of these specialty medications. Our participating specialty pharmacy Providers provide fulfillment and distribution services on a timely basis to meet the needs of our Customers and our participating physicians and other health care professionals. Our participating specialty pharmacy providers also provide reviews consistent with UnitedHealthcare’s Drug Policy for these drugs, and work directly with the Clinical Coverage Review unit in UnitedHealthcare’s Care Management Center to determine whether treatment is covered. The UnitedHealthcare Drug Policies for these drug preparations are reviewed and updated or revised periodically by the UnitedHealth Group National Pharmacy & Therapeutics Committee, consistent with published clinical evidence and professional specialty society guidance. Our participating specialty pharmacy Provider report clinical data and related information and are audited on an ongoing basis to support our clinical and quality improvement activities.

You must acquire these specialty medications from a participating specialty pharmacy Provider in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare. Requests for prescriptions of these specialty
medications should be submitted to the participating specialty pharmacy using the applicable enrollment request forms that are available at UnitedHealthcareOnline.com ➔ Tools & Resources ➔ Pharmacy Resources ➔ Specialty Pharmacy Program ➔ Prescription Enrollment Forms, Protocols & Administrative Guides. The specialty pharmacy will dispense these drugs in compliance with the UnitedHealthcare Drug Policy and the Customer’s benefit plan and eligibility, and bill UnitedHealthcare for the medication.

Physicians will only need to bill UnitedHealthcare the appropriate code for administration of the medication and should not bill us for the medication itself. The specialty pharmacy will advise the Customer of any medication cost share responsibility and arrange for collection of any amount due prior to dispensing of the medication to the physician office.

For a listing of the participating specialty pharmacy provider(s) by medication, please refer to the enrollment forms online (see path above).

**Administrative actions for non-network acquisition of Botox®, Dysport®, Gel-One®, Hyalgan®, Monovisc®, Myobloc®, Orthovisc®, Supartz®, Synagis®, Xeomin® and Xolair®.**

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

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

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

**Administration of Xolair in a health care setting**

Xolair contains a black box warning on the risk of anaphylaxis that has been reported to occur after as early as the first dose of Xolair but also has occurred beyond 1 year of regularly administered Xolair treatment. The labeling advises that patients should be observed closely for an appropriate period of time after Xolair administration and Xolair should only be administered in a health care setting by physicians or other health care professionals.

Physicians and other health care professionals administering Xolair should be prepared to manage anaphylaxis and Customers should be informed of the signs and symptoms of anaphylaxis and instructed to seek immediate medical care should symptoms occur.

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

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

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

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

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

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

**Prohibition of provision of non-contracted services**

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

• This protocol does not apply when the administration of specialty medications is conducted in an office setting by a physician or other health care professional who procures and bills directly to us for the specific specialty medications.

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

UnitedHealthcare has contracted with a network of specialty pharmacy and home infusion Providers by therapeutic category to distribute specialty medications covered under a Customer’s medical benefit. The contracted specialty pharmacy and home infusion Providers have been selected by therapeutic category for network inclusion based upon their distribution, contracting, clinical capabilities, and Customer services. This national network provides fulfillment and distribution of the specialty medications on a timely basis to meet the needs of our Customers and our network. Full program participation requirements are identified in the contracted specialty pharmacy or home infusion Provider’s participation agreement.

**Our claims process**

**Reimbursement policies**

UnitedHealthcare reimbursement policies are available online at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides. Reimbursement policies may be referred to in your agreement with us as “payment policies.”

**Prompt claims processing**

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

1. Review the Customer’s eligibility to ensure that you submit the claim to the correct payer. There are multiple options for checking eligibility:
   • Online in the Eligibility and Benefits Center application on Link (formally known as Optum Cloud) or UnitedHealthcareOnline.com – where you will find eligibility and benefits, copayments, out of pocket maximum or view a copy of the Customer’s health care ID card.
   • Via electronic data interchange (EDI) using the Eligibility & Benefit Inquiry & Response (270/271). By calling the Enterprise Voice Portal at (877) 842-3210 or the Customer Care number on the back of the Customer’s health care ID card.

Eligibility and benefit information provided is not a guarantee of payment or coverage in any specific amount. Actual reimbursement depends on various factors, including compliance with applicable administrative protocols, date(s) of services rendered, and benefit plan terms and conditions. For Medicare Advantage plans, reimbursement is also dependent on CMS guidance and claims processing requirements.

2. When applicable, notify us in accordance with the How to submit Advance Notification or Admission Notifications and requests for Prior Authorizations section in this Guide.

3. Prepare complete and accurate claims (see Complete claims and encounter data submissions section).

4. Submit claims electronically for fast delivery and confirmation of receipt.
   a. Connectivity Director is a web-based application, available at no cost, for those who can create a claim file in the HIPAA 837 format. Additional information can be found at UnitedHealthcareCD.com.
   b. UnitedHealthcare Online All-Payer Gateway™ is a web-based solution that links UnitedHealthcareOnline.com users to UnitedHealthcare’s clearinghouse vendor OptumInsight™. Multi-payer transactions and services are offered at preferred pricing. For more information: UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions → EDI Options for Submitting Claims.
c. Electronic Data Interchange (EDI) and Clearinghouse Connections: Both participating and nonparticipating physician, health care professional, facility and ancillary Provider claims are accepted electronically, using UnitedHealthcare’s primary Payer ID (87726). A complete list of payer IDs can be found on UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions → Payer List for UnitedHealthcare, Affiliates and Strategic Alliances.

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

For more information and tips for submitting claims electronically, visit UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions → Electronic Claims. If you need additional information on EDI, contact the EDI Support Line at (800) 842-1109, Option 3. Issues can also be submitted online at UnitedHealthcareOnline.com → Contact Us → Electronic Data Interchange (EDI) Claims → EDI Transaction Support Form

Electronic Payments and Statements (EPS)
Optum’s Electronic Payments and Statements (EPS) is a free electronic funds transfer (EFT) and electronic remittance advice (ERA) service brought to you by UnitedHealthcare. It is the standard for receiving UnitedHealthcare payments and explanation of benefits (EOBs)/remittance advice.

EPS delivers electronic payments and provides online remittance advice and 835 files to physicians, hospitals and other health care professionals.

Electronic payments may be made by direct deposit/EFT into an organization’s bank account or by Virtual Card Payment (VCP). With VCP, your bank account information is not needed as you process payments like a credit card transaction.

If VCP is available to you and you are receiving paper checks and remittance advice, you will be required to elect your preferred claim payment method: EPS with direct deposit, EPS with VCP, or paper checks and remittance advice.

You will receive a deadline and instructions for making your election. If you do not take action by your given deadline, your tax identification number (TIN) will default to Virtual Card Payments. If you choose to continue receiving paper, you will need to confirm your election annually.

EPS with direct deposit: No credit card processing fees
While funds are deposited to your account, UnitedHealthcare will not debit or deduct claim adjustments from your checking or savings account. You can also contact your bank to ensure that you have appropriately placed controls over the electronic funds transfers to and from your account.

Posting and balancing with EPS with direct deposit:
1. Receive email notifications when payments are deposited to your designated bank account(s).
2. Log into EPS and view, save, or print remittance advice to post payments manually to your practice management system, or auto-post using the free electronic remittance advice 835/ERA.

Note: You should enroll with your clearing house if you would like to receive the 835 file from them.

EPS with Virtual Card Payments:
• Virtual Card Payments can be processed using the same method leveraged by your organization to process credit card transactions. Please note, your current credit card processing fees will apply. Please confirm those rates with your bank of choice directly.
• Banking information is not shared outside your organization.

Posting and balancing with Virtual Card Payment:
1. Your practice will receive one or more virtual card numbers (a card number is issued for each payer ID) in the mail. This card number should be retained in a secure location as you will need it for future payments.
2. You will be notified of new claim payments via email.
3. Log on to EPS and view, save or print remittance advice to post payments manually to your practice management system, or auto-post using the free electronic remittance advice 835/ERA.

**Note:** You should enroll with your clearinghouse if you would like to receive the 835 file from them.

**EPS Registration**
To learn more about EPS and to register, visit WelcometoEPS.com. If you have questions about EPS, direct deposit, Virtual Card Payments or enrollment, call us at (866) 842-3278 and select option 5, to speak with an EPS representative.

**Complete claims and encounter data submissions**
For proper payment and application of deductibles and coinsurance, it is important to accurately code all diagnoses and services in accordance with national coding guidelines. It is particularly important to accurately code because a Customer’s level of coverage under his or her benefit plan may vary for different services. You must submit a claim and/or encounter for your services, regardless of whether you have collected the copayment, deductible or coinsurance from the Customer at the time of service.

To assist you in correctly coding your claims, UnitedHealthcareOnline.com’s Claim Estimator includes a feature called Professional Claim Bundling Logic which helps you determine allowable bundling logic and other Commercial claims processing edits for a variety of CPT and HCPCS procedure codes.

**Note:** Only bundling logic and other claims processing edits are available under this option. Pricing and payment calculations for professional Commercial claims are available under the Pre-Determination of Benefits option. After allowing enough time for your claims to process you can check the status in the Claims Management application on Link before sending second submissions or tracers. If you do need to submit a second submission or a tracer, please submit it electronically no sooner than 45 days after original submission.

Complete claims include the information listed below under the Complete Claims and Encounter Data Submission Requirements below. Such information must be submitted using valid codes, as recognized by CMS and other national coding guidelines, on both paper and electronic claims and encounters. If required information is not provided or invalid codes used, if submitted in an electronic transaction the claim may not be processed or if submitted via paper form, the claim will be pended in order to obtain the correct information. In addition, we may require additional information for particular types of services, or based on particular circumstances or state requirements.

If you have questions about submitting claims to us, please contact Customer Care at the phone number listed on the Customer’s health care ID card.

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

**Note:** To order CMS-1500 and CMS-1450 (also known as UB-04) forms, contact the U.S. Government Printing Office at (202) 512-0455, or visit the Medicare website at: cms.gov ➔ Medicare ➔ Billing ➔ ElectronicBilling&EDITransactions.

**Complete claims and encounter data submission requirements**
Your claim may be pended or not processed if you omit any of the following:

- Customer’s name
- Customer’s address
- Customer’s gender
- Customer’s date of birth (dd/mm/yyyy)
- Customer’s relationship to subscriber
- Subscriber’s name (enter exactly as it appears on the Customer’s health care ID card)
- Subscriber’s ID number
- Subscriber’s employer group name
• Subscriber’s employer group number
• Rendering Physician, Health Care Professional, Ancillary Provider, or Facility Name
• Rendering Physician, Health Care Professional, Ancillary Provider, or Facility Representative’s Signature
• Address where service was rendered
• Physician, Health Care Professional, Ancillary Provider, or Facility “remit to” address
• Phone number of Physician, Health Care Professional, Ancillary Provider, or Facility performing the service (provide this information in a manner consistent with how that information is presented in your agreement with us)
• Physician, Health Care Professional, Ancillary Provider, or Facility NPI and/or federal TIN
• Referring physician’s name and TIN (if applicable)
• Date of service(s)
• Place of service(s)
• Number of services (day/units) rendered
• Current CPT-4 or its successor, and HCPCS procedure codes, with modifiers where appropriate
• Current ICD-10-CM diagnostic codes by specific service code to the highest level of specificity (it is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item)
• Charge per service and total charges
• Detailed information about other insurance coverage
• Information regarding job-related, auto or accident information, if available
• Retail purchase cost (or a cumulative retail rental cost) greater than $1,000 for DME
• Current NDC (National Drug Code) 11-digit number for all claims submitted with drug codes. The NDC number must be entered in the 24D field of the CMS-1500 Form or the LIN03 segment of the HIPAA 837 Professional electronic form.
• Method of Administration (Self or Assisted) for Hemophilia Claims – the method of administration must be noted and submitted with the claim form with applicable J-CODES and hemophilia factor, in order to enable accurate reimbursement. Method of administration is either noted as self or assisted.

Additional information needed for a complete UB-04 or CMS-1450 form:
Your claim may be pended or not processed if you omit any of the following:
• Date and hour of admission
• Date and hour of discharge
• Customer status-at-discharge code
• Type of bill code (3 digits)
• Type of admission (e.g., emergency, urgent, elective, newborn)
• Current 4-digit revenue code(s)
• Current principal diagnosis code (highest level of specificity) with the applicable Present on Admission (POA) indicator on hospital inpatient claims per CMS guidelines.
• Current other diagnosis codes, if applicable (highest level of specificity), with the applicable Present on Admission (POA) indicator on hospital inpatient claims per CMS guidelines.
• Current ICD-10-CM or its successor procedure codes for inpatient procedures
• Attending physician ID
• For outpatient services/procedures, the specific CPT or HCPCS codes, line item date of service, and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic)
• Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449)

• Submit claims according to any special billing instructions that may be indicated in your agreement with us.

• On an inpatient hospital bill type of 11x, the admission date and time should always reflect the actual time the Customer was admitted to inpatient status.

• If charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, a nominal monetary amount ($01 or $100) must be reported on all other surgical revenue code lines to assure appropriate adjudication.

• Include the condition code designated by the National Uniform Billing Committee (NUBC) on claims for outpatient preadmission non-diagnostic services that occur within 3 calendar days of an inpatient admission and are not related to the admission.

Risk adjustment data – Medicare Advantage and Commercial

Risk adjustment is required by the U.S. Department of Health and Human Services (HHS) for commercial small group and individual plans. Similar to the CMS risk adjustment program for Medicare Advantage plans, HHS utilizes Hierarchical Condition Categories (HCCs) to calculate an annual patient risk score that represents the individual patient’s disease burden. In order to perform the calculation, CMS and HHS require information from us annually about the demographic and health status of our Customers. Therefore, the clinical documentation and diagnosis code information you submit to us must be accurate and complete. Because patient diagnoses do not carry forward from one year to the next under the commercial risk adjustment program, all existing and chronic conditions must be evaluated and documented at least once each calendar year in the patient’s medical record and claims or encounters you submit.

The risk adjustment data you submit to us must be accurate and complete. It is critical for your office to refer to the ICD-10-coding manual and code accurately, specifically and completely when submitting claims and/or encounters to us. To comply with risk adjustment guidelines, specific ICD-10-CM codes are required. Some unspecified ICD-9 codes that were acceptable for risk adjustment are not acceptable for risk adjustment when submitted as an ICD-10-CM.

For example, The former ICD-9 diagnosis 366.41 - Diabetic cataract maps to several more specific ICD-10 codes:

<table>
<thead>
<tr>
<th>ICD-10 Risk Adjustable Code</th>
<th>ICD-10 Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E08.36</td>
<td>Diabetes mellitus due to underlying condition with diabetic cataract</td>
</tr>
<tr>
<td>E09.36</td>
<td>Drug or chemical induced diabetes mellitus with diabetic cataract</td>
</tr>
<tr>
<td>E10.36</td>
<td>Type 1 diabetes mellitus with diabetic cataract</td>
</tr>
<tr>
<td>E11.36</td>
<td>Type 2 diabetes mellitus with diabetic cataract</td>
</tr>
</tbody>
</table>

• Remember that risk adjustment is based on ICD diagnosis codes, not CPT codes.

• Use the correct ICD-10-CM coding manual and code accurately, specifically, and completely when submitting claims and/or encounters to us.

• Diagnosis codes must be supported by the medical record. Therefore, medical records must be clear, complete and support all conditions coded on claims or encounters you submit.

• Be sure to code all conditions that co-exist at the time of the Customer visit and require or affect Customer care, treatment or management.

• Never use a diagnosis code for a “probable” or “questionable” diagnosis. Instead, code only to the highest degree of certainty.

• Be sure to distinguish between acute and chronic conditions in the medical record and in coding. Only choose diagnosis code(s) that fully describe the Customer’s condition and pertinent history at the time of the visit. Do not code conditions that were previously treated and no longer exist.

• Always carry the diagnosis code all the way through to the correct digit for specificity. For example, do not use a 3-digit code if a 5-digit code more accurately describes the Customer’s condition.

• Be sure that the diagnosis code is appropriate for the Customer’s gender.

• Be sure to sign chart entries with credentials.
All claims and/or encounters submitted to UnitedHealthcare for Risk Adjustment consideration are subject to federal and/or internal audit. CMS, HHS or we may select certain medical records to review to determine if the documentation and coding are complete and accurate. Please provide any medical records requested in a timely manner and provide all available medical documentation for the services rendered to the Customer.

National Provider Identification (NPI)
The Health Insurance Portability and Accountability Act (HIPAA), federal Medicare regulations, and many state Medicaid agencies mandate the adoption and use of a standardized NPI for all health care professionals. In compliance with HIPAA, all covered health care providers and organizations must obtain an NPI for identification purposes in standard electronic transactions.

In addition, based on state-specific regulations, NPI may be required to be submitted on paper claims.

HIPAA defines a covered health care Provider as any Provider who transmits health information in electronic form in connection with a transaction for which standards have been adopted. These covered health care providers must obtain an NPI and use this number in all HIPAA transactions, in accordance with the instructions in the HIPAA electronic transaction x12N Implementation Guides.

To avoid payment delays or denials, we require that a valid Billing NPI, Rendering NPI and relevant Taxonomy code(s) be submitted on both paper and electronic claims and encounters. In addition, we strongly encourage the submission of all other NPIs as defined below.

It is important that, in addition to the NPI, you continue to submit your TIN.

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

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

- UnitedHealthcareOnline.com: To update your NPI and related information online, login and go to “Practice/ Facility Profile” and select the TIN. Click “continue”, then select the “View/Update NPI Information” tab.
- Fax: For all UnitedHealthcare business, you can fax your NPI to the appropriate fax number based on your geographic location/state. The fax form can be found at UnitedHealthcareOnline.com ➔ Tools & Resources ➔ Forms ➔ Form: Provider Demographic Change Form.
- Call the United Voice Portal (UVP) at (877) 842-3210. Select the “Health Care Professional Services” prompt. Say “Demographic changes” and your call will be directed to the Service Center to collect your NPI, Health Care Provider Taxonomy Codes, other NPI related information.
- Credentialing/Contracting: NPI and NUCC taxonomy indicator(s) are collected as part of credentialing, recredentialing, new Provider contracting and re-contracting efforts.

How to submit NPI, TIN and Taxonomy on a claim and/or encounter
Information is provided for the location of NPI, TIN and Taxonomy on paper and electronic claims on UnitedHealthcareOnline.com ➔ Tools & Resources ➔ National Provider Identifier.

Medicare Advantage benefit plan claim processing requirements
Section 1833 of the Social Security Act prohibits payments to any Provider unless the Provider has provided sufficient information to determine the “amounts due such Provider.” To that end, UnitedHealthcare applies various claims processing edits based on National and Local Coverage Determinations, the Medicare Claims Processing Manual, National Correct Coding Initiative (NCCI), and other applicable guidance from CMS, including but not limited to the Official ICD-10-CM Guidelines for Coding and Reporting. These edits are designed to provide UnitedHealthcare with sufficient information to determine:

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

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

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

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

**Hospice – Medicare Advantage**

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

**Claim submission tips**

**Estimating treatment costs**

To facilitate the discussions you may have with your patients about treatment costs, we encourage you to take advantage of UnitedHealthcare’s online Claim Estimator.

The Claim Estimator tool provides a fast and simple way to obtain your Commercial professional claim predeterminations through UnitedHealthcareOnline.com → Claims & Payments → Claim Estimator. With Claim Estimator, you can receive an estimate on whether a procedure will be covered, at what percentage, if any, and what the claim payment will be. Claim Estimator enables you to share this information with your patient before treatment.

**Claims submission tips for UnitedHealthcare HRA and HSA plans**

To promote timely claims turnaround and accurate reimbursement for services you render to Customers with UnitedHealthcare HRAs or HSAs, please verify Customer eligibility and benefits coverage online at: UnitedHealthcareOnline.com → Patient Eligibility & Benefits.

Alternatively, you can call the Customer Service number on the back of your Customer’s health care ID card.

**Note:** regarding UnitedHealthcare HRA enrollees: Once logged into the Patient Eligibility section of UnitedHealthcareOnline.com, the “HRA Balance” field will be displayed if the Customer is enrolled in any UnitedHealthcare consumer-driven health plan. When there are funds available in an HRA account, the current balance will be displayed.

This amount is based on the most recent information available and is subject to change. The actual balance may differ from what is displayed if there are outstanding claims or adjustments that have not yet been submitted or processed. Balances for UnitedHealthcare HSA enrollees are not available through the Patient Eligibility application.
Most UnitedHealthcare HRA and HSA plans do not require copayments; therefore, please do not ask your UnitedHealthcare Customers to make a copayment at the time of service unless it is expressly indicated on their health care ID card.

Submit claims electronically through your clearinghouse or UnitedHealthcareOnline.com. Alternatively, you may submit claims to the address on the back of the Customer’s health care ID card.

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

**Consumer account cards and qualified medical expenses**

Providers may charge UnitedHealthcare HRA or FSA consumer account cards only for expenses that are “qualified medical expenses” (as defined in Section 213(d) of the Internal Revenue Code) incurred by the cardholder or the cardholder’s spouse or dependent. “Qualified medical expenses” are expenses for medical care which provide diagnosis, cure, mitigation, treatment or prevention of any disease, or for the purpose of affecting any structure or function of the body.

Providers may not process charges on the consumer account cards for any expenses that do not qualify as qualified medical expenses; such non-qualifying expenses include, but are not limited to:

**Cosmetic surgery/procedures** (i.e., procedures directed at improving a person's appearance that do not meaningfully promote the proper function of the body or prevent or treat illness or disease), including the following:

- Face lifts
- Liposuction
- Hair transplants
- Hair removal (electrolysis)
- Breast augmentation or reduction.

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

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

An expense can be defined as a “qualified medical expense”, but might not be covered under a Customer’s benefit plan. For updated information regarding qualified medical expenses, please consult the Internal Revenue Service (IRS) website at: irs.gov or call the IRS toll-free phone number at (800) TAX-FORM; (800) 829-3676.

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

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

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

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

Reporting requirements for anesthesia services

- One of the CMS-required modifiers (AA, AD, QK, QX, QY, QZ, G8, G9 or QS) must be used for anesthesia services reporting.
- For electronic claims and/or encounters, report the actual number of anesthesia minutes in loop 2400 SV104 with an “MJ” qualifier in loop 2400 SV103. For CMS-1500 paper claims, report the actual number of minutes in Box 24G with qualifier MJ in Box 24H.
- When using qualifying circumstance codes 99100, 99116, 99135 and/or 99140, report the qualifier on the same claim with the anesthesia service.

Laboratory claim submission requirement

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

Therefore, all laboratory claims and/or encounters must include the name of the referring physician and NPI number of the referring physician, in addition to the other elements of a complete claim and/or encounter described in this Guide. Laboratory claims that do not include the identity of the referring physician will be rejected or denied.

This requirement applies to claims and/or encounters for both anatomic and clinical laboratory services. This requirement also applies to claims and/or encounters received from both participating and non-participating laboratories, unless otherwise provided under applicable law. This requirement does not apply to claims for laboratory services provided by physicians in their offices. Please also refer to the Laboratory Services Protocol section of this Guide.

Assistant surgeons or surgical assistants claim submission requirements

The practice of directing or using non-participating providers significantly increases the costs of services for our Customers, UnitedHealthcare requires our participating providers to use reasonable commercial efforts to use the services of network providers, including network surgical assistants or assistant surgeons to render services to our Customers. Payment is subject to our payment policies (reimbursement policies).

Submission of claims for services subject to medical claim review

In some instances, a claim may be pended or denied with a request for medical records for medical claim review under an applicable medical or drug policy, to determine whether the service rendered is a covered service and eligible for payment. In these cases, a letter will be sent explaining the additional information that is needed.

All participating providers must report Serious Adverse Events by populating Present on Admission (POA) indicators on all acute care inpatient hospital claims and ambulatory surgery center outpatient claims. In the instance that the “Never Event” has not been reported, we will attempt to determine if any charges filed with us meet the criteria, as outlined by the National Quality Forum (NQF) and adopted by CMS and The Leapfrog Group, as a Serious Reportable Adverse Event.

To the extent that a Provider fails to comply with these requirements, that provider’s claim will be denied and will be a provider’s liability; the Provider may not bill the Customer for these charges.

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

For more information about UnitedHealthcare’s Medical and Drug Policies, please see UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Medical & Drug Policies and Coverage Determination Guidelines-Commercial.

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

For Erythropoietin (EPO) claims we require the Hematocrit (Hct) level to be submitted in order for us to determine coverage under the Customer’s benefit plan. For claims submitted via paper to UnitedHealthcare on a CMS-1500 Form, you must enter the Hematocrit (Hct) level in the shaded area of line 24a in the same row as the J-code. Enter Hct and the lab value (Hctxx).

For electronic claims, the Hct level is required in the (837P) Standard Professional Claim Transaction, Loop 2400 – Service line, segment MEA, Data Element MEA03.

The MEA segment should be reported as follows:

- MEA01 = qualifier “TR”, meaning test results
- MEA02 = qualifier “R2”, meaning hematocrit
- MEA03 = hematocrit test result Example: MEA*TR*R2*33~

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

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

For EPO claims submitted on a UB-04 claim form, an Hct level is not required.

Additional information is available online at UnitedHealthcareOnline.com ➔ Clinician Resources ➔ Oncology ➔

**Erythropoietin (EPO) Drug Policy**

**Overpayments**

If you identify a claim for which you were overpaid by us, or if we inform you in writing or electronically of an overpaid claim that you do not dispute, you must send us the overpayment within 30 calendar days (or as required by law or your participation agreement), from the date of your identification of the overpayment or our request. We may also apply the overpayment against future claim payments unless precluded by your agreement with us and applicable law. All refunds of overpayments in response to overpayment refund requests received from UnitedHealthcare, or one of our contracted recovery vendors, should be sent to the name and address of the entity outlined on the refund request letter. Refunds of any credit balances existing on your records should be sent to:

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

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

If we determine that a claim was paid incorrectly, we may make a claim adjustment without requesting additional information from the provider. In the case of an overpayment, we will initiate a claim adjustment and request a refund at least 30 days prior to implementing a claim adjustment, or as provided by applicable law or your agreement with us. You will see the adjustment on the EOB or Provider Remittance Advice (PRA).

If additional or correct information is needed, we will ask you to provide it.

If you disagree with the claim adjustment, our request for an overpayment refund or a recovery made to recoup the overpayment, you can appeal the determination (see the [Claim reconsideration, appeals process and resolving disputes](#) section of this Guide).
Subrogation and Coordination of Benefits

Our benefit plans are subject to subrogation and Coordination of Benefits (COB) rules.

1. **Subrogation** — To the extent permitted under applicable state and federal law and the applicable benefit plan, we reserve the right to recover benefits paid for a Customer’s health care services when a third party causes the Customer’s injury or illness.

2. **Coordination of Benefits (COB)** — COB is administered according to the Customer’s benefit plan and in accordance with applicable law. We accept secondary claims electronically. To learn more, go to UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions → Quick Tips for Electronic Claims → Secondary/COB or Tertiary Claims. You can also contact EDI Support at (800) 842-1109 or UnitedHealthcareOnline.com → Contact Us → Electronic Data Interchange (EDI) Claims → EDI Transaction Support Form.

**Note:** When coordinating benefits with Medicare, if Medicare is the primary payer, we will process up to the Medicare allowed amount when the Provider is a Medicare participating provider. CMS determines the rules for when Medicare processes claims as the primary or secondary payer.

3. **Workers’ Compensation** — In cases where an illness or injury is employment-related, workers’ compensation is primary. If notification is received that the workers’ compensation carrier has denied a claim for services rendered to one of our Commercial or Medicare Advantage Customers, the Provider should submit the claim to UnitedHealthcare, regardless of whether the case is being disputed. It is also helpful to send us the worker’s compensation carrier’s denial statement with the claim.

Retroactive eligibility changes

Eligibility under a benefit contract may change retroactively if:

1. We receive information that an individual is no longer a Customer;
2. The Customer’s policy/benefit contract has been terminated;
3. The Customer decides not to purchase continuation coverage;
4. The Customer fails to pay their full premium within the 3 month grace period established by the Affordable Care Act (and applicable regulations) for subsidized Individual Exchange Customers; or
5. The eligibility information we receive is later determined to be incorrect.

If you have submitted a claim(s) that is affected by a retroactive eligibility change, a Claim Reconsideration may be necessary, except as otherwise required by state and/or federal law. The reason for the claim reconsideration will be reflected on the EOB or Provider Remittance Advice (PRA). If you are enrolled in Electronic Payment System (EPS), you will not receive an EOB; however, you will be able to view the transaction online or in the electronic file you receive from us. If we implement a Claim Reconsideration and a refund is requested, you will be notified at least 30 days prior to any adjustment, or as provided by applicable law or your agreement with us.

Claim correction/resubmission

**Electronic Process:**

- A correction of a claim that was previously paid or denied can be resubmitted through the Claims Reconsideration application on Link. Please use the reason for submission drop down indicating a corrected Claim.
- If you received a letter asking for additional information, you can submit it using the Claims Management application on Link.
- When correcting or submitting late charges on 837 institutional claims, use bill type xx7, Replacement of Prior Claim. Do not submit corrected or additional charges using bill type xx5, Late Charge Claim.

**Paper Process:**

- Submit a new CMS-1500 or UB-04 CMS-1450 indicating the correction being made. Please attach the Claim Reconsideration Request form located on UnitedHealthcareOnline.com → Tools & Resources → Forms. Check Box number 4 for resubmission of a corrected claim.
Claim reconsideration, appeals process and resolving disputes
Claim reconsideration does not apply to some states based on applicable state legislation (e.g. California or Colorado Commercial, excluding Individual Exchange plans). Please refer to Provider Dispute Resolution (PDR) section for more information. The 2 step process described below allows for a total of 12 months for timely submission, not 12 months for step 1 and 12 months for step 2.

Step 1: Claim Reconsideration (a reconsideration must be requested before an appeal can be filed.)
- A processed claim in which the Provider does not agree with the outcome of the original payment/corrected claim

Timeframe:
You must submit your Claim Reconsideration within 12 months (or as required by law or your participation agreement) from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) as required by law, together with a completed UnitedHealthcare Claim Reconsideration Request form.

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

1. Online: in the Claim Reconsideration application on Link. More information is available at UnitedHealthcareOnline.com → Quick Links → Link: Learn More → Claim Reconsideration.

2. Paper: A form can be found on UnitedHealthcareOnline.com → Tools & Resources → Forms → Claim → Claim Reconsideration Form. The form should be mailed to the applicable address listed on the form instructions. (Note: Address may differ based on product. Please see applicable plan supplement section for specific contact information.)

3. Phone: You can call the number on the Customer’s health care ID card to request an adjustment for a claim that does not require written documentation.

Note: If you have a request involving 20 or more paid or denied claims and attachments are not required, aggregate these claims online. Go to UnitedHealthcareOnline.com → Claims & Payments → Claim Research Project.

If you are submitting a request for a claim which was denied requesting medical documentation:
1. Online – Go to the Claims Management application on Link.

2. Paper:
   ‣ Complete the Paper Claim Reconsideration Request Form and check “Previously denied/closed for Additional Information” as your reason for request.
   ‣ Provide a description of the documentation being submitted along with all pertinent documentation. It is extremely important to include the Customer name and health care ID number as well as the provider name, address and TIN on the Claim Reconsideration form to prevent processing delays.

If you are submitting a Claim Reconsideration Request for a claim which was denied because filing was not timely:
1. Electronic claims - include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.

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

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

Step 2: Claim appeal
If you do not agree with the outcome of the Claim Reconsideration decision in Step 1, you may follow the Claim Appeal process outlined below, a second review in which the Provider does not agree with the outcome of the reconsideration
**Timeframe:**
You must submit your appeal to us within 12 months (or as required by law or your participation agreement), from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA).

Medical Records Request Submission Timeframe (Which may include providing a copy of the denial notice) – if medical records are requested to process an appeal, the below timeframes are when the information is due:

- Expedited appeals – within 2 hours of receipt of the request
- Standard appeals – within 24 hours of receipt of the request.

Timeframes may change based on applicable law, or your participation agreement.

**What to Submit:**
Attach all supporting materials such as Customer-specific treatment plans or clinical records to the formal appeal request, based on the reason for the request. Include information which supplements your prior adjustment submission that you wish to have included in the appeal review.

Our decision will be rendered based on the materials available at the time of formal appeal review. If you are appealing a claim that was denied because filing was not timely:

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

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

Where To Send Your Appeal (Note: Address may differ based on product. Please see applicable plan supplement section for specific contact information):

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

**Response details:** If, as a result of the appeal review, the claim requires an additional payment, the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) will serve as notification of the outcome on the review. If the original claim status is upheld, the Provider will be sent a letter outlining the details of the review.

**Applies to California only:** If a claim requires an additional payment, the Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) itself is insufficient to serve as notification of the outcome of the review. A letter will be sent to the Provider with the determination. In addition, payment must be sent within 5 calendar days of such determination based on the date on the determination letter. We will respond to the Provider within the applicable time limits set forth by Federal and State agencies. After the applicable time limit has passed, the Provider may contact Provider Relations at (877) 847-2862 to obtain a status.

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

**Medicare Advantage hospital discharge appeal rights protocol**
Medicare Advantage Customers who are hospital inpatients have the statutory right to request an immediate review by the Quality Improvement Organization (QIO) when UnitedHealthcare and the hospital, with physician concurrence, determine that inpatient care is no longer necessary.

The QIO notifies the facility and UnitedHealthcare of an appeal.

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

If the Medicare Advantage Customer fails to make a timely request to the QIO for immediate review and remains in the hospital, he/she may request an expedited reconsideration (appeal) by UnitedHealthcare.

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

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

If your concern or complaint relates to a matter involving UnitedHealthcare administrative procedures, including but not limited to the notification or claim appeal processes described in this Guide, we both will follow the dispute procedures set forth in those plans to resolve the concern or complaint. After following these procedures, if one of us remains dissatisfied, an arbitration proceeding may be filed as described below and in your agreement with us. For disputes regarding payment of claims, you must timely complete the claim reconsideration and appeal process as set forth in this Guide prior to initiating arbitration.

If we have a concern or complaint about your compliance with your agreement with us, we will send you a letter containing the details. If we cannot resolve the complaint through informal discussions with you, an arbitration proceeding may be filed as described in your agreement with us. Arbitration proceedings will be held at the location described in your agreement with us, or if a location is not specified in your agreement, then at a location as described in the Arbitration counties by location section below.

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

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Charging Customers

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

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

For Medicare Advantage Customers, in addition to first obtaining the Customer’s written consent as indicated above, the following must also occur in order for you to seek and collect payment from our Customer for a non-covered service or item.

- If you know or have reason to know that a service or item you are providing or referring may not be covered (as described below), you must request a pre-service organization determination from UnitedHealthcare prior to providing or referring for the service or item and UnitedHealthcare must issue a determination before you render or refer for the non-covered service or item.

- If after you request a pre-service determination, UnitedHealthcare determines that the service or item is not covered, UnitedHealthcare will issue an Integrated Denial Notice (IDN) to the Customer and you. The IDN informs the Customer of his or her liability for the non-covered service or item and appeal rights. You must make sure the Customer has received the IDN prior to rendering or referring for non-covered services or items in order to collect payment. Please be aware that when a Medicare Advantage Customer wishes to receive a non-covered service or item, CMS requires that the Customer be provided an IDN in order for the Customer to be financially liable for the non-covered service or item unless the service or item is clearly excluded in the EOC or other related materials.

- A pre-service organization determination is not required in order to seek and collect payment from the Customer where the Medicare Advantage Member’s Evidence of Coverage (EOC) or other related materials is clear that a service or item is never covered.
A pre-service organization determination must be requested by submitting an Advance Notification request in the Eligibility and Benefits Center on Link or using UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Notifications/Prior Authorizations Submissions.

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

- We have provided general notice through an article in a newsletter or bulletin, or information provided on UnitedHealthcareOnline.com, (including clinical protocols, medical and drug policies) either that we will not cover a particular service or item, or that a particular service or item will be covered only under certain circumstances not present with the Customer; or

- We have made a determination that the planned service or item is not covered and have communicated that determination to you on this or a previous occasion.

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

If, in accordance with the terms of this Protocol, you requested a pre-service organization determination and an IDN was issued before the non-covered service was rendered, you must include the –GA modifier on your claim for the non-covered service. Including the –GA modifier on your claim will help ensure your claim for the non-covered service is appropriately adjudicated as Customer liability.

You must not bill a Customer for non-covered services in cases in which you do not comply with the terms of the Protocol outlined above. Failure to comply with the terms of the Protocol, including but not limited to failure to request a pre-service organization determination for a Medicare Advantage Customer or rendering the service to a Medicare Advantage Customer before UnitedHealthcare issues the pre-service organization determination, will result in an administrative claim denial. You cannot bill the Customer for claims that are administratively denied.

**Customer financial responsibility**

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

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

Some claims may be adjudicated in real time while the Customer is still in your office. After services have been rendered, you can use the claim submission feature on UnitedHealthcareOnline.com. Within seconds you will receive a fully adjudicated claim that shows the plan’s responsibility and the Customer’s responsibility, based on contracted discounts and plan benefits. This will help promote accurate collections and avoid overpayment or underpayment situations.

In the event the Customer pays you more than the amount indicated on the medical claim EOB/remittance advice, you are responsible for promptly refunding the difference to the Customer.

For Medicare Advantage Customers who are eligible for Medicaid, you will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Medicare Advantage Customer, or his or her representative, or against the Medicare Advantage organization for Medicare Part A and B cost sharing (e.g., copayments, deductibles, coinsurance). You will either: (a) accept payment made by or on behalf of the Medicare Advantage organization as payment in full; or (b) bill the appropriate state source for such cost sharing amount.
Preventive Care
The Department of Health and Human Services has released regulations that require most benefit plans to include preventive care without any cost-sharing (copayments, coinsurance or deductible) requirements as long as services are rendered by participating physicians and other health care professionals.

UnitedHealthcare has updated its Preventive Care Services Coverage Determination Guideline (CDG) to help physicians identify and correctly code preventive services they deliver to Customers.

The CDG is updated when new guidance is received about services that should be covered as preventive services and whenever the applicable codes are revised. The United States Preventive Services Task Force is one of the primary references driving changes to the CDG. Items that have an “A” or “B” rating must be covered without cost-share by non-grandfathered plans.

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

This provision does not apply to Customers enrolled in government health plans (Medicare/Medicaid) including UnitedHealthcare Medicare Solutions Medicare Advantage plans. For information on Medicare coverage of preventive services, please go to UnitedHealthcareOnline.com → Policies, Protocols and Guides → UnitedHealthcare Medicare Advantage Coverage Summaries → Preventive Health Services and Procedures. For more information please visit:

- **Benefit Verification**: You can verify the benefits and coverage of UnitedHealthcare Customers in the Benefits and Eligibility Center application on Link or UnitedHealthcareOnline.com.

- **Health care Reform**: UnitedHealthcareOnline.com → Quick Links → Health Reform Resources → Providers → Health Reform for Providers → Preventive Services.


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

The following sections are specific to our Standard Hospital Bill Audit (as described in the following paragraph). In accordance with the National Hospital Billing Audit Guidelines, UnitedHealthcare may conduct other audits, or make other records requests, in addition to Standard Hospital Bill Audits.

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

Hospital requirements and access
UnitedHealthcare’s Hospital Audit Services Department will notify the hospital of the intent to audit a claim by sending a Communication Form. This Communication Form will be addressed to the hospital CFO, his or her designee, or the hospital auditing representative.

The hospital will provide one of the following:

- A copy of the itemized bill to UnitedHealthcare’s Hospital Audit Services Department within 30 calendar days of the date requested.
• A copy of the bill breakdown to UnitedHealthcare's Nurse Reviewer at the time of the audit. (The hospital will notify the UnitedHealthcare Hospital Audit Services Department if a bill breakdown will be provided within 30 calendar days after we notify the hospital of our intent to audit.)

• The hospital will cooperate in a timely manner, so the UnitedHealthcare Nurse Reviewer can complete the audit scheduling process within 30 calendar days of the scheduling request.

• If there is a requirement for a valid authorization to release medical information, it is the hospital's responsibility to obtain this release from the Customer, or to waive the requirement if permitted under applicable law. In many cases, such authorizations are signed at the time of admission and may already be on file.

• If there is a hospital-imposed fee to audit the medical record, or a copy fee, such fee will be waived unless specified in the hospital’s agreement with us.

• Standard Hospital Bill Audits will be conducted at the hospital in cooperation with the hospital representative.

• At the time of the audit, the hospital will provide the UnitedHealthcare Nurse Reviewer with access to the medical record, all applicable department charge sheets and, if requested, any applicable hospital policy and procedures.

• The hospital will give our audit vendors the same level of access as our employee auditors, when those vendors are acting at our direction and on our behalf. Any vendor authorized by us to conduct an audit on our behalf will be bound by our obligations under the hospital's agreement with us. This includes any confidentiality requirements regarding the hospital audit, and compliance with HIPAA requirements and use of Protected Health Information.

• The hospital will not impose any time limitation on our right or ability to audit, unless stated in the hospital’s agreement with us or permitted by applicable state or federal law.

Audit findings and exit conference
At the completion of each audit, the UnitedHealthcare Nurse Reviewer will participate in an exit conference with the hospital representative. The purpose of the exit conference is to notify the hospital of our audit findings, including overcharges, undercharges, unbilled charges and disallowed unbundled charges for the claims reviewed. UnitedHealthcare's Nurse Reviewer will provide the hospital representative with a copy of the document findings. If the audit occurs at a location other than the hospital, a copy of the findings will be supplied promptly.

• The document findings will list all discrepancies noted during the course of the audit, including: item, unit cost, number charged, number documented, discrepancy, overcharge, undercharge, unbilled charge or disallowed/unbundled charge.

• During this conference, the hospital representative will have the opportunity to present any conflicting audit findings. If additionally required by your agreement with us or by applicable state regulation, hospital representative sign-off will be obtained.

Post-audit procedures
• Refund Remittance – In the event there is an undisputed overpayment, the hospital will remit the amount of the overpayment within 30 calendar days of receipt of the refund request, or as required by state or federal law.

• Disputed Audit Findings – In the event the hospital wishes to dispute any audit findings, the hospital will submit notification of its intent to dispute the audit findings to UnitedHealthcare’s Hospital Audit Services Department within 30 calendar days of receipt of the audit findings. The notification of dispute of audit findings must clearly identify the items in dispute, citing relevant authority and attaching relevant documentation specific to the disputed items.

• Dispute Resolution – UnitedHealthcare's Hospital Audit Services Department will respond to notification of disputed audit findings in writing within 60 calendar days of receipt.

• Escalated Dispute Resolution – In the event that the dispute remains unresolved, the hospital may request a conference call to include representatives of UnitedHealthcare's Hospital Audit Services Department as well as our Network Management staff. Escalated Dispute Resolution will cause suspension of recovery efforts associated with the disputed audit findings for the duration of ongoing discussion between parties.

• Unresolved Dispute – Either party may further pursue dispute resolution as outlined in this Guide and in your agreement with us.
• Offsets – When a refund request has been issued in connection with a Standard Hospital Bill Audit, we will recoup or offset the identified overpayment, underpayment, and/or disallowed charge amounts after the expiration of 35 calendar days from the date of the refund request provided by UnitedHealthcare’s Hospital Audit Services Department, except under the following circumstances: (1) the hospital has remitted the amount due within the 35 calendar day repayment period; or (2) the hospital has provided written notification of its dispute of the audit findings, in accordance with the process outlined above, within the 35 calendar day repayment period; or (3) your agreement or state law indicates otherwise.

Non-hospital audits

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

Audits – Corrective Action Plans
As an additional part of our payment integrity responsibility to evaluate the appropriateness of paid claims, we may initiate and implement a formal corrective action plan if a Provider fails to comply with UnitedHealthcare’s billing guidelines or performance standards. We will monitor the corrective action plan to ensure that it is implemented effectively, and to ensure that any billing or performance problems are addressed and not repeated.

Protocol for Notice of Medicare Non-Coverage (NOMNC)
You must deliver required notice to Customers at least 2 calendar days prior to termination of skilled nursing care, home health care, or comprehensive rehabilitation facility services. If the Customer’s services are expected to be fewer than 2 calendar days in duration, the notice should be delivered at the time of admission, or commencement of services in a non-institutional setting. In a non-institutional setting, if the span of time between services exceeds 2 calendar days, the notice should be given no later than the next to last time services are furnished.

Delivery of notice is valid only upon signature and date of Customer or Customer’s authorized representative, if the Customer is incompetent. You must use the most current version of the standard CMS approved notice entitled, “Notice of Medicare Non-Coverage” (NOMNC).

The standardized form and instructions regarding the NOMC may be found on the CMS website at cms.gov → Medicare → Beneficiary Notices Initiative (BNI) → MA ED Notices or you may contact your Quality Improvement Organization (QIO) for information. There can be no modification of this text and all required elements must be present, including but not limited to instructions on how to contact the QIO and the member’s Medicare Advantage plan.

Any appeals of such service terminations are called “fast track” appeals and are reviewed by the QIO. You must provide requested records and documentation to us or the QIO, as requested, no later than by close of calendar day of the day that you are notified by us or the QIO if the Customer has requested a fast track appeal. (This includes, but is not limited to, weekends and holidays.)
Health Management and Quality Management
Program Information

Complex Case and Disease Management programs

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

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

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

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

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

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

- Coronary Artery Disease
- Diabetes
- Heart Failure
- Asthma
- Chronic Obstructive Pulmonary Disease
- Cancer
- High Risk Pregnancy
- Kidney Disease
- Transplant

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

For some programs, Customers may receive:
• A comprehensive assessment by specially-trained registered nurses to help determine the appropriate level and frequency of interventions.
• Educational mailings, newsletters and tools such as a HealthLog to assist them in tracking their physician visits, health status and recommended targets or other screenings.
• Information on gaps in care and encouragement to discuss treatment plans, goals and results with their physician.
• Physicians with patients in moderate intensity programs may receive information on their patients’ care opportunities.
• Transitional case management when high-risk patients are discharged from a hospital.
• Outbound calls for the highest risk individuals to address particular gaps in care. You will be notified when patients are identified for the high-risk program.

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

Additional Care, Wellness, and Behavioral Health Programs
UnitedHealthcare offers multiple care coordination programs that may be available to our Customers depending on their health benefit plan. Many of the programs offered are focused on delivering skilled resources to assist Customers with improved self-management by helping them understand the provider’s care plan, helping them understand the medication instructions. In order to access these programs, please have Customers contact a UnitedHealthcare representative through the phone number listed on their health care ID cards.

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

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

Complex Medical Conditions programs
Transplant Resource Services: Customers eligible for this program have access to the OptumHealth Center of Excellence transplant network.

Congenital Heart Disease program: The Congenital Heart Disease (CHD) program offers members aged 18 and younger, with a clinical diagnosis of congenital heart disease specialized clinical management and supports them and their families throughout the process of facility selection, inpatient stay, and post-discharge management.

Bariatric Resource Services: The Bariatric Resource Services (BRS) program is designed to help facilitate optimal outcomes through the use of evidence-based guidelines, and access to a Centers of Excellence (COE)/designated Provider network of quality bariatric centers to help improve clinical and economic outcomes, and offer clinical case management by a dedicated nursing staff.

Women’s Health Services: We offer an integrated solution to rising costs related to complexities of pregnancy and childbirth. Within women’s health there are programs that focus on infertility, maternity and neonatal care.
Decision Support programs

**Nurse Line:** A decision support solution that leverages a coaching call model and eSync Platform technology to help facilitate better health outcomes. Each call becomes an opportunity to not only address a symptom, but to connect Customers with the right care, right provider, right medication and right lifestyle.

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

Wellness programs

**Healthy Back:** The Healthy Back program is a consumer-based program that provides support and guidance to Customers to help them navigate the health care system with the goal of improving access to a high level of care. It includes a phone-based coaching program enhanced with online back pain management tools to maximize outcomes and control costs.

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

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

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

Behavioral Health programs

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

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

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

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

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

**UnitedHealth Premium Designation Program (Commercial only)**

The UnitedHealth Premium® physician designation program uses clinical information from health care claims and other sources to assist physicians in their continuous practice improvement and to help consumers make more informed and personally appropriate choices for their medical care. The program uses evidence-based, medical society, and national industry standards with a transparent methodology and robust data sources to evaluate physicians across 27 specialties.
The program works to advance safe, timely, effective, efficient, equitable and patient-centered care. The program supports practice improvement and provides physicians with access to information on how their clinical practice compares with national and specialty-specific measures for quality, and with cost efficiency peer groups in the same geographic area.

Evaluation for quality compares a physician’s observed practice to the UnitedHealthcare national rate among other physicians who are responsible for the same interventions. Cost efficiency is assessed by comparing the case-mix adjusted cost of care attributed to the physician to a benchmark and applying a statistical test to determine if the difference is statistically significant. Quality is the fundamental measurement, demonstrating our commitment to evidence-based practice. The quality designation is separate from the cost efficiency designation. The results are used together to determine the physician’s designation. Quality and cost efficiency evaluations each incorporate adjustments for the case mix of the physician and the level of the patient’s severity of illness where appropriate.

Physicians who meet both the quality and cost efficiency designation criteria will receive the quality and cost efficiency designation. Physicians who meet the quality designation criteria will receive the quality designation regardless of their cost efficiency evaluation. Physicians who meet the cost efficiency designation criteria will receive the cost efficiency designation if they meet the cost of care evaluation but they do not have enough data to assess quality.

We use the UnitedHealth Premium Tier 1 symbol to identify physicians who have been recognized for providing value. UnitedHealth Premium Tier 1 physicians have received the Premium designation for:

- Quality & Cost Efficiency OR
- Cost Efficiency & Not Enough Data to Assess Quality

Customers in health plans that offer tiered benefits may pay lower co-payments and co-insurance amounts for services provided by UnitedHealth Premium Tier 1 physicians.

For more information on tiered benefits, go to UnitedHealthcareOnline.com → Tools & Resources → Products & Services → Tiered Benefit Plans.

We strongly support transparency in our performance assessment criteria and methods. For more information regarding the UnitedHealth Premium physician designation program (including the measures, measurement methodology and how we use the results) - go to UnitedHealthcareOnline.com → Quick Links → UnitedHealth Premium, or call our toll-free number at (866) 270-5588.

**Note:** The UnitedHealth Premium physician designation program does not apply to Medicare Advantage benefit plans.

**Consumer Transparency Tools: MyHealthcareCostEstimator (myHCE)**

The myHealthcareCostEstimator (myHCE) is an online cost estimator tool available in some markets to UnitedHealthcare commercial Customers at myUHC.com and is designed to assist them in making informed health care choices based on cost and quality. The tool displays provider-specific cost estimates in conjunction with UnitedHealth Premium physician designations and Hospital Quality Ratings. Information about each program can be found on UnitedHealthcareOnline.com → Tools and Resources → Health Resources for Patients → Transparency (myHCE).

If you would like to review your cost data and a description of the methodology underlying myHCE please contact your UnitedHealthcare Network Management Representative or Hospital or Physician Advocate.

**Oncology/Hematology - UnitedHealthcare Cancer Registry**

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

In support of our commitment to improving the quality of oncology care, we initiated the UnitedHealthcare Cancer Registry in 2007. The cancer registry includes clinical data such as clinical stage, date of diagnosis and current clinical status.

**Cancer Status Forms**

Please complete the information requested on the Cancer Status Form and fax the form to UnitedHealthcare’s toll free secure number on the Cancer Status Form. We appreciate your time and effort.

As covered entities engaged in performing health care operations, UnitedHealthcare and physicians participating in this initiative may share this clinical information without the need to obtain patient authorizations.
Why should I submit UnitedHealthcare Cancer Status Forms?
Submitting the UnitedHealthcare Cancer Status Form allows you to contribute clinical staging information to the UnitedHealthcare Cancer Registry. This information will be used to conduct ongoing Oncology Care Analysis in the area of cancer care, which may be leveraged to identify national quality improvement opportunities. UnitedHealthcare previously shared the Oncology Care Analysis reports with oncologists. These reports combined the clinical data supplied by oncologists and incorporated into our Cancer Registry with UnitedHealthcare claims data.

The reports compared patient care data to recognized and widely accepted treatment guidelines for four conditions: breast, colorectal, lung and prostate cancer.

Clinical and preventive health guidelines
UnitedHealthcare uses evidence-based clinical and preventive health guidelines from nationally recognized sources to guide our quality and health management programs. We hope you will consider this information and use it, when it is appropriate for your eligible patients. A list of the clinical guidelines is below, and can also be found at: UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Medical & Drug Policies and Coverage Determination Guidelines → Commercial → Clinical Guidelines.

Please note that there have been significant changes to the guidelines marked with an asterisk (*) below.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Myocardial Infarction with ST Elevation</td>
<td>American College of Cardiology / American Heart Association</td>
</tr>
<tr>
<td>Acute Myocardial Infarction without ST Elevation*</td>
<td>American College of Cardiology / American Heart Association</td>
</tr>
<tr>
<td>Asthma</td>
<td>National Heart, Lung and Blood Institute</td>
</tr>
<tr>
<td>Attention Deficit Hyperactivity Disorder (ADHD)</td>
<td>American Academy of Child and Adolescent Psychiatry</td>
</tr>
<tr>
<td>Bipolar Disorder: Adults</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>Bipolar Disorder: Children &amp; Adolescents</td>
<td>American Academy of Child and Adolescent Psychiatry</td>
</tr>
<tr>
<td>Cardiovascular Disease: Prevention in Women</td>
<td>American Heart Association</td>
</tr>
<tr>
<td>Cardiovascular Disease: Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease</td>
<td>American College of Cardiology/American Heart Association</td>
</tr>
<tr>
<td>Cholesterol Management</td>
<td>American College of Cardiology/American Heart Association</td>
</tr>
<tr>
<td>Chronic Obstructive Lung Disease*</td>
<td>Global Initiative for Chronic Obstructive Lung Disease (GOLD)</td>
</tr>
<tr>
<td>Depression/Major Depressive Disorder</td>
<td>American Psychiatric Association</td>
</tr>
<tr>
<td>Diabetes*</td>
<td>American Diabetes Association</td>
</tr>
<tr>
<td>Dietary Guidelines</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>American College of Cardiology/American Heart Association</td>
</tr>
<tr>
<td>Hemophilia and von Willebrand Disease</td>
<td>World Federation of Hemophilia and National Heart, Lung &amp; Blood Institute</td>
</tr>
<tr>
<td>Human Immuno deficiency Virus (HIV)</td>
<td>HIV Medicine Association of the Infectious Diseases Society of America</td>
</tr>
<tr>
<td>Hyperbilirubinemia in Newborns</td>
<td>American Academy of Pediatrics</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Panel Members Appointed to the Eighth Joint National Committee (JNC8)</td>
</tr>
<tr>
<td>Lifestyle Management to Reduce Cardiovascular Risk</td>
<td>American Heart Association/American College of Cardiology</td>
</tr>
<tr>
<td>Obesity</td>
<td>American Heart Association/American College of Cardiology/The Obesity Society</td>
</tr>
<tr>
<td>Physical Activity</td>
<td>U.S. Department of Health and Human Services</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>Agency for Healthcare Research and Quality</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>American Psychiatric Association/PsychiatryOnline Guideline Watch</td>
</tr>
<tr>
<td>Sickle Cell Disease *</td>
<td>National Heart, Lung and Blood Institute</td>
</tr>
<tr>
<td>Spinal Stenosis</td>
<td>North American Spine Society</td>
</tr>
<tr>
<td>Stable Ischemic Heart Disease*</td>
<td>American College of Cardiology/American Heart Association et al.</td>
</tr>
</tbody>
</table>
A list of the clinical guidelines is also published each September in the Network Bulletin found here: UnitedHealthcareOnline.com → Tools & Resources → News & Network Bulletin.

Important behavioral health information

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

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

<table>
<thead>
<tr>
<th>Depression</th>
<th>Patient Health Questionnaire (PHQ-9)†</th>
<th>CPT 99420</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Misuse</td>
<td>Alcohol Use Disorders Identification Test (AUDIT) or CAGE</td>
<td>CPT 99420</td>
</tr>
</tbody>
</table>

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

When doing a screening for depression in adults, remember to include the 99420 Procedure (CPT) and the ICD-10-CM Z13.89 code.

You will find these screening tools for free online. You may also email your request to UBH at BHInfo@uhc.com. For more information and resources on depression and alcohol misuse disorders, Customers may access the UBH website, liveandworkwell.com.

To refer a Customer to a UBH network Provider for assessment and/or treatment, call UBH at the toll free number on the back of the Customer’s UnitedHealthcare health care ID card. A list of UBH providers can be accessed at providerexpress.com.

The UnitedHealthcare Preventive Medicine and Screening reimbursement policy notes that counseling services are included in preventive medicine services. This policy and the Preventive Care Services Coverage Determination guideline are available at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Medical & Drug Policies and Coverage Determination Guidelines-Commercial. For information on coverage of mental health services and preventive health services for Medicare Advantage Customers, see the Medicare Advantage Coverage Summary for Preventive Health Services and Procedures, and the Medicare Advantage Coverage Summary for Mental Health Services and Procedures, both available at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → UnitedHealthcare Medicare Advantage Coverage Summaries.

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

UBH has developed online preventive health information that offers up-to-date, relevant information materials and practice tools to support your treatment of major depressive disorder, alcohol and drug abuse and addiction and attention-deficit/hyperactivity disorder (ADHD). A convenient, reliable and free source of pertinent health information, the preventive health website includes:

- A dedicated section for physicians and other health care professionals with articles addressing aspects of each condition;
- Information about co-morbid conditions;
- Links to nationally recognized practice guidelines;
- A self-appraisal that you can print, use or refer your patients to; and
- A listing of support resources for you, Customers and their families.

Physicians and other health care professionals may access the information via prevention.liveandworkwell.com.
The importance of collaboration between primary physicians and behavioral health clinicians
As you know, a substantial number of patients with serious medical illnesses also have behavioral health conditions. Continuity and coordination of care take on greater importance for patients with severe and persistent mental health and/or substance abuse problems. This is especially true when medications are prescribed, when medical/psychiatric symptoms co-exist and when patients have been hospitalized for a medical or psychiatric condition.

Please discuss with your patients the benefits of sharing essential clinical information. When applicable, we encourage you to obtain a signed release from each UnitedHealthcare Customer that allows you to share appropriate treatment information with the Customer’s behavioral health clinician.

Psychiatric consults for medical patients
Please contact UBH if you would like to: 1) arrange a psychiatric consultation for a Customer in a medical bed, 2) are unclear whether a consultation is warranted, or 3) want assistance with any needed authorization. UBH can be reached by calling the phone number on the back of the Customer’s health care ID card.

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

UnitedHealthcare is committed to providing quality health care products for our Customers. From the time your patient enrolls in one of our plans, our quality initiatives touch all aspects of the health plan experience, from claims, to phone calls, to physician visits. Our evidence-based wellness and care management programs are designed to help your patients achieve the best possible health, in coordination with physicians like you and with the support of our own clinicians. We have built a quality infrastructure to measure our patient safety, performance and quality, and make health care simpler, safer and more efficient.

Cooperation with quality improvement and patient safety activities
Every participating physician and Provider must cooperate with our quality improvement and patient safety activities and programs to improve quality of care and services and Customer experience. These include, but are not limited to, the following:

- Timely provision of medical records upon request including contracted business associates requests if the provision of copies or access to such records will be free of charge (or as indicated in your agreement with us) during site visits or via email, secure email, or secure fax;
- Cooperation with quality of care investigations including timely response to queries and/or completion of improvement action plans;
- Participation in quality audits, including site visits and medical record standards reviews, and Healthcare Effectiveness Data and Information Set (HEDIS®) record review;
- Allowing use of practitioner and Provider performance data.

Quality Management Programs
The Quality Management (QM) program focuses on ensuring access to the delivery of health care and services for all our Customers through the implementation of a comprehensive, integrated, systematic process that is based on quality improvement principles.

The QM Program activities include:

- Identification of the scope of care and services rendered by the Provider
- Development of clinical guidelines and service standards by which clinical performance will be measured
- Objective evaluation and systematic monitoring of the quality and appropriateness of services and medical care received from our network of Providers
- Assessment of the medical qualifications of participating physicians and other Health Care Professionals
- Continued improvement of Customer health care and services
• Efforts to ensure patient safety and confidentiality of Customer medical information
• Resolution of identified quality issues

The ultimate authority and oversight responsibility for our QM Program lies with our board of directors. Day-to-day QM operations are delegated to the Regional Quality Director and Senior Medical Director.

**Quality management committee structure**

The Medical Advisory Committee (MAC) oversees QM activities and addresses specific issues that arise. These issues include review and recommendations regarding clinical practice guidelines, medical policies, service standards, over-utilization and under-utilization of services by physicians and other health care professionals. This committee also makes recommendations regarding the selection of QM studies (based on identified high-volume, high-risk and problem-prone areas in their regions) and develops and implements regional components of the QM work plan.

The UnitedHealthcare Board of Directors has delegated responsibility for the oversight of health plan quality improvement activities to the Regional Quality Oversight Committee (RQOC).

The Regional Peer Review Committee (RPRC) provides a forum for qualified physicians to investigate, discuss and take action on Customer cases involving significant concerns about quality of care. The RPRC has been delegated decision-making authority by the National Peer Review Committee (NPRC).

The NPRC provides a forum for qualified physicians to discuss and take disciplinary action on Customer cases involving significant concerns about quality of care that were unresolved through Improvement Action Plan mechanism administered by the RPRC.

The National Provider Sanctions Committee (NPSC) provides a forum for qualified physicians to discuss and take action on sanction reports that raise issues regarding compliance with UnitedHealthcare’s credentialing plan, and/or patient safety concerns. Sanctions are monitored from government agencies and authorities including but not limited to CMS, Medicaid agencies, state licensing boards, and the Office of the Inspector General (OIG) that relate to Licensed Independent Practitioners (LIP).

**Scope of quality management program activities**

• Identifying high-volume, high-risk and problem-prone areas of care and service affecting our population.
• Developing clinical practice guidelines for preventive screening, acute and chronic care, and appropriate drug usage, based on the availability of accepted national guidelines, the ability to monitor compliance and aspects of care.
• Undertaking quality improvement studies in clinical areas identified through careful claims data analyses; including frequency and cost breakdowns by Customer’s age, sex and line of business, episode treatment groups, major medical procedure categories, diagnosis, and diagnosis-related groups (DRGs).
• Utilizing population-based preventive health care audits to assess the level of preventive care rendered across our membership; separate studies are completed for special risk groups.
• Conducting regular surveys to assess Customer satisfaction, physician satisfaction, employer satisfaction, and reasons for voluntary physician disenrollment.
• Tabulating adherence to physician service standards in areas such as wait times for appointments, in-office care and practice size and availability; some measurement methods we use are complaint data, Consumer Assessment of Healthcare Providers and Systems survey information and GeoAccess analysis.
• Monitoring performance of QM-related functions for compliance with contract, including activities such as oversight of medical policies and procedures, reporting activities, encounter reporting, and regulatory compliance.
• Conducting routine medical record audits to assess physician compliance with the medical record review standards and preventive care guidelines, as well as monitoring coordination and continuity of care between PCPs and Specialists.

*Note:* This is not the only reason we conduct such audits. Such other audits may have different procedures and processes depending on their purpose and design.

• Ensuring medical record documentation provides the plan for your patients’ care, including continuity and coordination of care with other physicians, facilities and health care professionals; proper documentation in the
medical record accurately and completely reflects the care provided to your patient and serves as both a risk management and patient safety tool.

- Reviewing and resolving Customer complaints regarding the provision of medical care and services; investigation may include verbal and written contact with the Customer and the physician or other health care professional, as well as a review of relevant medical records and responses to potential concerns identified.

**Monitoring the quality of medical care through review of medical records**

The purpose of one such medical record audit we may conduct is to review the quality of medical care, as reflected in medical records. A well-documented medical record reflects the quality and completeness of care delivered to patients.

Regular review of medical records can provide data that helps physicians and other health care professionals improve preventive, acute and chronic care rendered to patients. Accreditation and regulatory organizations, such as your state Department of Health and CMS, include review of medical records as part of their oversight activities. We require medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review.

**Medicare Advantage and Prescription Drug Plans**

Several industry quality programs, including the programs for CMS Star Ratings, provide external validation of our Medicare Advantage and Part D plan performance and quality progress. Quality scores are provided on a 1 to 5-star scale, with 1 star representing the lowest quality and 5 stars representing the highest quality. Star Ratings scores are derived from 4 sources:

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

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

**Imaging accreditation**

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

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

Accreditation is required for the following procedures: CT scan, MRI, Nuclear Medicine/Cardiology, PET scan and Echocardiography, in order to avoid the potential reimbursement reductions described below. This accreditation requirement applies to global and technical service claims.

The accreditation process takes approximately 6 to 9 months to complete. This Imaging Accreditation Protocol promotes compliance with nationally recognized quality and safety standards. Upon notice from us, failure to obtain accreditation will affect your right to be reimbursed for procedures rendered using these modalities. As a result, an administrative claim reimbursement reduction for global and technical service claims, in part or in whole, will occur.

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

Additional details regarding this accreditation requirement are available on UnitedHealthcareOnline.com ➔ Clinician Resources ➔ Radiology ➔ Imaging Accreditation.
General administrative requirements

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

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>Within 4 weeks</td>
</tr>
<tr>
<td>Regular/Routine Care Appointment</td>
<td>Within 14 days</td>
</tr>
<tr>
<td>Urgent Care Appointment</td>
<td>Same day</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>Immediate</td>
</tr>
<tr>
<td>After-Hours Care</td>
<td>24 hours/7 days a week for primary physicians</td>
</tr>
</tbody>
</table>

The guidelines listed above are general UnitedHealthcare guidelines; state or federal regulations may require more stringent standards. Contact your Network Management Representative for assistance with determining your state or federal-specific regulations.

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

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

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

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

Arrange substitute coverage
If you are unable to provide care and are arranging for a substitute, we ask that you arrange for care from other physicians and health care professionals who participate with the Customer’s benefit plan so that services may be covered under the Customer’s network benefit.

Go to UnitedHealthcareOnline.com ➔ Physician Directory to find the most current directory of our network physicians and health care professionals.

Continuity of Customer Care following termination of your participation
If your participation agreement terminates for any reason, you may be required to assist in the transition of our Customers’ care to another physician or health care professional who participates in the UnitedHealthcare network. This may include providing services for a reasonable time at our contracted rate during the continuation period, per your participation agreement and any applicable laws. Our Customer Care staff is available to help you and our Customers with the transition. We will notify affected Customers at least 30 calendar days prior to the effective date of termination of your participation agreement, or as required under applicable laws.

Additional Medicare Advantage requirements
If you participate in the network for our Medicare Advantage products, you must comply with the following additional requirements for services you provide to our Medicare Advantage Customers.
• You may not discriminate against Customers in any way based on health status.

• You must allow Customers to directly access screening mammography and influenza vaccination services.

• You may not impose cost-sharing on Customers for the influenza vaccine or pneumococcal vaccine or certain other preventive services. For additional information, please refer to the Medicare Advantage Coverage Summary for Preventive Health Services and Procedures, available at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → UnitedHealthcare Medicare Advantage Coverage Summaries.

• You must provide female Customers with direct access to a women’s health Specialist for routine and preventive health care services.

• You must make sure that Customers have adequate access to covered health services.

• You must make sure that your hours of operation are convenient to Customers and do not discriminate against Customers.

• You must make sure that medically necessary services are available to Customers 24 hours a day, 7 days a week.

• Primary Care Physicians must have backup for absences.

• You may only make available or distribute plan marketing materials to Customers in accordance with CMS requirements.

• You must provide services to Customers in a culturally competent manner, taking into account limited English proficiency or reading skills, hearing or vision impairment, and diverse cultural and ethnic backgrounds.

• You must cooperate with our procedures to inform Customers of health care needs that require follow-up and provide necessary training to Customers in self-care.

• You must document in a prominent part of the Customer’s medical record whether the Customer has executed an advance directive.

• You must provide covered health services in a manner consistent with professionally recognized standards of health care.

• You must make sure that any payment and incentive arrangements with subcontractors are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.

• You must comply with all applicable federal and Medicare laws, regulations, and CMS instructions including, but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.

• The payments that you receive from us or on behalf of us are, in whole or in part, from federal funds and you are therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.

• You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the Medicare Advantage Program, and all information determined by CMS to be necessary to assist Customers in making an informed choice about Medicare coverage.

• You must cooperate with our processes for notifying Customers of network participation agreement terminations.

• You must submit to us all risk adjustment data as defined in 42 CFR 422.310(a), and other Medicare Advantage program-related information as we may request, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to us, you represent to us, and upon our request you shall certify in writing, that the data is accurate, complete, and truthful, based on your best knowledge, information and belief.

• You must comply with our Medicare Advantage medical policies, quality improvement programs, and medical management procedures.

• You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance, and other indicators as specified by CMS.
• You must cooperate with our procedures for handling grievances, appeals and expedited appeals. This includes, but is not limited to, providing requested medical records within 2 hours for expedited appeals and 24 hours for standard appeals, including weekends and holidays.

Medicare Compliance Expectations and Fraud, Waste and Abuse Training

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

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

**Standards of Conduct Awareness:** FDRs working on Medicare Advantage and Part D programs – including contracted providers – must provide a copy of their own or the UnitedHealth Group’s (UHG’s) Code of Conduct at unitedhealthgroup.com → About → Ethics & Integrity → UnitedHealth Group’s Code of Conduct (PDF file) to their employees (including temporary workers and volunteers), the CEO, senior administrators or managers, governing body and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA or Part D benefits or services within 90 days of hire and annually thereafter (by the end of the year).

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

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

Effective January 1, 2016, CMS has amended the regulations to mandate only the use of CMS published training materials by FDRs of a contracted Medicare plan sponsor. FDRs cannot alter the published CMS training material content; however, CMS will allow FDRs to download CMS training material and add content and topics specifics to your organization.

FDRs meeting the FWA certification requirements through enrollment in the fee-for-service Medicare program or accreditation as durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Provider are deemed by CMS rules to have met the training and education requirements.

It is our responsibility to make sure that your organization has access to appropriate training. To facilitate that, we are providing you information on the CMS Parts C and D FWA and General Compliance training module. This module is available on the CMS Medicare Learning Network® at cms.gov.

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

**Exclusion Checks:** FDRs must review federal exclusion lists (HHS-OIG and GSA) and state exclusion lists, as applicable, prior to hiring/contracting with employees (including temporary workers and volunteers), the CEO, senior administrators or managers, and sub delegates who have involvement in or responsibility for the administration or delivery of UnitedHealthcare MA and Part D benefits or services to make sure that none are excluded from participating in Federal health care programs.

FDRs must continue to review the federal and state exclusion lists on a monthly basis thereafter. For more information or access to the publicly accessible excluded party online databases, please see the following links:

- General Services Administration (GSA) System for Award Management at SAM.gov
What You Need to Do for Exclusion Checks: Review applicable exclusion lists as outlined above and maintains a record of exclusion checks for 10 years. Documentation of the exclusion checks may be requested by UnitedHealthcare or CMS to verify that checks were completed.

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

Credentialing and re-credentialing

We are dedicated to providing our Customers with access to effective health care and, as such, we credential physicians and other health care professionals who seek to participate in our network and get listed in our Provider directory, and then re-credential them at least every 36 months thereafter in order to maintain and improve the quality of care and services delivered to our Customers. Our credentialing standards are fully compliant with and more extensive than the National Committee for Quality Assurance (NCQA) and CMS requirements.

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

We have implemented the CAQH process as our single source credentialing application nationally, unless otherwise required in designated states. All physicians and other health care professionals applying to begin participating in our network and those scheduled for re-credentialing are instructed on the proper method for accessing CAQH ProView. Participating physicians and other health care professionals are responsible to verify licensure and other credentials, as applicable, of their clinical support staff.

Rights related to the credentialing process

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

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

Customer rights and responsibilities

UnitedHealthcare Customers have certain rights and responsibilities, all of which are intended to uphold the quality of care and services they receive from you. These rights and responsibilities are outlined in the Customer materials for Commercial and Medicare Advantage benefit plans.

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

Inform Customers of advance directives

The federal Patient Self-Determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Under the federal act, physicians and providers including hospitals, skilled nursing facilities, hospices, home health agencies and others must provide written information to patients on state law about advance treatment directives, about patients’ rights to accept or refuse treatment, and about their own policies regarding advance directives. To comply with this requirement, we also inform Customers of state laws on advance directives through our Customers’ benefit material. We encourage these discussions with our Customers.
Access to records
We may request copies of medical records from you in connection with our utilization management/care management, quality assurance and improvement processes, claims payment and other administrative obligations, including reviewing your compliance with the terms and provisions of your agreement with us, and with appropriate billing practice. If we request medical records, you will provide copies of those records free of charge unless your participation agreement provides otherwise.

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

Medical record standards
A comprehensive, detailed medical record is vital to promoting high quality medical care and improving patient safety. You may access medical record tools and templates and patient safety resources here: UnitedHealthcareOnline.com → Clinician Resources → Patient Safety Resources.

Additionally, our recommended medical record standards are published each November for Commercial and Medicare plans in the Network Bulletin found here: UnitedHealthcareOnline.com → Tools & Resources → News & Network Bulletin.

Non-discrimination
You must not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a Customer of UnitedHealthcare or its affiliates, or if the Customer obtained coverage through the Health Insurance Marketplace, on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information, or source of payment. You must maintain policies and procedures to demonstrate you do not discriminate in delivery of service and accept for treatment any Customers in need of the services you provide.

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

- Material changes to, cancellation or termination of, liability insurance;
- Bankruptcy or insolvency;
- Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession;
- Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program;
- Loss, suspension, restriction, condition, limitation, or qualification of your license to practice; For physicians, any loss, suspension, restriction, condition, limitation or qualification of staff privileges at any licensed hospital, nursing home, or other facility;
- Relocation or closing of your practice, and, if applicable, transfer of Customer records to another physician/facility.

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

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

Provider Privileges
In order to help our Customers get access to appropriate care and to help minimize out-of-pocket costs for Customers, providers must have privileges at applicable participating facilities or arrangements with a participating practitioner to admit and provide facility services to Customers. This includes but is not limited to, full admitting hospital privileges, ambulatory surgery center privileges, and/or dialysis center privileges.

Provide timely notice of demographic changes

Physician/health care professional verification outreach
UnitedHealthcare is committed to providing our Customers with the most accurate and up-to-date information about our network. We are currently undertaking an initiative to improve our data quality. This initiative is called Professional Verification Outreach (PVO).

Your office may receive a call from us asking to verify your data that is currently on file in our Provider database. Please be assured that this information is confidential and will be immediately updated in our database.

Proactive notification of changes
You, or an entity delegated to conduct credentialing activities on behalf of UnitedHealthcare (a “Delegate”), are expected to review, update Provider records and attest to the information available to UnitedHealthcare Customers, including the information listed below, on not less than a quarterly basis. If upon review, you or the Delegate cannot attest to the information because it is inaccurate, you or the delegate must promptly supply updated information to UnitedHealthcare online or through the Provider service center. In addition, you or the Delegate must proactively notify UnitedHealthcare changes to all Provider information, including the information listed below, as well as the addition of new information and the removal of outdated information, not less than 30 days in advance of the effective date of the change. Delegates are responsible for notifying UnitedHealthcare of these changes for all of the participating providers credentialed by the Delegate. If you or a Delegate fail to update Provider records, or give 30 days prior notice of changes, or fail to attest to the information available to UnitedHealthcare Customers, you or the participating providers credentialed by the Delegate may be subject to penalties, including but not limited to, the delay of processing claims, or the denial of claims payment until the Provider records are reviewed and attested to, or corrections submitted.

You and the Delegates are required to update all Provider information, including but not limited to the following:
- The status as to whether the participating Provider is accepting new patients or not,
- The address(es) of the office locations where the participating Provider currently practices,
- The phone number(s) of the office locations where the participating Provider currently practices,
- The email address of the participating Provider,
- If the participating Provider is still affiliated with listed Provider groups,
- The hospital affiliation(s) of the participating Provider,
- The specialty of the participating Provider,
- The board certification(s) of the participating Provider,
- The license(s) of the participating Provider,
- The tax identification number used by the participating Provider,
- The NPI(s) of the participating Provider,
- The languages spoken/written by the participating Provider or the staff,
- Whether the participating provider is an Indican Health Service provider,
- The ages/genders served by the participating Provider,
- Office hours, and in the event of a departure of health care Providers from your practice, we ask that you notify us immediately to allow sufficient time for Customer notification.
To Change Status of Panel (Open/Closed)
If you wish to change your panel status with regard to being open to new patients, open to existing patients only, or closed, the request must be made in writing 30 days in advance and state that the change will apply to all patients for all products, not only UnitedHealthcare members. UnitedHealthcare may also notify providers in writing of changes in their panel status including closures based on state and/or federal requirements, current market dynamics and patient quality indicators.

Administrative Terminations for Inactivity
Up to date directories are a critical element of providing our members with the information they need to manage their health. In an effort to accurately reflect providers who are actively treating UnitedHealthcare members in our directories, UnitedHealthcare will take the following actions:

1. Administratively terminate Provider agreements for providers who have not submitted claims for a period of one (1) year on the basis that they are not actively treating UnitedHealthcare members, and have voluntarily ceased participation in our Network.

2. Inactivate any tax identification numbers (TINs) under which there have been no claims submitted for a period of one (1) year on the basis that they are not in active use. Because other TINs associated with a particular agreement have been active, this is not a termination of the agreement with the provider. Providers may contact UnitedHealthcare to reactivate an inactivated TIN.

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

The W-9 form and the Provider Demographic Change Form are available at UnitedHealthcareOnline.com → Tools & Resources → Forms.
Alternatively, you may submit detailed information about the change, the effective date of the change, and a W-9 on your office letterhead. This information can be faxed to the fax number on the bottom of the demographic change request form.

To update your practice or facility information
You can make all other updates to your practice information by going to the Provider Data Management application on Link or through UnitedHealthcareOnline.com by using the Practice/Facility profile function found on the global navigation at the top of any web page. You can also submit your change by: (a) completing the Provider demographic update fax form and faxing the form to the appropriate fax number listed on the bottom of the form; or (b) calling our Enterprise Voice Portal at (877) 842-3210.

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

Customer Appeals, Grievances or Complaints
We acknowledge that Customer disputes may arise with the health plan or its contracting/participating providers, especially related to coverage issues. UnitedHealthcare respects the rights of its Customers to express dissatisfaction regarding quality of care/services and to appeal any denied claim/service. All Customers receive instructions on how to file a complaint/grievance with us in their Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable.

Network Providers are required to comply with the following requirements when there is a Customer grievance or appeal:
• Assist the Customer with locating and completing the Appeals and Grievance form upon request from the Customer. This form is located at myUHC.com → Find a Form.
- Immediately forward all Customer grievances and appeals (complaints, appeals, quality of care/service concerns) in writing for processing to:

| Medicare Advantage (MA) and Medicare Advantage Prescription Drug (MAPD) Plans: | UnitedHealthcare  
P.O. Box 6106  
Mail Stop CA 124-0157  
Cypress, CA 90630 |
|---|---|
| For Medicare and Retirement Prescription Drug Plans (PDP) | UnitedHealthcare  
P.O. Box 6106  
Mail Stop CA 124-0197  
Cypress, CA 90630 |
| For Commercial plans: | UnitedHealthcare  
P.O. Box 30573  
Salt Lake City, UT 84130-0573 |

- Respond to UnitedHealthcare’s requests for information relevant to the Customer’s appeal or grievance within the designated timeframe. You must supply records as requested within 2 hours for expedited appeals and 24 hours for standard appeals. This includes, but is not limited to, weekends and holidays.

- Comply with all final determinations made by United Healthcare requesting Customer appeals and grievances.

- Cooperate with United Healthcare and the external independent medical review organization, including but not limited to, promptly forwarding to the external review organization copies of all medical records and information relevant to the disputed health care service in your possession, as well as any newly discovered relevant medical records or any information in the participating medical group/IPA's possession that is requested by external review organization.

- Provide United Healthcare with proof of effectuation within the stipulated timeframes on reversals of adverse determinations. Providers must supply proof of effectuation on overturned appeals to UHC (for expedited, within 2 hours of overturn notice; and for standard, within 24 hours of overturn notices). This applies to all calendar days (no exceptions or delays allowed for weekends or holidays).
All Savers Supplement

Important information regarding the use of this Supplement
All Savers Insurance Company (ASIC) a UnitedHealthcare company, offers off-Exchange health insurance to small employers, typically with 2-50 employees. All Savers may be on-Exchange but this supplement only applies to off-Exchange business.

How to contact us

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<thead>
<tr>
<th>ASIC</th>
<th>Where you go</th>
<th>What you can do there</th>
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</thead>
<tbody>
<tr>
<td>Notification</td>
<td>Call the number on the back of the Insured’s health care ID card.</td>
<td>To notify of hospitalizations upon admission, or 5 days prior to a transplant evaluation and clinical trials.</td>
</tr>
<tr>
<td>Benefits, Eligibility, and Claims Status</td>
<td>Call the number on the back of the Insured's health care ID card. myAllSaversProvider.com</td>
<td>To inquire about an Insured’s Eligibility, plan benefits or claims status, and other tools, such as access a Quick Reference Guide.</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>myallsavers.com</td>
<td>For information on the Prescription Drug List (PDL).</td>
</tr>
<tr>
<td></td>
<td>Call the pharmacy number on the back of the Insured's health care ID card.</td>
<td>For information on the Prescription Drug List (PDL).</td>
</tr>
</tbody>
</table>

Our claims process

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

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

Claim reimbursement (adjustments)
If you believe your claim was processed incorrectly, please call the number on the Customer’s health care ID card and request an adjustment as soon as possible and in accordance with applicable statutes and regulations. If you or our staff identifies a claim where you were overpaid, we ask that you send us the overpayment within 30 calendar days from the date of your identification of the overpayment or of our request.

Claims appeals
If you disagree with a claim payment determination you can appeal the determination. Send a letter of appeal to the following address:

ASIC Insureds:
Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371
Fax: (317) 715-7648
Phone: (800) 291-2634
If you feel the situation is urgent, you may request an expedited (urgent) appeal orally, by fax or in writing at:

Grievance Administrator
3100 AMS Blvd.
Green Bay WI 54313
Fax: (920) 661-9981
Phone: (800) 291-2634

Your appeal must be submitted to ASIC within 180 days from the date of payment shown on the EOB, unless your agreement with us or applicable law provide otherwise. This time frame applies to all disputes regarding contractual issues, claims payment issues, overpayment recoveries and medical management disputes. The review process is available to provide a fair, fast and cost-effective resolution of disputes, in accordance with state and federal regulations.

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

Please refer to Claim reconsideration, appeals process and resolving disputes section in this Guide for detailed information about the reconsideration and appeal process.

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

Be sure to check the Insured’s health care ID card at each visit and to copy both sides of the card for your files. When filing electronic claims, be sure to use ASIC electronic Payer ID number 81400.

For more detailed information on ID cards and to see a sample health care ID card, please refer to the Health care identification (ID) cards section of this guide.

Notice to Texas providers
For Verification of Benefits for ASIC Insureds, please call the number on the back of the insured’s health care ID card.

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

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

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

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

The program for participating providers must emphasize best practice guidelines to help prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment. You can find the Standards of Medical Care in Diabetes and Clinical Practice Recommendations at care.diabetesjournals.org.

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

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

**Important information regarding the use of this Supplement**

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

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

**Leased Supplement**

Any reference in the Guide to a physician’s, health care professional, facility, or ancillary provider’s “agreement with us” refers to your participation agreement with the entity operating the leased network (your “Master Contract Holder”).

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

Important information regarding use of this Supplement
This Medicare Advantage Capitated Provider Supplement (“Supplement”) is intended for use by participating physicians, health care providers, facilities and ancillary providers who are capitated for certain UnitedHealthcare Medicare Advantage products. This Supplement applies to all benefit plans for Customers (1) who have been assigned to or who have chosen a Provider that receives a capitation payment from UnitedHealthcare for such Customer, and (2) who are covered under an applicable Medicare Advantage benefit plan insured by or receiving administrative services from UnitedHealthcare, as identified by a reference to “UHC” on the back of the Customer health care ID card.

“Medical group/IPA” as used in this Supplement refers to any medical group/IPA participating, on a capitated basis, in the UnitedHealthcare Medicare Advantage network.

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

Note: Customer’s benefit structures may differ, and coverage is subject to eligibility, benefit design and medical necessity.

Customer Eligibility
Customer eligibility information via an electronic 834 file can be provided on a daily basis containing eligibility changes. A full eligibility file can be provided monthly. Initiation of electronic eligibility requires coordination with your software vendor and us.

Some of the advantages of receiving electronic eligibility are:

- An eligibility upload may reduce the administrative overhead by minimizing the effort currently required to maintain eligibility manually;
- Eligibility updates can be loaded into your system in a timely manner. Please contact your Physician Advocate, as applicable, for more information.

Eligibility files contain the following information:

- Customer subscriber ID
- Medicare ID number
- Medicaid ID number (if applicable)
- Customer full name
- Customer Social Security Number (SSN)
- Customer telephone number
- Customer address information (including zip code)
- Customer date of birth
- Customer gender
- Customer marital status
- Handicap status
- Death date of subscriber or dependent
- Customer benefit status
- Medicare plan code
- Medicare eligibility reason code
- Group or policy number
- The Center for Medicare and Medicaid Services (CMS) contract number
• PBP code
• Language code
• Insurance line
• Coverage level
• Benefit begin date
• Benefit end date
• Provider effective date
• Provider name and Provider group number
• NPI
• Provider gender
• Provider address (including zip code)
• COB begin date
• COB insured group or policy number
• COB end date
• Type of change to coverage
• PCP, when selection is required by UnitedHealthcare.

Capitation Processing & Payment
Capitation is a per member/per month (PM/PM) payment to a Provider that covers contracted services for assigned Customers. This is an alternative to a fee-for-service arrangement. Capitation payments are made whether or not the Customer obtains healthcare services.

Refer to the Division of Financial Responsibility (DOFR) grid or other applicable exhibit in your participation agreement, for a detailed listing of capitated services. Services not specifically excluded from capitation are included in the capitation payment made to the medical group/IPA or hospital, as applicable.

Capitation Reports
UnitedHealthcare runs capitation reports by process month for its Medicare Advantage products. Typically, all current activity and retroactivity up to the standard 6 month system window are reflected in each month’s capitation reporting and payment. The participation agreement may define a non-standard eligibility window for less than the standard 48 month system window. This non-standard eligibility window will override the standard 48 month system window. The nonstandard eligibility retro window will not limit the retroactivity related to premium increases/decreases from CMS.

Capitation reports and first-of-the-month eligibility reports are run from the same snapshot of UnitedHealthcare membership data. The actual date of this snapshot varies, but typically occurs during the last week of the prior month. As an example: the membership snapshot for November capitation is taken during the last week of October.

15/30 Rule
The capitation system uses a 15/30 rule to determine whether capitation is paid for the full month or not at all. If the effective date of a change falls between the 1st and 15th of the month, the change is effective for the current month, and capitation is paid for that month. However, if the effective date falls on the 16th or later, the change is reflected the 1st of the following month and capitation is paid for the following month.

For purposes of calculating capitation payments, Customers are added on the first day of the month or terminated on the last day of the month.

Retroactive Add
A Customer added retroactively between the 1st and the 15th of the month would generate a capitation payment for the entire month. However, a Customer added on the 16th or later would not generate a capitation payment for that month, even though the Customer would be considered eligible for services.
Retroactive Term
A Customer retroactively terminated between the 1st and 15th of the month would generate a capitation recoupment entry for the capitation previously paid for the entire month. However, a Customer retroactively terminated on the 16th or later, would not generate a capitation recoupment entry for the capitation previously paid for the entire month.

The Medicare Advantage capitation process uses the Customer’s date of birth (DOB), as reported by CMS, as a basis for capitation calculations driven by Customer age.

Capitation Payments
UnitedHealthcare makes monthly capitation payments to the medical group/IPA and capitated hospital as payment for providing and arranging covered services to our Customers.

Capitation payments are delivered via electronic funds transfer or via check on the date specified in the participation agreement. If the due date falls on a non-business day, the capitation payment is delivered the next business day.

Electronic Funds Transfer (EFT)
In order to receive capitation payments via EFT, UnitedHealthcare requires a signed Authorization Agreement Electronic Funds Transfer (EFT) Payments form, detailing the bank account and bank routing information. The EFT initial set-up, or a change in business information, requires 3 weeks processing time to take effect.

EFTs are deposited by the end of the banking day on the date specified in the participation agreement. Please note that most financial institutions charge a per transaction fee on electronic funds transfers.

CMS Premium
The Medicare Modernization Act payment methodology for Medicare Advantage organizations such as UnitedHealthcare, defines a competitive bid process. CMS will compare the bid from each organization against the CMS benchmark and modify the payment made to Medicare Advantage organizations accordingly.

The CMS premium received by UnitedHealthcare is based on several Customer-specific variables, including:

- Age
- Gender
- State and county code
- Plan benefit package selection and benefit configuration
- Health status
- The Medicare Advantage plan’s competitive bid
- The Medicare Advantage plan’s Customer premium
- Risk-adjusted factors based on the Customer’s Hierarchical Condition Category (HCC), based on inpatient and outpatient encounter data.

UnitedHealthcare uses the premium reported on the Monthly Membership Report (MMR) from CMS as the first step in development of the premium that is used for the percent of premium calculation. The algorithm, methodology-blend percentage and rates/factors are posted on the CMS website at cms.gov for all periods.

Unpaid CMS Premium
If we do not receive payment from CMS for a particular Customer, we do not pay capitation for that Customer. Typically unpaid CMS premiums occur in the 1st month of eligibility and the payment is usually received within 60 calendar days.

If the medical group/IPA has unpaid premiums, it must continue to arrange for the Customer’s medical care and pay for services accordingly.

If CMS does not retroactively pay the premium within 120 calendar days, the medical group/IPA should notify its Physician Advocate with the specific information for that Customer so that the non-payment can be pursued with CMS.

Out-of-Area Premium
UnitedHealthcare receives premium from CMS based, in part, on the Customer’s State and County Code (SCC) as reported by CMS. We use the premium reported by CMS as a basis for percent of premium capitation.
CMS may report a Customer in a different state than the state the Customer’s assigned medical group/IPA is located. As an example, CMS may report a Customer’s SCC as Washington, yet the Customer’s assigned medical group/IPA is in Oregon.

Once the SCC is updated via the CMS system, CMS will pay the correct SCC going forward. Typically, CMS does not retroactively adjust premium for changes in SCC.

**End Stage Renal Disease (ESRD) Premium**

ESRD premiums are paid using a Risk-Adjusted model. The model provides a 3-tier approach: (1) dialysis status, (2) receiving a transplant, and (3) functioning graft status. CMS communicates these tiers using the Customer’s Risk-Adjusted Factor Type Code.

In addition to the ESRD flag, the flat file will report the Customer-level Risk-Adjusted Factor Type code to aid the medical group/IPA with identifying their ESRD Customer. The risk-adjusted factor type code is not reported on the image reports. Additional information on the Risk-Adjusted ESRD model can be found on the CMS website at cms.gov.

**Extended Retro Process Adjustments**

CMS sends premium payment adjustments to UnitedHealthcare that can span up to a 48 month timeframe. These adjustments will be processed for a medical group/IPA or hospital whose capitation calculation method is percent of premium.

**Working Aged Premium Adjustments**

A unique working aged factor is applied to each Medicare Advantage contract by CMS. The working aged factor is developed for the entire calendar year based on survey results received by CMS during the preceding year.

UnitedHealthcare has a separate contract with CMS for each state in which we do business. The working aged adjustment is reflected as a Customer specific adjustment in the premium payment to UnitedHealthcare from CMS. The working aged adjustment will be calculated based on a yearly Medicare Secondary Payor (MSP) factor determined by CMS. The working aged adjustment is reported at the Customer level. Specifics on the CMS Working Aged Program can be found on the CMS website at cms.gov.

**Delegated Claims Process**

UnitedHealthcare may delegate claims processing to medical groups/IPAs and hospitals (collectively referred to as “delegated entities” in this section) that have requested delegation and have shown through a pre-delegation assessment that they are capable of processing claims that are compliant with applicable federal regulatory requirements.

Delegated entities are required to develop and maintain claims operational and processing procedures that allow for accurate and timely payment of claims - taking into consideration proper application of benefit coverage, eligibility requirements, appropriate reimbursement methodology, etc. and which meet all applicable federal regulatory requirements.

**Claims Processing**

**Medicare Advantage - Contracted Provider** claims must be processed in accordance with the agreed upon contract rates and within applicable federal regulatory requirements. Claims are to be adjudicated within 60 calendar days of receipt.

**Medicare Advantage - Non-contracted Provider** claims should be reimbursed in accordance with, but not limited to, the current established locality-specific Medicare Physician Fee Schedule, DRG, APC, and other applicable pricing published in the Federal Register. Non-contracted, clean claims must be adjudicated within 30 calendar days of receipt. Non-clean claims are to be adjudicated within 60 calendar days of receipt.

**Interest Payment Requirements**

Delegated entities are required to automatically pay applicable interest penalty on claims according to established federal and/or state regulatory requirements. For Medicare Advantage, CMS requires the payment of interest for non-contracted Provider clean claims not paid within 30 calendar days from the first date stamp. Interest will be paid at the current rate for the period beginning on the day after the required payment date and ending on the date the check is mailed. CMS updates the interest rate twice annually, in January and July. This information can be found in the Federal Register or on the official CMS website.
Timely Filing
Timely filing limit for contracted Provider claims should follow the contractual arrangements that the delegated entity has with its downstream providers.

The timely filing requirement for non-contracted Provider claims should follow the CMS guidelines for original Medicare claims (i.e., claims received more than one calendar year beyond the date of service will be denied as being past the timely filing deadline).

Please also refer to the official CMS website at cms.gov, for additional rules and instructions on timely filing limitations.

Service Area
The financial responsibility for providing covered medical and/or hospital services within a designated service area is determined by your participation Agreement. Please refer to your participation agreement for your specific service area definition.

Out-of-Area (OOA) Urgent or Emergent Claims
Urgent or emergent services provided within the delegated entity’s service area are typically the financial risk of the delegated entity regardless of whether services were in or out of the delegated entity’s network of providers. Please refer to your DOFR.

In most contractual arrangements, however, UnitedHealthcare has financial responsibility for OOA medical and hospital services provided on an urgent or emergent basis. UnitedHealthcare follows the federal regulations regarding payment of claims related to access to medical care in urgent or emergent situations. If UnitedHealthcare determines the claims are not emergent or urgent, we will forward the claims to the delegated entity for further review. Medical services provided outside of the delegated entity’s defined service area that are arranged and/or authorized by the Customer’s medical group/ IPA are the delegated entity’s responsibility and are not considered OOA medical services.

The delegated entity remains responsible to issue appropriate denials for Customer-initiated, non-urgent/non-emergent medical services outside of the delegated entity’s defined service area.

Misdirected Claims
In order to meet CMS regulatory timeliness standards, it is important that misdirected claims are forwarded to the proper payer in accordance with applicable federal regulations. Claims that are misdirected to UnitedHealthcare rather than to the appropriate delegated entity will be identified, batched and forwarded in accordance with federal regulations to the delegated entity responsible for processing the claim. UnitedHealthcare will send the Provider of service a notice that the Customer’s claim has been forwarded to another entity for processing.

All claims received in error at the delegated entity must be identified and tracked (manually or systematically). Tracking must include the name of the entity of where the claims were sent and the date mailed. Claims must be forwarded to the appropriate payor immediately upon receipt, in accordance with federal regulatory timeframes. To prevent forwarding delays, the delegated entities are held accountable to forward misdirected claims within 14 calendar days of receipt. If it is determined that the Customer had been assigned to another medical group/IPA on the date of service, the Provider should forward the claim to the appropriate delegated entity in accordance with federal regulatory timeframes for processing. The delegated entity must, however notify the Provider of service of the correct payor name, if known, on the Explanation of Payment (EOP) provided to the Provider when the claim is adjudicated.

Reporting
Delegated entities are accountable for submitting all required information to UnitedHealthcare and appropriate regulatory agencies in accordance with the guidelines established by federal regulations. Delegated entities are required to submit regulatory and plan reporting requirements timely including, but not limited to, Monthly/Quarterly CMS Part C reporting requirements deemed by the plan necessary to conduct the proper level of oversight monitoring, and the Claims Quarterly Reports (CMS Part C Reporting Requirements) in accordance with federal regulations.

Compliance Audits
UnitedHealthcare has established policies and procedures specifically designed to monitor the delegated entities’ compliance with federal claims processing requirements. Our auditors will conduct claims processing compliance audits of each delegated entity on a regular basis. Delegated entities with compliant results will be audited at minimum annually.
Additional audits will be performed for other circumstances, including, but not limited to:

- Audit results indicate non-compliance
- Self-reported timeliness reports indicate non-compliance for 2-3 months
- Non-compliance with reporting requirements
- Lack of resources or staff turnover
- Overall performance warrants an audit (claims appeal activity, claims denial letters, or Customer and Provider claims-related complaints)
- Allegations of fraudulent activities or misrepresentations
- Changes to or conversion of information systems
- New management company or change of processing entity
- Established Management Service Organization (MSO) acquires new business
- Significant increase in Membership or volume of claims
- Significant increase in claims-related complaints
- Regulatory agency request
- Significant issues concerning financial stability

Delegated entities are required to comply with and submit all audit requirements including, but not limited to, timely and complete submission of claims universe reports, and all required audit materials necessary to conduct and successfully complete the audit.

Delegated entities found to be non-compliant will be placed on corrective action plan and will be required to correct any identified deficiencies including, but not limited to, the following:

- Processing timeliness issues
- Failure to pay interest or penalties
- Canceling audits
- Failure to submit all audit requirements
- Failure to provide access to canceled checks or bank statements

Delegated entities that do not achieve compliance within the established timeframes may be sanctioned until such time as they achieve compliance. Claims processing is a delegated function subject to revocation. Sanctions may consist of additional/ enhanced auditing, on-site claims management, revocation, and enrollment freeze. There may be costs to the delegated entity depending on the sanction put in place.

**Claims Denial Letters**

When a claim is received for a Medicare Advantage Customer, the delegated entity must assess the claim for the following components before issuing a denial letter:

- Customer’s eligibility status with UnitedHealthcare on the date of service
- Responsible party for processing the claim (forward to proper payer)
- Contract status of the Provider of service or referring provider
- Presence of sufficient medical information to make a medical necessity determination
- Covered benefits
- Authorization for routine or in-area urgent services
- Maximum benefit limitation for limited benefits
- Prior to denial for insufficient information, the delegated entity must document their attempts to obtain necessary information to make a determination.
There are two types of claim denial letters outlined below. In both instances, the party that holds the financial risk is responsible for providing the notification.

**Customer Denial Letter**

In instances when a Customer is financially responsible for a denied service, UnitedHealthcare or the delegated entity (whichever holds the risk) must provide the Customer with written notification of the denial decision in accordance with federal regulatory standards.

The delegated entity must use the most current CMS-approved Integrated Denial Notice (IDN) known as the Notice of Denial of Medical Coverage/ Payment (NDMCP) template to accurately document and issue a claim denial letter to a Medicare Advantage plan Customer. The denial letter must be sent out within the appropriate regulatory timeframes. At a minimum, the Customer denial letter must include the following:

- Applicable Customer information
- The entity issuing the letter
- The date of denial
- The claim amount
- The date of service
- The Provider of service
- 12-point font
- The envelope must state “Important Plan Information” in a minimum of 12-point font.
- The proper appeal rights
- CMS approval (OMB) numbers and revision dates
- The denial code and the reason for the denial must be clear, accurate, and based on appropriate criteria
- The delegated entity must make correct claim determinations, which include developing the claims for additional information when necessary to determine possible urgent or emergent services.

Each Customer denial letter must meet the necessary criteria to be considered compliant. All claims denial letters issued to Customers are subject to audit by UnitedHealthcare. All delegated entities will receive instructions as to their denial letter audit status and oversight process. A compliance audit of each delegated entity’s Customer denial letters will be conducted on a regular basis as described in the Compliance Audits section above.

The delegated entity remains responsible to issue appropriate denials for Customer-initiated, non-urgent/non-emergent medical services outside of the delegated entity’s defined service area.

**Provider Denial Letter**

In instances when the Customer is not financially responsible for the denied service, it is not necessary to notify the Customer of the denial. The Provider must be notified of the denial and its financial responsibility (i.e., writing the charges off or claims payment). When the Customer has no financial responsibility for the denied service, the denial letter or EOP issued to any participating Provider of service must clearly state that the Customer is not to be billed for the denied or adjusted charges. In addition, the Provider must be notified of their right to dispute the decision. The denial notice (letter or EOP) must also specify the Customer is not to be balance billed.

**CMS Non-Contracted Provider Payment Dispute Resolution Process**

The Provider payment dispute resolution (PDR) process includes any decisions where a non-contracted Provider contends that the amount paid by the delegated entity for a covered service is less than the amount that would have been paid under original Medicare. This process also includes instances where there is a disagreement between a non-contracted Provider and the delegated entity about the entity’s decision to pay for a different service than that billed, for example, bundling issues, disputed rate of payment, DRG payment dispute. The timeframe for submitting a payment dispute is 120 calendar days from the original claim determination. At a minimum, the delegated entity must adhere to the following requirements when handling Medicare non-contracted Provider claim payment disputes:

- Well-defined internal payment dispute process in place, including a system for receiving PDRs.
• Proper identification of payment disputes in place. (Non-contracted Providers must clearly state what they are disputing and why, supply relevant information that will help support their position, including description of the issue, copy of submitted claim, supporting evidence to demonstrate what original Medicare would have allowed for the same service).

• Well-defined internal dispute process in place, including a system for tracking disputes and monitoring of PDR claims inventory.

• Timeframe for submitting a payment dispute (timely filing limit of 120 calendar days from the original claim determination) accurately established and communicated to the non-contracted Provider at time of claim payment.

• Information on how to submit an internal claim payment dispute to the organization is communicated to the non-contracted Provider at time of claim payment, including the organization’s mailing address where disputes are to be submitted and other appropriate information for disputes (i.e., email addresses, phone numbers).

• Timeframe of 30 calendar days from the PDR claim received date to process and respond (i.e., to finalize the PDR claim) to the non-contracted Provider is in place and being met.

• Ensure correct calculation of interest payments on overturned PDRs is made. Interest is required on a reprocessed non-contracted Provider clean claim if the delegated entity made an error on the original organization determination. Interest is only applied on the additional amount paid; it is calculated from the oldest receive date of the original claim until the “check mail date” of the additional amount paid.

• Complete and clear rationale provided to the non-contracted Provider for upheld PDRs.

• Information contained in the PDR Acknowledgement Letter, Provider Remittance Advice (PRA) or Explanation of Payment (EOP), and upholds PDR Determination Letter is appropriate and met requirements.

• Information given within the Provider notice on upheld or overturned payment disputes on how to contact the organization if the non-contracted providers have additional questions.

• Process in place to update the organization’s claims system, if needed, if the root-cause of overturned PDRs is identified to be system-related so that future claims from non-contracted providers will reimburse appropriately.

• End-to-end quality review process in place, from the time a dispute is received from the non-contracted Provider to the time when the dispute decision is sent to the non-contracted provider.

**Customer Grievance and Appeals**
Delegated entities are required to comply with the following requirements when there is a Customer grievance and appeals:

• Immediately forward all Customer grievances and appeals (complaints, appeals, quality of care/service concerns) in writing for processing to:

  West Region
  (AK, AZ, CA, CO, HI, ID, MT, NM, NV, UT, WA, WY)
  UnitedHealthcare
  P.O. Box 6106
  Cypress, CA 90630

  Other States
  UnitedHealthcare Provider Appeals
  P.O. Box 30559
  Salt Lake City, UT 84130-0575
• Respond to UnitedHealthcare’s requests for information relevant to the Customer’s appeal or grievance within the
designated timeframe. You must supply records as requested within 2 hours for expedited appeals and 24 hours for
standard appeals. This includes weekends and holidays.

• Comply with all final determinations made by UnitedHealthcare requesting Customer appeals and grievances.

• Cooperate with UnitedHealthcare and the external independent medical review organization, including but not limited
to, promptly forwarding to the external review organization copies of all medical records and information relevant to
the disputed health care service in the medical group/IPA’s possession, as well as any newly discovered relevant
medical records or any information in the participating medical group/IPA’s possession that is requested by external
review organization.

• Provide UnitedHealthcare with proof of effectuation within the stipulated timeframes on reversals of adverse
determinations. Providers must supply proof of effectuation on overturned appeals to UnitedHealthcare (for
expedited, within 2 hours of overturn notice; and for standard, within 24 hours of overturn notices). This applies to all
calendar days (no exceptions or delays allowed for weekends or holidays).

Physician/Provider Complaints and Customer Appeals, Grievances or Complaints

UnitedHealthcare maintains a centralized system of logging, tracking and analyzing issues received from Customers
and from physicians and other health care providers to measure and improve Customer and Provider satisfaction. This
system operates to assist us in fulfilling the requirements and expectations of our Customers and our participating
physicians. In addition, we support compliance with CMS, the National Committee for Quality Assurance (NCQA), the
Joint Commission, and other accrediting and/or regulatory requirements. Information regarding Provider and Customer
complaints is important to the re-credentialing process because it helps us attract and retain physicians and health care
providers, employer groups and Customers.

All written complaints will be entered into the complaint database. If a potential quality of care issue is identified within the
complaint (using pre-established triggers), an acknowledgement letter is sent and the case is forwarded to the Quality of
Care Department to investigate the care elements. If the complaint involves an imminent and serious threat to the health of
the Customer, the case is referred to the Quality Intervention Services group for immediate action. Quality of care complaints
are investigated by identifying and requesting relevant medical records/information necessary to make a determination.
Case review findings are reflected in assigned severity levels and data collection codes to objectively and systemically
monitor, evaluate and improve the quality and safety of clinical care and quality of service provided to our Customers.

Complaints received are tracked and trended by physician/Provider and the information is utilized at the time of
physician/provider’s recredentialing. An annual analysis of the complaint data is performed to identify opportunities for
improvement.

Customers have the right to appeal the determination of any denied services or claim by filing an appeal with
UnitedHealthcare. Timeframes for filing an appeal is 60 calendar days of the denial notice.

Requirements for Submission of Encounter Data

We require the submitting entity to submit all professional and institutional claims and/or encounter data for Medicare
Advantage Customers:

• To comply with regulatory requirements of the Balanced Budget Act (BBA)
• To submit to CMS for risk adjustment reporting and accurate Medicare reimbursement
• To comply with NCQA-HEDIS reporting requirements
• To provide the submitting entity with comparative data
• To produce the Provider Profile and Quality Index
• To facilitate utilization management oversight
• To facilitate quality management oversight
• To support Services 75 FR 19709-Maximum Allowable Out-of-Pocket Cost Amount for Medicare Parts A and B
• To comply with CMS regulation 42 CFR 422.111(b)(12) which requires an EOB for Part C benefits
• To facilitate settlement calculations, if applicable
To comply with the CMS regulation 75 FR 19709 to report Customer cost share as well as out-of-pocket maximums, we require contracted providers to submit current, complete and accurate encounter data, including Customer cost share/revenue, to us within the CAS segment of the ANSI ASC X12N 837 Health Care Claims transaction for each service line of your assigned Medicare Advantage Customers.

To comply with the CMS regulation 42 CFR 422.111(b) (12) which requires an EOB for Part C benefits, all encounter submissions from contracted providers with dates of service of January 1, 2014 and later must include all data fields contained in an ANSI ASC X12N 837 Health Care Claims transaction and follow guidance specified in the technical report document for the ANSI ASC X12N 837 Health Care Claims transaction implementation guide. In addition, UnitedHealthcare requires that all encounter data submitted via EDI should be sent to Payer ID 95958. We will continuously monitor encounter data submissions for quality and quantity for Medicare Advantage. Submission levels below the current established thresholds as defined by the Capitation/Encounter Data Collection Team will be considered non-compliant. The capitated medical group/IPA, or other submitting entity, must correct any encounter errors identified by a clearinghouse or trading partner at least on a monthly basis. As a capitated delegated entity processing claims on our behalf, it is our expectation that all encounter submissions are an accurate reflection of the original claim received without exception.

All encounter data submitted to UnitedHealthcare is subject to federal audit. We have the right to perform routine medical record chart audits on any or all of the medical group’s/IPA’s participating providers at such time or times as we may reasonably elect to determine the completeness and accuracy of encounter data ICD and CPT coding. The medical group/IPA shall be notified in writing of audit results pertaining to coding accuracy. As outlined in your participation agreement, the medical group/IPA may be subject to financial consequences if it or another submitting entity fails to submit or meet the encounter data element requirements. In addition, the medical group/IPA may be required to perform a complete medical record chart audit of its participating physicians with notice from UnitedHealthcare. HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

**Hierarchical Condition Category (HCC) reporting**

CMS mandates that services are paid based on Hierarchical Condition Category (HCC) Reporting. This payment methodology requires physicians and health care providers to be accurate in chart documentation and diagnosis reporting, through claims and encounter data submissions to all health insurance carriers.

CMS reimburses all Medicare Advantage plans based on the Customer’s health status. CMS uses the diagnosis codes from the Medicare Advantage claims and/or encounter data (inpatient, outpatient and physician) to establish each Customer’s health status or HCC. The HCC is used by CMS to calculate Medicare reimbursement payments for each Customer.

As a result, we are required to send all payable claims and capitated encounter data for Medicare Advantage Customers to CMS. These claims and encounters must pass all the edits that CMS applies to its fee-for-service HIPAA 5010 837, CMS-1500, and UB-04 submissions.

In order to minimize rejected claims and encounter data, physicians and health care providers must process their Medicare Advantage claims and encounters in the same manner as their Medicare fee-for-service bills, subject to the specific claims submission and other requirements stated in this Supplement.

If the claims and encounter data do not pass the CMS edits, CMS will return the claims and/or encounter to UnitedHealthcare via the MA002 report. Our claims/encounter data staff will then contact the physicians or health care providers’ billing department to obtain the correct or missing information for resubmission. Only the Provider and/or their designee can change or submit new CMS-1500 or UB-04 data. Cooperation and quick turnaround time from the Provider in obtaining correct information is required.

CMS may at any time audit our submission. The billing and Customer medical information must be able to be tracked back to the medical record.

**Referrals & Referral Contracting**

*Provide or Arrange Covered Services*

Each Customer is assigned a PCP at the time of enrollment. The PCP has primary responsibility for coordinating the Customer’s overall health care, including behavioral health care, and the appropriate use of pharmaceutical medications.
PCPs and specialty care practitioners (SCPs) not affiliated with a medical group/IPA that is delegated for medical management must follow our Medical Management processes for referrals. Refer to the Medical Management section of this Supplement.

Referral Authorization Procedure
The delegated medical group/IPA may be responsible to initiate the referral authorization request when referring a Customer to another provider. The following capitated medical services are examples where a referral authorization may be necessary:

- Outpatient services
- Laboratory and diagnostic testing (non-routine, performed outside the delegated medical group/IPA’s facility)
- Specialty consultation/treatment

The medical group/IPA, PCP and/or other referring physician is responsible for verifying eligibility and participating Provider listings on all referral authorization requests, so that the referral is to the appropriate network provider. The medical group/IPA must comply with the following procedure:

- When a Customer requests specific services, treatment or referral to a physician, the PCP or treating physician shall review the request for medical necessity.
- If there is no medical indication for the requested treatment, the physician shall discuss an alternative treatment plan with the Customer.
- If the treatment option selected by the Customer requires referral or prior authorization, the PCP or treating physician must submit the Customer’s request to the medical group/IPA Utilization Management Committee or its designee for determination. The PCP or treating physician should include appropriate medical information and commentary on the referral regarding why he/she believes the requested treatment is or is not indicated and alternative treatments as appropriate.
- If the request is not approved in whole, the medical group/IPA (or if not delegated, UnitedHealthcare) must issue a denial letter to the Customer, specific to the requested services, treatment or referral and which complies with the applicable federal requirements.

Possible authorization determinations include:

- Approved as requested – No changes.
- Approved as modified – Services were approved, but the original requested Provider or treatment plan was modified. Denial letter for the originally requested service, including rationale for denial, must be sent if the requested Provider is changed, or specific treatment modality is changed, (e.g., requested chiropractic services, approved physical therapy).
- Extension – Delay of decision for a specific service (e.g., need additional documentation or information, or requires consultation by an expert reviewer).
- Delay in Delivery – The authorizing entity requires a postponement of access to an approved service for a specified period of time or until a specified date. To facilitate timely processing of claims, the medical group/IPA referral authorization process should include claims processing guidelines for the referral provider.

Referral Authorization Form
The medical group/IPA may design its own request for authorization form, without approval by UnitedHealthcare; however, the font of the form must be at least 12-point, with “Times New Roman” being the preferred style. In addition, the form shall, at a minimum, include all of the following components:

- Customer identification (e.g., Customer ID number and birth date)
- Services requested for authorization including appropriate ICD-10-CM and/or CPT codes
- Authorized services [including appropriate ICD-10-CM and/or CPT codes
- Proper billing procedures (including the medical group/IPA address)
- Verification of Customer eligibility
Within 2 business days of the decision, the medical group/IPA shall provide copies of the referral authorization form to the following:

- Referral provider
- Customer
- Customer’s medical record
- Managed care administrative office

If UnitedHealthcare is financially responsible for the services, the medical group/IPA shall submit the authorization information to us.

**Direct Access Services**

**Women’s Health Specialists**

Female Customers may receive obstetrical and gynecological (OB/GYN) physician services directly from a participating OB/GYN, family practice physician, or surgeon identified by the medical group/IPA or UnitedHealthcare as providing OB/GYN physician services. This means the Customer may receive these services without Prior Authorization or a referral from her PCP. In all cases however, the physician must be affiliated with the Customer’s assigned medical group/IPA and participating with UnitedHealthcare.

**Flu Vaccine**

Each Customer has direct access to an network physician for an annual flu vaccine. The medical group/IPA shall educate each Customer about annual flu vaccine providers and the availability of flu vaccines through the Customer’s PCP.

**Medical Management**

The purpose of the Medical Management Program is to determine if the medical services proposed or rendered are:

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

With limited exceptions, physicians and health care providers will not be reimbursed for services that are not medically necessary, or for which correct procedures have not been followed (e.g., notification requirements, Prior Authorization, or verification guarantee process).

NCQA Accreditation standards require that all health care organizations, health plans and medical group/IPAs, delegated for utilization/medical management, distribute a statement to all Customers, physicians and health care providers and employees who make utilization management (UM) decisions affirming the following:

- UM decision-making is based only on appropriateness of care and service and existence of coverage
- Practitioners or other individuals are not specifically rewarded for issuing denials of coverage or service
- Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization

Regardless of the Medical Management Program determination, the decision to render medical services lies with the Customer and the attending physician.

If the Provider and Customer decide to go forth with the medical service once UnitedHealthcare or the delegated medical group/IPA has denied Prior Authorization, (and issued a denial notice to the Customer and physician as appropriate), no physician, hospital, or ancillary services will be reimbursed by UnitedHealthcare or the delegated medical group/IPA. Medical directors are available to discuss their decisions and our criteria with you. Medical policies are also available on the Provider website at UnitedHealthcareOnline.com or from the delegated medical group/IPA as applicable.

**Criteria for Determining Medical Necessity**

UnitedHealthcare and medical group/IPAs delegated for utilization/medical management review nationally-recognized criteria to determine medical necessity and appropriate level of care for services whenever possible. UnitedHealthcare and delegated medical group/IPAs will utilize multiple resources and guidelines to determine medical necessity and appropriate level of care.
For Medicare Advantage Customers, we use Medicare guidelines, including National Coverage Determinations and Local Coverage Determinations to determine medical necessity of services requested.

If other nationally-recognized criteria contradict MCG, UnitedHealthcare and delegated medical group/IPAs will follow the Medicare guidelines for Medicare Advantage Customers. Individual criteria will be provided to you upon request.

**Provider Requirements**

Physicians and health care providers are required to participate, cooperate and comply with UnitedHealthcare Medical Management policies. All physicians and health care providers must render covered services at the most appropriate level of care, based on nationally-recognized criteria.

UnitedHealthcare may delegate medical management functions to a medical group/IPA that demonstrates compliance with UnitedHealthcare’s established standards (refer to the *Delegated Medical Management* section of this Supplement). Physicians associated with these delegated medical groups/IPA must use the medical group/IPA’s medical management office and protocols.

In addition, we may retain responsibility for some medical management functions, such as inpatient admissions and outpatient surgeries. When the Provider is not associated with a delegate or where UnitedHealthcare retains responsibility for the specific medical management function, the Provider is required to comply with the UnitedHealthcare Medical Management procedures.

Details of UnitedHealthcare’s pre-service, concurrent review, case management, post-service/retrospective review, and medical claim review protocols are available online at UnitedHealthcareOnline.com.

**Provider Responsibilities under UnitedHealthcare’s Medical Management Program**

Physicians and health care providers are required to confirm a request for services has been authorized prior to rendering services for a specified Customer. If a Prior Authorization has not been requested, the Provider must request Prior Authorization for services within 3 business days prior to providing or ordering the covered service except in the case of emergent or urgent services.

In order to confirm a Prior Authorization has been approved for a particular date of service, physicians and health care providers may check online in the Eligibility and Benefits Center application on Link if registered, or UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Notification/Prior Authorization Status. If the Customer is assigned to a delegated medical group/IPA, a Provider may check with this medical group/IPA for confirmation.

UnitedHealthcare must be notified of urgent or emergent cases within 24 hours of services being rendered or an admission. Failure to obtain Prior Authorization or to notify us within the appropriate timeframe may result in a denial of payment.

**Note:** In no event shall UnitedHealthcare or the Customer be held responsible to reimburse physicians and health care providers for medical services, admissions, inappropriate hospital days, and/or not medically necessary services if required Prior Authorization was not obtained. Receipt of an authorization does not affect the application of any applicable payment policies in determining reimbursement. The delegated medical group/IPA sets its own policies regarding the responsibilities of physicians and health care providers.

**Emergency Services and/or Urgent Hospital Admissions**

Some admissions cannot be scheduled. In these cases, the Provider is required to contact UnitedHealthcare of an admission as soon as possible on the same day (but no later than 24 hours from admission). The Provider must work with our medical management department to obtain authorization. Admission notification can be sent to the medical management department at:

- **Phone:** (800) 799-5252
- **Fax:** (800) 274-0569
- **24 hours/day, 7 days/week**

Eligibility determination should occur before the admission of any after-hours or weekend admission whenever possible. The UVR confirmation eligibility system is available 24 hours per day, 7 days per week.

The delegated medical group/IPA sets its own policies regarding notification and authorization for the above services.
Emergency Services and Emergency Medical Conditions

Emergency services are defined as covered inpatient and outpatient services that are furnished by a Provider qualified to furnish emergency services and needed to evaluate and treat an emergency condition. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the Customer’s condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: (a) placing the patient’s health in serious jeopardy; (b) serious impairment to bodily functions; (c) serious dysfunction of any bodily organ or part; (d) serious disfigurement; or (e) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Retrospective denial of services for what appears to the “prudent layperson” to be an emergency is prohibited. If a physician or other representative affiliated with the medical group/IPA instructs the Customer to seek emergency services, the medical group/IPA is responsible for payment for medically necessary emergency services regardless of the prudent layperson standard. The definition of an Emergency Medical Condition is as follows:

- A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
  - Serious jeopardy to the health of the individual or, in the case of a pregnant woman the health of the woman or her unborn child,
  - Serious impairments to bodily functions, or
  - Serious dysfunction of any bodily organ or part.

Post Stabilization Care

CMS defines post-stabilization care as services that are:

- Related to an Emergency Medical Condition,
- Provided after a Customer is stabilized, and
- Provided to maintain the stabilized condition, or under certain circumstances to improve or resolve the enrollee’s condition.

UHC or its delegates must:

- Have a process to respond to requests for post-stabilization care
- Respond to requests for authorization of post-stabilization services within one hour

If UHC or Delegate does not respond within one hour, care is deemed authorized until:

- The Customer is discharged,
- A participating physician arrives and assumes responsibility for the Customer’s care, or
- The treating physician and UHC or its delegate, agrees to another arrangement.

Based on contract, the delegate is financially responsible for:

- ER and post-stabilization services in area
- Out of Area (OOA) services

Medical Observation

UnitedHealthcare or its respective designee will authorize hospital observation status when medically indicated. Hospital observation status is generally designed to evaluate a Customer’s medical condition to determine the need for inpatient admission, or to stabilize a Customer’s condition. Typically, observation status is used to rule out a diagnosis or medical condition that responds quickly to care. A Customer’s outpatient admission status may later be converted to an inpatient admission if medically necessary and if appropriate criteria have been met.
Out of Area (OOA) Medical Services

OOA medical and hospital services are those emergent or urgently needed services to treat an unforeseen illness or injury that arises while a Customer is outside of the medical group/IPA’s contracted service area. These OOA services are services that would have been the financial responsibility of the medical group/IPA had the services been provided within the medical group/IPA service area.

- UnitedHealthcare retains the ultimate accountability for the management of OOA cases, unless otherwise contractually defined. Refer to the Division of Financial Responsibility (DOFR) section of your participation agreement to determine financial risk for OOA.

- Services provided outside of the medical group/IPA defined service area that are arranged and/or authorized by the Customer’s medical group/IPA are the medical group/IPA’s responsibility, and are not considered OOA medical services. This includes those out-of-network (OON) services referred by a practitioner affiliated with the delegated medical group/IPA, whether or not that practitioner obtained appropriate authorization. In such cases, it remains the responsibility of the medical group/IPA to perform all delegated medical management activities, including issuing appropriate authorization and denials.

- The delegated medical group/IPA remains responsible to issue appropriate denials for Customer-initiated non-urgent, non-emergent medical services provided outside of the medical group/IPA’s defined service area.

- The medical group/IPA shall notify UnitedHealthcare’s OOA department of all known OOA cases no later than the first business day after receiving Customer notification of an OOA admission, procedure and/or treatment. Failure to notify us within this timeframe may result in UnitedHealthcare holding the medical group/IPA financially responsible for the OOA care and service.

- Once a UnitedHealthcare Customer is deemed stable for transfer, the medical group/IPA must work actively and collaboratively with UnitedHealthcare on the return of the Customer to a network Provider and facility in a timely fashion.

- The medical group/IPA shall facilitate the return of the Customer to network Provider by making sure that the following process occurs in a timely fashion:
  - Medical group/IPA efforts shall include, but are not limited to:
    - The Customer’s PCP or medical group/IPA identified Specialist speaks with the out-of-area attending physician to determine the Customer’s stability for transport.
    - The Customer’s PCP, or medical group/IPA identified Specialist, determines the appropriate mode of transportation.
    - The Customer’s PCP or medical group/IPA identified Specialist determines the appropriate level of care or facility for the Customer’s care.
  - The medical group/IPA must arrange for a bed at the accepting network facility. If the medical group/IPA delays the transfer of a Customer considered medically stable for transfer, UnitedHealthcare may hold the medical group/IPA financially responsible for any additional out-of-area charges incurred as a result of the delay.
  - If an accident or illness occurs within the medical group/IPA contracted service area, and the Customer is transported by emergency personnel to a facility outside the contracted service area for treatment, the services are not considered out-of-area and must be handled by the medical group/IPA in the same manner as in-area services. The medical group/IPA must authorize and direct the Customer’s care in the same manner as if the Customer were receiving services at the affiliated hospital or Provider facility.
  - Travel dialysis is not considered an out-of-area medical service unless otherwise contractually defined; it is the responsibility of the medical group/IPA.

Trauma Services

Trauma services are defined as covered services that are medically necessary services rendered at a state-licensed, designated trauma hospital or a hospital designated to receive trauma cases. Trauma services must meet identified county or state trauma criteria.

The medical group/IPA shall review and authorize care and trauma services using the applicable provision review criteria.
UnitedHealthcare may retrospectively review trauma service claims and medical records in order to verify that the services met trauma criteria and that trauma services were delivered. UnitedHealthcare may also confirm that the trauma facility has an active trauma license. Contracts for trauma services may vary and definitions and reimbursement methods specified therein will apply.

The following provision criteria shall be considered when authorizing trauma services:

- Trauma team activated.
- Trauma surgeon is the primary treating physician.
- Customer’s clinical status meets the county’s current EMS protocols for designating a trauma patient.
- Trauma services, once rendered, shall apply to the first 48 hours post-hospital admission, unless there is documented evidence of medical necessity indicating that trauma level services are continuing to be delivered.
- Trauma service status shall no longer apply when, based on medical necessity, the Customer is determined to be hemodynamically stable and/or medically appropriate for transfer out of the critical care arena.
- Clinical management of a Customer by the trauma team shall not be the sole criteria used to determine and authorize continued trauma services care.

**Transplant Services/Case Management**

For medical groups/IPAs that have risk for transplant services, we request that you notify the case management department when a Customer is referred for evaluation, authorized for transplant and admitted for transplant and/or may meet criteria for service denial.

For medical groups/IPAs that do not have risk for transplant services Customers must be referred into the UHC transplant case management program if they are identified as:

- Requiring evaluation for a bone marrow/stem cell or solid organ transplant
- Undergoing transplant evaluation
- Receiving a transplant
- Being within the first year post-transplant
  The transplant case manager works in conjunction with the Customer’s transplant team, PCP, and other clinicians to complete an assessment of the Customer’s healthcare needs, develop, implement and monitor a care plan, coordinate services and re-evaluate the care plan for the Customer.
- Participating physicians and health care providers must obtain prior authorization for transplant evaluations and transplant surgery, regardless of financial risk.
- Transplant evaluations and surgery must be performed at one of OptumHealth’s Centers of Excellence, or facility approved by UnitedHealthcare/OptumHealth’s Medical Directors.
- We shall be responsible for the authorization and management for all transplant-related care and services from the evaluation through 1-year post-transplant, unless otherwise dictated by the Customer’s benefit.
- We shall be responsible for the authorization and management of donor care and services directly related to transplant services from date of initiation of the stem cell/bone marrow collection, or 24 hours prior to solid organ donation surgery, until 60 calendar days post-transplant date, unless otherwise dictated by the Customer’s benefit.
- We shall be responsible for authorization and reimbursement of all travel expenses as covered under the Customer’s benefit plan.
- Authorization and management of all non-transplant-related, medically necessary, covered services (including services needed to treat the Customer’s underlying disease and maintain the Customer until transplant can be completed) for the Customer and donor remain the financial responsibility, of the delegated medical group/IPA, as described in the DOFR.
- Medical group/IPA is required to comply with our transplant protocols, policies and procedures. We may, at our sole discretion, modify these protocols, policies and procedures from time to time.
Referrals may be made to OptumHealth as follows:

- Phone Referrals: (866) 300-7736 or
- Fax Referrals: (888) 361-0502

**Prior Authorization Requirements for Elective and Urgent Services**

A minimum notification of 3 business days is required for elective services to complete a thorough clinical analysis prior to a Customer’s proposed elective procedure date. Procedures are not considered scheduled, and should not be communicated to the Customer as being scheduled, until they have been authorized. An authorization or notification number with the approved date range will be returned by fax to your office within appropriate regulatory guideline requirements.

For services that are considered to be urgent and are scheduled to be provided within 2 calendar days, Medical Management will reply by fax within appropriate regulatory guideline requirements, but not to exceed 3 calendar days/72 hours. Please be sure to identify urgent care services, so appropriate priority status can be identified.

**Authorization of Acute Inpatient Rehabilitation Facilities (AIR) or Long Term Acute Care Facilities (LTAC) for shared risk groups**, the medical group/IPAs are strongly encouraged to consult with a plan medical director prior to authorizing a Customer transfer to Acute Inpatient Rehabilitation (AIR) and/or Long Term Acute Care (LTAC).

**Prior Authorization Protocol** - For any service which requires a Prior Authorization, the admitting Provider initiates an authorization request by fax at least 3 business days prior to the scheduled date of service. A list of those services can be found at UnitedHealthcareOnline.com.

- The Provider must complete and submit the appropriate Prior Authorization Request Form. Incomplete forms will not be accepted. The Prior Authorization Request Form can be found at UnitedHealthcareOnline.com ➔ Notifications/ Prior Authorizations.

- Medical Management will document the information, respond to the authorization request, and provide a decision within the required regulatory timeframes. If approved, an authorization number will be issued to the Provider. If denied, the reason for denial will be forwarded to the provider and the Customer.

- In the case of a denial, the Provider will be offered the opportunity to speak with UnitedHealthcare’s Medical Director to discuss the case.

- The authorized Provider will deliver care to the Customer. Documentation of the recommended treatment plan should be shared with the Customer’s PCP.

- The Provider will submit a claim with the authorization number in the usual manner to the appropriate address.

**Medical Management Denials/Adverse Determinations**

A denial/adverse determination may be issued when there is no apparent medical necessity for a health care service, a non-covered benefit is requested, or when no information or insufficient information is provided. If you disagree with a Medical Management decision to deny requested health care services, you may request an appeal as outlined in this section. Our reviewers are available to discuss denial cases with the treating or attending practitioner. Reviewers may be a physician, pharmacist, chiropractor, dentist or other licensed practitioner type, as appropriate to the case.

**Denials, Delays or Modifications**

Decisions to approve, modify or deny requests for authorization of health care services, or to delay delivery of services, based on medical necessity or benefit coverage, must be made and communicated in a timely manner appropriate for the nature of the Customer’s medical condition, and in accordance with the applicable federal law.

All authorization decisions must be based on sound clinical evidence including, but not limited to, review of medical records, consultation with the treating practitioners, and review of nationally recognized criteria. The criteria for determining medical appropriateness must be clearly documented and include procedures for applying criteria based on the needs of individual patients and characteristics of the local delivery system.

All information to support decision-making shall be consistently gathered and documented. Disclosure of such criteria will be made in accordance with applicable state and federal law.
Referral requests not meeting the criteria for immediate authorization must be reviewed by the Medical Director or the Utilization Management Committee (UMC)-designated physician or presented to the collective UMC or subcommittee for discussion and a determination.

Only a physician (or pharmacist, psychiatrist, doctoral level clinical psychologist or certified addiction medicine Specialist, as appropriate) may determine to delay, modify or deny services to a Customer for reasons of medical necessity. Board-certified licensed physicians from appropriate specialty areas must be utilized to assist in making determinations of medical necessity, as appropriate:

- Physicians will not review their own referral requests.
- Referral requests being considered for denial will be reviewed by physicians qualified to make an appropriate determination.
- Any referral request where the medical necessity or the proposed treatment plan is not clear will be clarified and discussed with the requesting physician. Complex cases may be brought to the UMC/Medical Director for further discussion and decision.
- Individual(s) who meet the qualifications of holding financial ownership interest in the organization may not influence the clinical decision making regarding payment or denial of a service.

Possible request for authorization determinations include:

- Approved as requested – No changes.
- Approved as modified – Referral approved, but the requested Provider or treatment plan was modified. Denial letter must be sent if requested Provider is changed or specific treatment modality is changed (e.g., requested chiropractic, approved physical therapy).
- Extension – Delay of decision regarding a specific service (e.g., need additional documentation or information or requires consultation by an expert reviewer).
- Delay in Delivery – Access to an approved service must be postponed for a specified period of time or until a specified date. This is not the same as a modification. A written notification in the denial letter format is required.
- Denied – Non-authorization of a request for health care services. Reasons for denials of requests for services include, but are not limited to, the following:
  - Not a covered benefit – the requested service(s) is a direct exclusion of benefits under the Customer’s benefit plan - specific benefit exclusion must be noted.
  - Not medically necessary or benefit coverage limitation – specify criteria or guidelines used in making the determination as it relates to the Customer’s health condition.
  - Customer not eligible at the time of service.
  - Benefit exhausted - include specific information as to what benefit was exhausted and when it was exhausted.
  - Not a participating Provider – a participating provider/service is available within the medical group/IPA network.
  - Experimental or investigational procedure/treatment.
  - Self referred/no prior authorization (for non-emergent post-service).
  - Services can be provided by the PCP.

UnitedHealthcare has aligned its “Professional Reimbursement Policy on Wrong Surgery” or “Other Invasive Procedure Events” to be consistent with CMS. UnitedHealthcare will not reimburse for a surgical or other invasive procedure when the physician erroneously performs:

- A different procedure all together,
- The correct procedure, but on the wrong body part, or
- The correct procedure, but on the wrong patient.

UnitedHealthcare also will not provide reimbursement for facilities or Provider services related to these wrong surgical or other invasive procedures.
Written Denial Notice
The written denial notice serves many purposes and is an important component in the Customer’s chart and the medical group/IPA records. The denial letter serves to document Customer and practitioner notification of:

- The denial, delay, partial approval or modification of requested services.
- The basis of denial, delay, partial approval or modification, including medical necessity, benefits limitation or benefit exclusion.
- The appeal rights.
- An alternative treatment plan, if applicable.
- Benefit exhaustion or planned discharge date.

Note: CMS requires the use of the standard Integrated Denial Notice (IDN) known as the Notice of Denial of Medical Coverage Coverage/Payment (NDMCP) for Medicare Advantage plan Customers. Medicare Marketing Guidelines require that templates have appropriate, plan-specific Medicare Marketing ID numbers and CMS approval (OMB) numbers and revision dates.

Minimum Content of Written or Electronic Notification
Written or electronic notice to deny, delay in delivery, or modify a request for authorization for health care services shall include the following:

- The specific service(s) denied, delayed in delivery, modified or partially approved
- The specific reference to the benefit plan provisions to support the decision
- The reason the service is being denied, delayed in delivery, modified, or partially approved including:
  - Clear and concise explanation of the reasons for the decision, in sufficient detail, using an easily understandable summary of the criteria, so that all parties can understand the rationale behind the decision,
  - Description of the criteria or guidelines used, reference to the benefit provision, protocol or other similar criterion on which the denial decision is based, and
  - How those criteria were applied to the Customer’s condition.
- Notification that the Customer’s physician can request a peer to peer review
- Clinical reasons for decisions regarding medical necessity
- Contractual rationale for benefit denials
- Alternative treatment options offered, if applicable (not applicable for retrospective review)
- A description of any additional material or information necessary for the Customer to “perfect” the request, and why that information is necessary
- If the request is for an experimental or investigational treatment, an explanation of the scientific or clinical judgment for making the determination
- Appeal and grievance processes, including:
  - Information regarding the Customer’s right to appoint a representative to file an appeal on the Customer’s behalf.
  - Customer’s right to submit written comments, documents or other additional relevant information
  - Information notifying the Customer and their treating practitioner of the right to an expedited appeal for the time-sensitive situations (not applicable for retrospective review).
  - Information regarding the Customer’s right to file a grievance or appeal with the applicable state agency including information regarding the independent medical review process (IMR), as applicable.
- Envelopes containing organization determination letters should state “Important Plan Information” in a minimum of 12-point font.
- The requesting Provider should include the name and direct phone number of the health care professional responsible for the decision.
Facility Denial Process
When the medical group/IPA is delegated for authorization and concurrent review, UnitedHealthcare expects the medical group/IPA to issue a facility denial letter to the contracted hospital when the hospital medical record and/or claim fails to support the level of care and/or services rendered. This may be determined through concurrent or retrospective review.

There are 3 types of facility denial letters:

- Delay in inpatient services
- Delay in change of level of care within the same facility
- Delay in hospital discharge

The delegated medical group/IPA must comply with UnitedHealthcare’s protocols, policies and procedures for denials, including turn-around times for issuing, delivering and submitting facility denial letters to UnitedHealthcare. Facility denials are not sent to the Customer and specifically exclude the Customer from liability for the denied level of care and/or services.

Experimental/Investigational Services Denials
UnitedHealthcare provides the opportunity for an independent, external review whenever an authorization for any drug, device, procedure, or other therapy deemed experimental or investigational is denied to a Customer who has either a life-threatening or seriously debilitating disease or condition, as defined below.

- Life threatening is defined as:
  - Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or
  - Diseases or conditions with potentially fatal outcomes, where the end-point of clinical intervention is survival.
- Seriously debilitating is defined as diseases or conditions that cause major irreversible morbidity.

- Experimental or investigational therapies are any drug, device, treatment, or procedure that meets one or more of the following criteria:
  - It cannot be lawfully marketed without approval of the United States Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
  - It is the subject of a current investigational new-drug or new-device application on file with the FDA.
  - It is being provided pursuant to Phase I or Phase II clinical trial or as the experimental or research arm of Phase III clinical trial, as the Phases are defined by regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services (HHS).
  - It is being provided pursuant to written protocol that describes among its objectives determinations of safety and/or efficacy as compared with standard means of treatment.
  - It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations and other official actions and publications issued by the FDA and HHS.
  - The predominant opinion among experts as expressed in the published authoritative literature is that the usage should be substantially confined to research settings.
  - The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives; or
  - It is not investigational or experimental in itself, as defined above, and would not be medically necessary, except for the provision of a drug, device, treatment, or procedure that is investigational or experimental.

UnitedHealthcare does not delegate utilization management activities related to requests for authorization of experimental/investigational therapies. The delegated medical group/IPA must not issue a denial for experimental/investigational therapies/service(s) requests.

The medical group/IPA must forward the request and all relevant case documentation to UnitedHealthcare for review and determination. We will issue a determination letter to the Customer and the requesting provider. The experimental/
investigational denial notice requires disclosure of additional rights and information regarding the independent external review process, which includes:

- An Independent Medical Review (IMR) packet
- Physician certification form

The practitioner denial notice also includes the experimental/investigational information packet. If a UnitedHealthcare Medical Director determines the Customer’s condition does not meet the experimental/investigational criteria, we shall notify the delegated medical group/IPA. The delegated medical group/IPA shall then make a coverage determination in accordance with established utilization management procedures.

**Cancer Clinical Trials**

The Customer’s treating participating practitioner must recommend participation in a cancer clinical trial after determining that participation in the clinical trial has a meaningful potential to benefit the Customer. UnitedHealthcare does not delegate utilization management activities related to requests for authorization of cancer clinical trials, and as such, the delegated medical group/IPA must forward referral requests for cancer clinical trials and all relevant case documentation to UnitedHealthcare for review and determination.

We will issue a written determination notice to the Customer and the requesting provider.

Clinical trials are not a benefit of UnitedHealthcare Medicare Advantage plans and may not be approved by UnitedHealthcare or its delegated IPA/medical group. Providers should bill Medicare, as Medicare will directly pay providers for Medicare qualified clinical trial services furnished to a UnitedHealthcare Medicare Advantage Customer. Customers may be directed to (800) MEDICARE for additional information on clinical trials.

**Delegated Medical Management**

UnitedHealthcare may delegate medical management to a medical group/IPA that demonstrates compliance with UnitedHealthcare’s established standards for the medical management function. This function may also be referred to as utilization management. Physicians associated with these delegated IPA/medical groups must use the medical group/IPA’s medical management office and protocols for all authorizations for which the medical group/IPA is delegated.

A delegated medical group/IPA may have processes and forms that differ somewhat from those outlined in this section. Please contact your Physician Advocate, as applicable, if you have questions concerning medical management delegation.

If a medical group/IPA is delegated for medical management, it may also be delegated for case management and/or disease management, as documented in its participation agreement with UnitedHealthcare. In such cases, the delegated medical group/IPA (“delegate”) is also held responsible for meeting the NCQA standards for complex case management, unless the contract states otherwise.

We will perform an initial audit to measure compliance of the medical group/IPA with our standards for delegation of medical management. At least annually thereafter, UnitedHealthcare will audit the medical group/IPA to make sure of continued compliance. We may initiate a focused audit based on specific activity at the medical group/IPA that warrants such an audit. The medical group/IPA is required to provide specific documents/evidence to the auditor as applicable.

Based on the compliance audit findings, UnitedHealthcare may require the delegate to develop and implement a corrective action plan designed to bring the Provider back into compliance. Delegates who do not achieve compliance within the established timeframes may be sanctioned until such time as they achieve compliance.

Medical management is a delegated function that is subject to revocation. Sanctions may consist of delegation with a corrective action plan or revocation. There are costs to the delegate should the function be revoked.

**Semi-Annual Reporting**

The delegate will provide UnitedHealthcare with reports a minimum of semi-annually and as outlined in the delegation agreement. Reporting should include an analysis/explanation of any variances or trends.
Mid-Atlantic Regional Supplement

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

Important information regarding the use of this Supplement
This Mid-Atlantic Regional Supplement ("Supplement") applies to services provided to Customers enrolled in MD-Individual Practice Association, Inc. ("M.D. IPA") or Optimum Choice, Inc. ("Optimum Choice"). In the event of any inconsistency between the UnitedHealthcare Guide found on UnitedHealthcareOnline.com – regarding payments policies and protocols and this Mid-Atlantic Regional Supplement, this Supplement will prevail for the products described in this section.

A complete list of Mid-Atlantic Healthplan Protocols pertaining to M.D. IPA, M.D. IPA Preferred, Optimum Choice, and Optimum Choice Preferred can be located on UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Healthplan Protocols.

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

<table>
<thead>
<tr>
<th>Attributes</th>
<th>M.D. IPA and Optimum Choice</th>
<th>M.D. IPA Preferred and Optimum Choice Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do Customer’s access physician and health care professionals?</td>
<td>Customers choose a PCP who arranges or coordinates their care, except emergency services, network OB/GYN and routine eye refraction care.</td>
<td>Network benefits: Customers choose a PCP who arranges or coordinates their care, except emergency services, network OB/GYN and routine eye refraction care, Products may also referred to as Gated HMO. Out-of-network benefits: Customers are not required to have their care be arranged or coordinated by a PCP.</td>
</tr>
<tr>
<td>Does a PCP have to write a referral to a Specialist?</td>
<td>Yes; except for visits to a network OB/GYN routine eye refraction care, or for emergency services.</td>
<td>Network benefits: Yes, except for visits to a network OB/GYN, routine eye refraction care, or for emergency services. Out-of-network benefits: No referral needed.</td>
</tr>
<tr>
<td>Is the treating physician required to obtain prior authorization for procedures or services?</td>
<td>Yes; please view section on Prior Authorization process located within this Supplement A complete list of codes requiring Prior Authorization can be located on UnitedHealthcareOnline.com → Tools and Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Protocols → Preauthorization Code List.</td>
<td>Yes; please view section on Prior Authorization process located within this supplement A complete list of codes requiring Prior Authorization can be located on UnitedHealthcareOnline.com → Tools and Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Protocols → Preauthorization Code List.</td>
</tr>
</tbody>
</table>

On January 1, 2014, UnitedHealthcare introduced Optimum Choice Small Business Health Options Program (SHOP) Exchange for Maryland and District of Columbia. The Health Insurance Marketplaces, also known as Exchanges, are intended to help small groups research, compare and enroll in quality health plans from health insurers. Products offered on and of the Exchange will follow the same policies and protocols as outlined within the Mid-Atlantic Regional Supplement, except as otherwise required by your agreement. Your agreement with us determines if you are participating in these products. If a Customer presents a health care ID card with a product name with which you are not familiar, please contact Customer Care at the number at (877) 842-3210. This product list is provided for your convenience and is subject to change from time to time.

Key Points | Optimum Choice Small Business Health Options Program (SHOP) Exchange
---|---
Product Name | Optimum Choice, Inc.
How do Customers access physicians and health care professionals? | For each covered family member, Customers choose a network primary care physician, or are assigned a PCP, to manage the Customer’s care and generate referrals to network Specialists when required.
Is a special referral required? | Yes, on selected procedures, see guidelines in the referral requirements section of Mid-Atlantic Supplement Guide.
Are treating physicians and/or facilities required to give Prior Authorization when providing certain services? | on selected procedures, see guidelines in the Prior Authorization List located on UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Healthplan Protocols → Prior Authorization Code List.
**UnitedHealthcare Optimum Choice HSA Plan**

UnitedHealthcare has added Health Savings Account (HSA) benefit plans to Optimum Choice, Inc. in the Mid-Atlantic region. These plans expand our product portfolio in your market and support our commitment to provide quality affordable health care options for our Customers.

The Optimum Choice and Optimum Choice Preferred HSA plans are high-deductible medical plans that combine our traditional gated HMO plans with a Health Savings Account (HSA) option. All expenses under this plan are the Customer’s responsibility until their deductible is reached. HSA plans require that reimbursement for services rendered to Customers is based on a fee-for-service reimbursement methodology.

<table>
<thead>
<tr>
<th>Key Points</th>
<th>Optimum Choice, Inc. Health Savings Account</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Requirement</td>
<td>The Optimum Choice HSA product requires each UnitedHealthcare Customer to choose a primary care physician.</td>
</tr>
<tr>
<td>PCP Referrals to Network Specialists</td>
<td>The Customer’s PCP generates referrals for specialty care and hospital care.</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>Services for Customers enrolled in Optimum Choice HSA will be excluded from your capitation payment and will be paid on a fee-for-service (FFS) basis per the All Payer Payment Appendix included in the UnitedHealthcare physician agreement.</td>
</tr>
<tr>
<td>OCI HSA Customer Health Care ID Card</td>
<td>The Optimum Choice HSA product name and Customer’s PCP are indicated on the Customer’s health care ID card. References to Specialist referral requirements are on the back of the health care ID card. When confirming eligibility, please use the Eligibility and Benefits Center application on Link or UnitedHealthcareOnline.com.</td>
</tr>
</tbody>
</table>

**Health care ID cards**

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

1. Laboratory Provider information is located on the front of the cards; please see the Laboratory Services section of this Supplement.
2. Radiology county information is located on the front of the cards; please see the Radiology Services section of this Supplement.
3. Information regarding the necessity of referral and prior authorization requirements is now listed on the back of the cards.

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

For more detailed information on ID cards and to see a sample health care ID card, please refer to the Health care identification (ID) cards section of this guide.

M.D. IPA and Optimum Choice Customers must use the outpatient commercial medical laboratory noted on their health care ID card for outpatient commercial medical laboratory services. Any specimens collected in the office, MUST be sent to the laboratory indicated on the Customer’s health care ID card. Depending on where the Customer lives, the health care ID will note:

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

Please refer to UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Healthplan Protocols → Laboratory Services.

**Radiology Services**

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

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

1. Customers with M.D. IPA and Optimum Choice benefits must obtain a referral from their PCP for most specialty services.

2. Customers do not need a referral for routine eye refraction exams, OB/GYN visits and emergency/urgent care services.

3. Customers with M.D. IPA Preferred or Optimum Choice Preferred benefits do not need a referral when using their Point of Service (non-preferred) of benefits.

4. The referral must be:
   › Issued (electronic or paper) referrals to a network physician or health care professional; and
   › Signed and dated by the PCP (Note: electronic referrals do not require signatures).

5. The referral is valid only:
   › When it is signed and dated on or prior to the service date (paper referrals).
   › When it is created and submitted on or prior to the service date (electronic referrals).
   › For 4 visits except for those services listed below. If the PCP does not indicate number of visits, the referral is valid for 1 visit only; for a maximum of 6 months from the date it is signed or electronically filed.

6. Retroactive referrals are not valid.

7. Either the Customer may present the referral form or the electronic referral number to the Specialist at the time of the visit, or the PCP’s office can mail or fax the written paper referral.

8. Exceptions to the Referral Rules: There are exceptions to the general referral rules. Some services require Prior Authorization before the PCP may issue the referral. Some referrals are for more than 4 visits. These exceptions are as follows:
   › **Allergy Consultation and Shots**: Referrals to a Specialist for an initial allergy consultation cover the initial office visit, skin testing, any allergy antigen, and one follow-up visit within 30 days. A second referral marked “Allergy Shots” may be issued which is valid for 6 months from the date of the referral for any number of visits.
   › **Behavioral Health**: A referral must be written for the first visit to a behavioral health provider. Authorizations are required after the first visit.
   › **Chemotherapy**: A referral is valid for any number of chemotherapy visits up to 6 months from the date of the referral.
   › **Chiropractic Care**: Some benefit plans provide coverage for chiropractic services while others do not. Therefore, it is important to verify Chiropractic services in the Eligibility and Benefits Center application on Link or by phone prior to writing or creating a referral.
   › **Dialysis**: A referral is valid for any number of dialysis visits up to 6 months from the date of the referral. Dialysis facilities require prior authorization. For information on prior authorization requirements, go to: UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Protocols for the Mid-Atlantic Healthplan Protocols → Preauthorization Code list.
› **Fracture Care:** A referral for fracture care is global and is valid for 6 months from the date of the referral.

› **Laboratory Services:** No referral is required. Either the PCP or the Specialist may order services utilizing a commercial laboratory requisition. For information regarding which outpatient commercial medical laboratory to use, please refer to the Customer’s health care ID card. For additional information on the Laboratory protocol, go to: UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Protocols for the Mid-Atlantic Healthplan Protocols → Laboratory Services.

› **Routine Obstetrical and Gynecological Care:** Referrals are not necessary.

› **Routine Eye Refraction Exam:** Referrals are not required for a routine vision refraction exam when performed by a participating optometrist or ophthalmologist. Please refer to the protocol on UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Healthplan Protocols → Ophthalmology & Optometry.

› **Physical Therapy, Occupational Therapy and Speech Therapy:** The initial referral for physical or occupational therapy is valid for up to 8 visits per condition within 6 months from the referral date. If the referral does not indicate the number of visits, the referral will only be valid for 1 visit. Additional visits after the first 8 require pre-authorization. For facilities, an authorization must be obtained for these services prior to the first visit.

› **Post-Operative Care:** Referrals are not required for services related to a surgical procedure during the postoperative period included in the Global Fee if performed by the same physician practice. The PCP must write a new referral if the Customer needs to be seen by the same physician for a new issue or for a new physician for services related to the surgical procedure.

› **Psychiatric Medication Management:** A referral must be written for the first visit to a behavioral health provider. Authorizations are required after the first visit.

› **PUBA, PUVA and PAUB:** Referrals for these services are valid for any number of visits up to 6 months from the date of the referral.

› **Radiology Services:** A referral is not needed for routine radiology services. Either the PCP or Specialist can order these services on a prescription or requisition form. If the PCP is referring a Customer to a Specialist for non-routine radiology services (e.g., a carotid ultrasound performed by a cardiologist who is a Participating Physician) a referral is needed. For additional information on the Radiology protocol, go to: UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Healthplan Protocols → Radiology Services.

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**Prior Authorization requirements-Mid-Atlantic Region**

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

**How to submit requests for Prior Authorizations**

Multiple submission options are available to submit requests for Prior Authorizations to UnitedHealthcare, including electronic methods. To avoid duplication, once a Prior Authorization is submitted and confirmation is received, please do not resubmit.

1. **Online:** UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Notification/Prior Authorization Submission.

2. **Phone:** Toll-free (877) 842-3210. The Clinical Services staff is available during the business hours of 8:00 a.m. to 8:00 p.m. EST.

3. **Fax:** You may fax your requests for Prior Authorization by using the Universal Prior Authorization Request Form located at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Healthplan Protocols → Universal Prior Authorization Request Form to:
General Outpatient (866) 255-0959
Infertility (866) 369-4119
Durable Medical Equipment (866) 362-6101
Homecare (877) 269-1045
Radiology (866) 589-4848
Transplant (866) 537-9371
Inpatient Prior Authorization (866) 892-4582

Note: Prior Authorization requests cannot be submitted through online for physical, occupational, speech, and any other therapy-related service. Please reference the Physical, Occupational, and Speech Therapy section that follows for additional information.

Rehabilitation (Physical, Occupational, and Speech Therapy) Prior Authorization Request
You may fax your requests for prior authorization to the Clinical Care Coordination Department at (888) 831-5080 by using the Rehab Extension Form located at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Healthplan Protocols → Rehab Extension Form.

Chiropractic Services Prior Authorization Request
You may fax your requests for prior authorization to the Clinical Care Coordination Department at (888) 831-5080 by using the Chiropractic Services Extension Form located at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Healthplan Protocols → Chiro Extension Form along with a copy of the current Consultant Treatment Plan (PCP Referral).

Please allow two business days for extension request decisions. Missing information may result in a delayed response. Decisions are based on the Customer's plan benefits, progress with the current treatment program, and documented need.

Exception Requests
All exceptions to the health plan's policies and procedures must be preauthorized. The most common, but not comprehensive lists of exception requests are:

- Immunizations (outside the scope of health plan guidelines).
- Referral of an HMO Customer out-of-network to a non-participating physician, health care practitioner or facility.

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

Inpatient Admission Notification
It is the responsibility of the facility to notify UnitedHealthcare within 24 hours after actual weekday admission (or by 5:00 p.m. local time on the next business day if 24 hour notification would require notification on a weekend or federal holiday). For weekend and federal holiday admissions, notification must be received by 5:00 p.m. local time on the next business day.

For emergency admissions when a Customer is unstable and not capable of providing coverage information, the facility, should notify UnitedHealthcare as soon as the information is known and communicate the extenuating circumstances.

Prior Authorization is required for all elective inpatient admissions for all M.D. IPA and Optimum Choice Customers; it is the admitting physician's responsibility to obtain the relevant Prior Authorization. However, the facility should verify that Prior Authorization has been obtained prior to the Admission. Payment may be denied to the facility and attending physician for services rendered in the absence of Prior Authorization. Please remember Prior Authorization does not guarantee coverage or payment. All final decisions concerning coverage and payment are based upon Customer eligibility, benefits and applicable state law.
State-Specific Variations from the Standard Notification Requirements for Maryland Facilities:
If Prior Authorization is required for the requested elective inpatient procedure, it is the physician’s responsibility to obtain the relevant approval. It is the responsibility of the facility to notify UnitedHealthcare within 24 hours (or the following business day if the admission occurs on a weekend or holiday) of the elective admission. If the physician has obtained Prior Authorization, the initial day of the inpatient admission will be paid unless:

1. The information submitted to UnitedHealthcare regarding the service to be delivered to the Customer was fraudulent or intentionally misrepresented;
2. Critical information requested by UnitedHealthcare regarding the service to be delivered to the Customer was omitted such that UnitedHealthcare’s determination would have been different had it known the critical information;
3. A planned course of treatment for the patient that was approved by UnitedHealthcare was not substantially followed by the provider; or
4. On the date the service was authorized the Customer was not covered by UnitedHealthcare and the Provider could have verified the Customer eligibility status by using the Eligibility and Benefits Center application on Link, UnitedHealthcareOnline.com or by calling UnitedHealthcare’s Enterprise Voice Portal at (877) 842-3210.

Note: The online verification must indicate that the Customer is not covered by UnitedHealthcare.

Provide Admission Notification to Health Services via phone at (800) 962-2174 or via fax at (800) 352-0049.
All participating facilities are required to notify the applicable health plan of an admission of a Customer within 24 hours or the next business day following a weekend or federal holiday, whichever comes first. The health plan will initiate a case review upon receipt of your notification. If notification is not provided in a timely manner, the health plan may still review the case and request additional medical information. If you fail to notify in a timely manner, the health plan may retroactively deny 1 or more days based upon its case review. In the event a Customer receiving outpatient services needs an inpatient admission, the facility must notify the health plan as noted above. Emergency room services that culminate in a covered admission will be payable as part of the inpatient stay provided the facility has notified the health plan of the admission as noted above.

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

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

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

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

When a Customer has been discharged before notification to the health plan can occur or before information is available for certification of all the days, a post-discharge review will be conducted. A health plan representative will request the Customer’s records from the Medical Records Department or via a telephonic review and review each non-certified day for appropriateness and acuity.

Inpatient Days that do not meet acuity criteria will be referred to a medical director for determination and may be retrospectively denied. Delays in service or days that do not meet criteria for level of care may be denied for payment.

**Hospital-to-hospital transfers**

The hospital must notify the health plan of a request for hospital-to-hospital transfer. In general, transfers are approved when there is a service available at the receiving hospital that is not available at the sending hospital; the Customer would receive a medically appropriate change in the level of care at the receiving facility; or the receiving facility is a network facility and has appropriate services for the Customer.

If any of the conditions above are not met, coverage for the transfer will be denied. Services at the receiving hospital will be approved if:

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

**Injectable medications**

**Drugs that require both Prior Authorization and the use of a specific vendor:** This protocol applies to the acquisition, including prescription ordering and purchase of these specialty medications by physicians and other healthcare professionals. You must acquire these specialty medications from a participating specialty pharmacy Provider in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare. The specialty pharmacy will bill UnitedHealthcare for the medication. Physicians will only need to bill UnitedHealthcare for the appropriate code for administration of the medication and should not bill us for the medication itself. The specialty pharmacy will advise the Customer of any medication cost share responsibility and arrange for the collection of any amount prior to dispensing of the medication to the physician office. For a listing of specialty pharmacy provider(s), please refer to:

- For a listing of specialty drug codes that also require procurement through a designated specialty pharmacy, please refer to UnitedHealthcareOnline.com → Tools & Resources → Pharmacy Resources → Specialty Pharmacy Program.

**Note:** Medications may require inclusion of a specific diagnosis for payment. For current listings, go to UnitedHealthcareOnline.com or call contact numbers below.

- Information on our medical evidence-based policies is available at: UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Policies → Medical & Drug Policies and Coverage Determination Guidelines - Commercial. For additional policies and information, call (800) 355-8530.

Requests for preauthorization must be faxed to (800) 787-5355. Include clinical notes and name of specialty pharmacy vendor. For questions on required information or the Prior Authorization process, call (800) 355-8530. UnitedHealthcare will call provider’s office within 3 days if conditions are not met for Prior Authorization of the drug. If authorized, Pharmacy Services will provide a written authorization number and coverage dates.

This authorization must be submitted to the specialty pharmacy vendor along with the medication order.

Specialty pharmaceutical vendor information is available at: UnitedHealthcareOnline.com → Tools & Resources → Pharmacy Resources.

**Claims process**

Please refer to the Prompt claims processing section in the main section of this Guide for detailed information about our claims process. All referrals should be submitted through UnitedHealthcareOnline.com so the associated claims can be submitted electronically. If the referral is issued on paper then the claim must be submitted on paper with a copy of the referral. Please refer to the Referral Process Policy, which can be found on UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Healthplan Protocols → Referral Process.
All claims that can be submitted electronically must be submitted electronically to Payer ID 87726. For claim reconsiderations for M.D. IPA and Optimum Choice, please submit your request on Link.

Reconsideration and appeals processes

Claim Denial Reconsideration Request Process

Step 1: Claim Reconsideration
You must submit your Claim Reconsideration within 12 months from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). If you believe we underpaid you, the first step in addressing your concern is to submit a Claim Reconsideration. The quickest way to submit a Claim Reconsideration request is online.

- **Online**: Online (preferred method) via the Claim Reconsideration application on Link
  
  **Note**: If you have a request involving 20 or more paid or denied claims, aggregate these claims online. Go to UnitedHealthcareOnline.com → Claims & Payments → Claim Reconsideration Quick Reference.

- **Paper**: Please send your request for reconsideration to the address on the back of the Customer’s health care ID card or follow the instructions on the Provider Remittance Advice (PRA) or on the correspondence received from UnitedHealthcare. Instructions are also available on UnitedHealthcareOnline.com → Claims & Payments → Claim Reconsideration Request Form. You may use the form that is found on UnitedHealthcareOnline.com → Tools & Resources → Forms → Paper Claim Reconsideration Form. The form should be mailed to the address located on the back of the Customer ID card.

If you are submitting a request for a claim which was denied requesting medical documentation:

- **Online**: use the Claims Reconsideration application on Link.

- **Paper**:
  
  - Complete the Claim Reconsideration Request Form and check “Previously denied/closed for Additional Information” as your reason for request.
  
  - Provide a description of the documentation being submitted along with all pertinent documentation.
    
    It is extremely important to include the Customer name and health care ID number as well as the Provider name, address, and TIN on the Claim Reconsideration form to prevent processing delays.

- **Phone**: You can call (877) 842-3210 to request an adjustment for a claim that does not require written documentation.

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

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

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

All proof of timely filing requests must also include documentation that the claim is for the correct patient and the correct date of service.

Step 2: Claim appeal
If you do not agree with the outcome of the Claim Reconsideration decision in Step 1, you may submit a formal appeal request to:

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

You must submit your appeal to us within 12 months (or as required by law or your participation agreement), from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). Attach all supporting materials such as Customer-specific treatment plans or clinical records to the formal appeal request, based on the reason for the request. Include information which supplements your prior adjustment submission that you wish to have included in the appeal review.
Our decision will be rendered based on the materials available at the time of formal appeal review. If you are appealing a claim that was denied because filing was not timely:

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

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

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

If you disagree with the outcome of any claim appeal, or for any other dispute other than claim appeals, you may pursue dispute resolution as described in the Resolving disputes - concern or complaint section, and in your agreement with us. In the event that a Customer has authorized you to appeal a clinical or coverage determination on the Customer’s behalf, such an appeal will follow the process governing Customer appeals as outlined in the Customer’s benefit contract or handbook.

**Clinical appeals**

To appeal an adverse decision (a decision by us not to prior authorize a service or procedure or a denial of payment because the service was not medically necessary or appropriate), you must submit a formal letter outlining the issues and submit supporting documentation. The denial letter will provide you with the filing deadlines and the address to use to submit the appeal. In the event a Customer designates a health care professional to appeal the decision on the Customer’s behalf a copy of the Customer’s written consent is required and must be submitted with the appeal.

**Direct Access Services**

**Women’s Health Specialists**

Female Customers may receive obstetrical and gynecological (OB/GYN) physician services directly from a participating OB/GYN, family practice physician, or surgeon identified by the medical group/IPA or UnitedHealthcare as providing OB/GYN physician services. This means the Customer may receive these services without prior authorization or a referral from her PCP. In all cases however, the physician must be affiliated with the Customer’s assigned medical group/IPA and participating with UnitedHealthcare.

**PCP**

The PCP is the primary Provider of medical services for Customers. This includes preventive care and chronic care. The PCP is responsible for coordinating all care that Customers may need through the Network Specialists. This includes Referrals to consultant Specialists, Home Health Care, and testing facilities such as Radiology and Laboratory Centers. PCPs are reimbursed for medical services through capitation or fee-for-service payments. Primary Care Physicians are required to submit encounter data for services covered under capitation.

When a Customer enrolls in a M.D. IPA or Optimum Choice benefit plan, he or she is asked to select a PCP. The collective group of Customers who have chosen a specific PCP is referred to as the PCP Panel. United-Healthcare of the Mid-Atlantic region may close any PCP panel if any Customer complains about access, or if United-Healthcare of the Mid-Atlantic region identifies a quality related issue.

**Note:** For all requests relating to panel status (i.e., Open/Closed to New/Existing Patients), the physician is required to contact their Network Account Representative 30 days prior to any action. To locate your Network Account Representative, please go to UnitedHealthcareOnline.com → Contact Us → Network Contacts located near the bottom of the page.

**Discharge of a Customer from physician’s care:** If, after reasonable effort, the physician is unable to establish and maintain a satisfactory relationship with a Customer, the physician may request that the Customer be discharged from
care and transferred to an alternate physician. The physician must notify the Customer Care Center to have the Customer removed from their panel. This number is on the back of the Customer’s health care ID card. Reasons for discharge may include:

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

The PCP must provide adequate documentation in the Customer’s medical record of the verbal and written warnings. The physician is obligated to provide emergency care to the Customer for 30 days from the Customer’s receipt of the dismissal letter. For more information go to: UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Healthplan Protocols → Preferred PCP Selection, Panel Closure and Member Dismissal Protocol.

M.D. IPA and Optimum Choice copayment amounts for PCP services are printed on the Customer’s health care ID card. Eligibility and Copayment amounts may also be determined by using the Eligibility and Benefits Center application on Link or by calling the Enterprise Voice Portal. You may also view and print out the Customer’s current health care ID card online in the Eligibility and Benefits Center application on Link. Copayments are due at the time PCP services are rendered.

Prior to seeing any Customer, it is important that the physician verify that the Customer has selected the physician as the Customer’s PCP. Verification can be done by looking at the assigned physician on the health care ID card, or online using the Eligibility and Benefits Center application on Link.

You may also call Provider Services at (877) 842-3210. If a Customer has selected another physician that is not a part of the physician's practice as the Customer’s PCP, the physician should request the Customer contact the Customer Service number on the Customer’s health care ID card and request a change in PCP. Failure to confirm a Customer is assigned to the physician’s PCP panel could result in denial of payment for services rendered.

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

**Capitation**

Capitation payment will be paid to the practice for covered services on a per member per month (PMPM) basis. The PCP receives separate capitation payments for Customers of M.D. IPA and Optimum Choice monthly on the 5th day of the month.

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

**Payment Rules:**

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

For purposes of capitation payments, Customers are added on the 1st day of the month or terminated on the last day of the month, with the exception of newborns, which are added on the date of their birth(s). Capitation will be paid for full months, and conversely recouped for full months if appropriate. As an example:

**Retroactive Add:**
A Customer added retroactively on the 14th of the month would generate a capitation payment for the entire month. However, a Customer added on the 16th or later would not generate a capitation payment, even though the Customer would be considered eligible for services. To aid the Provider in identifying these Customers, the Customer’s standard services capitation will be reported as $0.

**Retroactive Term:**
A Customer retroactively terminated between the 1st and 14th of the month would generate a capitation recoup entry for the capitation previously paid for the entire month. However, a Customer retroactively terminated on the 16th or later would not generate a capitation recoup entry for the capitation previously paid for the entire month.

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

<table>
<thead>
<tr>
<th>ECap Report Name</th>
<th>ECap Report Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>7030-A01: Capitation Analysis Summary – Provider Medical Group Report</td>
<td>High-level capitation information by current and retro periods for each provider.</td>
</tr>
<tr>
<td>7010-A02: Capitation Paid ECap – Primary Care Provider Report - Detail</td>
<td>A PCP-level report that summarizes the capitation paid by current and retro periods. The 3 sections of the report include amounts for: 1. Standard services; 2. Supplemental benefits and capitated adjustments; 3. Non-capitated adjustments and withholds.</td>
</tr>
<tr>
<td>7210-A01: Capitation Details – Primary Care Provider Report for Standard Services-(PMG)</td>
<td>Detailed capitation information for each current Customer assigned to a PCP.</td>
</tr>
</tbody>
</table>

**Note:** The PCP Practice should reconcile the capitation payment and report upon receipt. Any requests for an adjustment or reconciliation of the capitation payment must be made within 60 days of receipt. If the PCP/Medical Group (Practice) does not request reconsideration of the capitation payment within 60 days, the capitation payment provided will be accepted as payment in full (as per contract). Copies of the reports above can be obtained by calling Provider Services at (877) 842-3210.

**Bill above**
In addition to the capitation payments, certain covered services are eligible for reimbursement. To obtain a copy of this information, please contact your Network Representative. To locate your Network Representative, please go to UnitedHealthcareOnline.com → Contact Us → Network Contacts section.
Important information regarding the use of this Supplement

This Neighborhood Health Partnership ("NHP") Supplement applies to covered services provided to Customers enrolled in NHP benefit plans when those covered services are provided by Participating Providers in either of the following categories:

The Participating Provider’s participation agreement with UnitedHealthcare includes a reference to the NHP protocols or manuals, or they have directly contracted with NHP to participate in networks maintained for NHP Customers;

OR

The Participating Provider is located in the NHP Service Area. The “NHP Service Area” is the following Florida counties: Broward, Flagler, Hernando, Highlands, Hillsborough, Lake, Lee, Martin, Miami Dade, Orange, Osceola, Pasco, Palm Beach, Pinellas, Polk, Sarasota, Seminole, and Volusia.

With respect to NHP Flex Benefit Plans, this Supplement does not apply to Providers located outside the NHP Service Area.

In the event of any inconsistency between the Guide and this NHP Supplement, the NHP Supplement and all protocols and payment policies found on myNHP.com will prevail for NHP Customers, other than NHP Customers covered by an NHP Flex Benefit Plan.

On or about April 1, 2016, we anticipate beginning to migrate members upon their employer renewal date from a legacy NHP system to United’s platform. We will keep you informed via the Network Bulletin, letters, and town hall meetings.
## How to contact us:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Where to go</th>
<th>What you can do there and how</th>
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</thead>
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<tr>
<td>Appeals</td>
<td>Mail: Attn: Appeals Dept. P.O. Box 5210 Kingston, NY 12402-5210 Fax: (801) 994-1106</td>
<td>• Reconsiderations and appeals</td>
</tr>
</tbody>
</table>
| Cardiology:  
Diagnosis Catheterization, Electrophysiology Implants, Echocardiogram and Stress Echocardiogram | Online: carecorenational.com  
Phone: (866) 889-8054 | • Prior Authorization of cardiology services as described in the *Cardiology Notification/Prior Authorization Protocol for Commercial Customers* section of this Guide. |
| Chemotherapy (outpatient) | Phone: (855) 252-1116  
Online: UnitedHealthcareOnline.com ➔ Notifications/ Prior Authorizations ➔ Oncology Authorization Submission & Status. | • Prior Authorization of injectable chemotherapy |
| Chiropractic | Quality Managed Healthcare, Inc.  
Phone: (954) 236-3143  
Fax: (954) 236-3254 | • Obtain information about chiropractic services |
| Claims | Electronic Payer ID: 95123 or 96107  
Address: P.O. Box 5210, Kingston, NY 12402-5210 | • Submit claims and claims attachments |
| Eligibility Verification | Online: myNHP.com  
Phone: (877) 972-8845  
• For the hearing impaired, please call the National Relay Center: (800) 828-1120  
• Customer Service hours: 8 a.m.- 6 p.m. ET  
• IVR/Automated Referral Line Phone: (877) 972-8845  
As members renew beginning 4/1/16, the new Provider Services number will be (877) 842-3210. Please refer to the back of the member ID card to ensure the appropriate Provider services department is contacted. | • Verify Primary Care Physician  
• Verify eligibility and benefits  
• Check claim(s) status  
• Request referrals to Specialist  
• Obtain status of referrals  
• Office visit copay  
• Inpatient copay  
• Prescription drug copay (if applicable) |
| Electronic Data Interchange (EDI) Support | Phone: (866) 509-1593 | • Obtain information on submitting claims electronically |
| Home Health Care, Durable Medical Equipment and Home Infusion Services | Apria (855) 613-8303, apria.com  
Lincare (855) 236-8277, lincare.com  
Rotech (877) 623-5272, rotech.com | • Obtain Prior Authorization for services |
| Intensity Modulated Radiation Therapy (IMRT) | Phone: (800) 550-5568  
Fax: (800) 731-2515 | • Fax completed IMRT form for Prior Authorization for services |
| Mental Health Services | United Behavioral Health (UBH)  
Phone: (800) 817-4705 | • Obtain information and Prior Authorization for mental health services |
| Pharmacy | OptumRx Prior Authorization Phone: (800) 711-4555  
OptumRx Phone: (888) 739-5820  
Fax: (800) 837-0959 | • Obtain information about pharmacy services  
• Call for medications requiring Prior Authorization (PA) |
| Physical, Occupational and Speech Therapy | OptumHealth  
Phone: (800) 873-4575  
Fax: (248) 733-6070 | • Obtain Prior Authorization for physical therapy (PT)  
• Occupational therapy (OT)  
• Speech therapy (ST) |
| Podiatry | Foot and Ankle Network (FAN)  
Phone: (305) 558-0444  
Fax: (305) 557-3810 | • Obtain information about podiatry services |
<table>
<thead>
<tr>
<th>Resource</th>
<th>Where to go</th>
<th>What you can do there and how</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology/Advanced Outpatient Imaging Procedures:</td>
<td>Online: carecorenational.com Phone: (866) 889-8054</td>
<td>• Prior Authorization of radiology services as described in the Outpatient Radiology Notification/Prior Authorization Protocol for Commercial Customers section of this Guide.</td>
</tr>
<tr>
<td>CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Referrals through IVR</td>
<td>myNHP.com</td>
<td>• Use 12-digit PCP and Specialist numbers printed in the IVR listing and Customer’s 7-digit ID number</td>
</tr>
<tr>
<td></td>
<td>Note: Referrals processed through the NHP IVR System are not guarantees of eligibility, benefit limitations, or coverage at the time of service. Effective 4/1/15 and upon member renewal, the new Provider Services number will be (877) 842-3210 and the automated referral line will be discontinued. Please refer to the back of the members ID card to ensure the appropriate Provider services department is contacted.</td>
<td>• PCPs require a password and can only refer to a Specialist</td>
</tr>
<tr>
<td></td>
<td>Effective 4/1/15 and upon member renewal, the new Provider Services number will be (877) 842-3210 and the automated referral line will be discontinued. Please refer to the back of the members ID card to ensure the appropriate Provider services department is contacted.</td>
<td>• Referrals entered through the IVR System within the last 180-days can be verified</td>
</tr>
<tr>
<td></td>
<td>Note: Referrals processed through the NHP IVR System are not guarantees of eligibility, benefit limitations, or coverage at the time of service. Effective 4/1/15 and upon member renewal, the new Provider Services number will be (877) 842-3210 and the automated referral line will be discontinued. Please refer to the back of the members ID card to ensure the appropriate Provider services department is contacted.</td>
<td>• Referral letter will be generated and mailed to the Specialist and Customer within 24 hours</td>
</tr>
<tr>
<td>Substance Abuse Services</td>
<td>United Behavioral Health (UBH) Phone: (800) 817-4705</td>
<td>• Obtain information and Prior Authorization for substance abuse services.</td>
</tr>
<tr>
<td>Transplant Services</td>
<td>OptumHealth Phone: (888) 936-7246 Fax: (855) 250-8157</td>
<td>• Prior Authorization of transplant services</td>
</tr>
<tr>
<td>Utilization Management (UM)</td>
<td>Phone: (800) 550-5568 Prior Authorizations: Fax (800) 731-2515 or (800) 729-1574 Obstetrical: Fax (800) 731-7954 Hospital Admissions: Fax (800) 731-2430</td>
<td>• Request Prior Authorizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Obtain status of Prior Authorizations</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Request urgent pre-service appeals on behalf of a Customer</td>
</tr>
</tbody>
</table>

**Health care identification (ID) card**

The NHP Customer’s health care ID card indicates what type of plan the Customer has, and applicable copayments. For more detailed information on ID cards and to see a sample health care ID card, please refer to the Health care Identification (ID) cards section of this guide.

**Definitions**

**Medically Necessary:** Covered services that, as determined by the NHP Medical Director or designee, are appropriate and necessary to diagnose and treat the Customer’s symptoms or medical condition.

**Participating Provider:** A physician or other healthcare professional, hospital, or ancillary service Provider who participates in NHP’s network pursuant to a participation agreement.

**PCP:** A physician, who has agreed to provide Primary Care Services to Customers.

**Primary Care Services:** Services for coordination of care including, without limitation, health promotion and maintenance, treatment of illness and injury, early detection of disease and Referrals to Participating Providers when appropriate.

**Referral:** The process by which a PCP determines and sends a Customer to another Participating Provider as described in this Supplement.

**Specialist:** A Participating Provider who is a physician or other healthcare professional, other than a PCP.

**Urgent Referral:** A Referral for which waiting the routine time period for could seriously jeopardize the life or health of the Customer or the ability of the Customer to regain maximum function; or, in the opinion of a physician with knowledge of the Customer’s medical condition, would subject the Customer to severe pain that cannot be adequately managed without the care or treatment.

**Referrals**
The PCP is responsible for determining when he or she should refer the Customer for “specialty care”. Initial Referrals can only be initiated by the PCP. All Referrals must be made to Participating Providers. Claims for services rendered without a proper Referral will be denied and the Customer may not be billed for those services unless prior to receiving the service...
the Customer, with knowledge that a Referral is not in place or that the service is not a covered service, agrees in writing to be financially responsible for the cost of the service. Referrals to a Specialist may be necessary:

- When a Customer fails to respond to current medical treatment,
- To confirm or establish a Customer’s diagnosis and/or treatment modality,
- To provide diagnostic studies, treatments or procedures that range beyond the scope of the PCP. PCPs may make referrals to Specialist according to the 3 levels below. The following specialty services do not require Referral:
  - Chiropractic (subject to benefit limitations)
  - Dermatology (5 visits per calendar year)
  - Gynecology
  - Podiatry (See the Prior Authorization Requirements section of this Supplement)
  - Alcohol/chemical dependency treatment*
  - Mental health*

**Specialty referral guidelines:**

- Once the specialty services have been properly authorized, the Customer or PCP may schedule an appointment with the Specialist.
- Faxed or mailed Referrals will be date-stamped by NHP and processed in the order received and/or severity of the request as defined below. Urgent Referrals will be handled on a priority basis.
- If there is a question or concern regarding the Referral, such as eligibility, coverage or medical necessity, the NHP UM staff will notify the PCP’s office staff.
- An authorization letter will be mailed to the Specialist for the Customer’s medical record.
- Specialist claims will not be paid without a Referral.
- The Specialist should re-verify the Customer’s eligibility at the time of visit by calling Customer Care at (877) 972-8845. As members renew beginning 4/1/16, the new Provider Services number will be (877) 842-3210. Please refer to the back of the member ID card to ensure the appropriate Provider services department is contacted.
- IVR system cannot be used for Referrals to physicians in the following specialties:
  - Hematology
  - Oncology
  - Plastic & reconstructive surgery
  - Behavioral health
  - Perinatology
  - Neonatology
  - Ophthalmology Sub-specialties (Retinal, Corneal, Occuloplasty)
  - Reproductive Endocrinology/Infertility

With the exception of Behavioral Health Services, requests for these specialties can be sent to NHP UM at (800) 550-5568 or faxed to (800) 731-2515 or (800) 729-1574. Paper Referrals may result in certification delays.

The PCP may choose to complete the “Participating Provider Referral Form”, available on myNHP.com → Forms, for those specialties or services not available through the IVR. Please note that all fields on the form must be completed in their entirety. Please include any documentation of pertinent clinical summary information (including diagnosis) which would be helpful to the Specialist or NHP UM. The PCP must sign and date the Referral form and fax to NHP UM: (800) 731-2515 or (800) 729-1574.

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

- **Level I** - Consult: PCP is authorizing a consultation only. The PCP requires a written or verbal communication prior to authorizing additional services. This level certifies a Specialist to see the Customer for 1 visit during a 60-day period.

- **Level II** - Consultation & Diagnostics: PCP is authorizing a consultation and diagnostic tests that will be performed by the Specialist and billed by the Specialist on the same day as the consultation. Specialized diagnostic tests that are identified on the Prior Authorization list are not covered as part of this Referral. This level certifies a Specialist to see the Customer 3 times during a 90-day period.

- **Level III** - Consultation, Diagnostics & Treatment: PCP is authorizing a consultation, diagnostic tests and any treatment that will be performed by the Specialist and billed by the Specialist on the same day as the consultation. Specialized diagnostics and treatments that are identified on the Prior Authorization list are not covered as part of this Referral. This level certifies a Specialist to see the Customer 3 times during a 90-day period.

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

**Additional Specialist visits:**

- If the PCP determines that the Customer requires continued specialty visits or treatments by the Specialist, the PCP may Request additional visits by submitting a Prior Authorization form (treatment plan) available on myNHP.com to NHP UM. The Prior Authorization form may be faxed to NHP UM: (800) 731-2515 or (800) 729-1574.

  - The treatment plan must include the following information:
    - Date of request
    - PCP name
    - Customer name, health care ID number, and date of birth
    - Specialist name, phone number, and specialty
    - Medical information substantiating the need for additional visits
    - Number of additional visits requested and the time frame for the visits

**Out-of-network referrals**

Out-of-network Referrals are only approved when the services required are not available from a Participating Provider. Out-of-network Referrals may be requested by calling NHP at (800) 550-5568. Upon receipt of the Referral by NHP, the data will be reviewed and, if approved, entered into the system to ensure payment of the Specialist claims.

**Obstetrical referrals:**

The obstetrician will complete the Global OB Care Notification Form (available on myNHP.com) for pregnant Customers to obtain Referral for total OB Care. The Referral for total OB Care includes all prenatal care, 1 ultrasound between 13 and 24 weeks of gestation and delivery. During a Customer’s pregnancy, the obstetrician acts as a PCP for the Customer and may issue Referrals. Prior Authorization for the maternity inpatient admission is required at the time of delivery. Total OB care should be billed at the time of delivery along with the hospital authorization number of the delivery.

The following procedures are not included in the Referral for total OB Care and require Prior Authorization: amniocentesis, fetal echo, biophysical profiles, consultation with a Specialist, non-stress tests, venipuncture outside the Obstetrician’s office and any additional ultrasounds. LabCorp must be used for all laboratory services, including any genetic testing.

**Prior Authorization Requirements:**

Except as otherwise provided, NHP requires Prior Authorization prior to the following admissions:

- All hospital*
- Inpatient rehabilitation facility
- Skilled nursing facility
- Long term acute care facility
- Special care unit

The provider must provide clinical information to support the Medical Necessity of the admission and/or observation stay, by the next business day following the admission. Final determinations will be made by a Medical Director as appropriate.

**Concurrent review**

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

All discharge planning, and cases requiring comprehensive services for catastrophic or chronic conditions are coordinated through NHP Case Management, including OB care. If the diagnosis or treatment of a Customer is delayed secondary to the inability of the facility to provide a needed service, payment for these days will be denied, including but not limited to, the unavailability of diagnostic and/or surgical services on weekends and holidays, delays in the interpretation of diagnostic testing, delays in obtaining requested consultations and late rounding by the admitting physician.

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

**Clinical Laboratory Services**

All NHP Customers should be directed to LabCorp, Inc. service centers for outpatient laboratory procedures. If a Participating Provider draws the specimen in the office the specimen should be sent to LabCorp, Inc.

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

Claims for clinical laboratory services performed by a Participating Provider that is a hospital for following services: (i) emergency room services; (ii) chemotherapy; (iii) ambulatory surgery; (iv) transfusions; or (v) hemodialysis will be paid in accordance with the Participating Provider’s participation agreement. Clinical laboratory specimens drawn at a skilled nursing facility must be processed by LabCorp, Inc.

Participating Providers may perform clinical laboratory services in the office as listed on the NHP laboratory procedure lists I & II below. Procedures on list I may be performed by any physician in the office in accordance with state and federal guidelines. Procedures on list II may be performed by a Specialist as listed in list II. When these clinical laboratory services are performed in the office, then claims for those services will be paid in accordance with the Participating Provider’s participation agreement.

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*Admissions from the emergency room, to the ICU/CCU, or admission for emergency surgery must be Post-certified by the next business day following admission.
<table>
<thead>
<tr>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urinalysis, non-automated, with microscopy for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrile, pH, protein, specific gravity urobilinogen, any number of these constituents, with microscopy non-automated</td>
</tr>
<tr>
<td>Urinalysis, automated, with microscopy</td>
</tr>
<tr>
<td>Urinalysis, non-automated, without microscopy</td>
</tr>
<tr>
<td>Urinalysis, automated, without microscopy</td>
</tr>
<tr>
<td>Urinalysis, qualitative or semiquantitative, except immunoassays</td>
</tr>
<tr>
<td>Urinalysis, bacteriuria screen, by non-culture technique, commercial kit (specify type)</td>
</tr>
<tr>
<td>Urinalysis, microscopic only</td>
</tr>
<tr>
<td>Urine pregnancy test</td>
</tr>
<tr>
<td>Blood, occult; feces, 1-3 simultaneous determinations</td>
</tr>
<tr>
<td>Glucose quantitative, blood (except reagent strip)</td>
</tr>
<tr>
<td>Glucose blood, reagent strip</td>
</tr>
<tr>
<td>Glucose blood, one-touch monitor</td>
</tr>
<tr>
<td>Gonadotropin, chorionic (hCG); qualitative</td>
</tr>
<tr>
<td>Manual blood smear examination without differential parameters</td>
</tr>
<tr>
<td>Differential WBC count, buffy coat</td>
</tr>
<tr>
<td>Spun microhematocrit</td>
</tr>
<tr>
<td>Blood count, other than spun hematocrit</td>
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<tr>
<td>Blood count, hemoglobin</td>
</tr>
<tr>
<td>Hemogram and platelet count, automated, and automated complete differential WBC count (CBS)</td>
</tr>
<tr>
<td>Prothrombin time</td>
</tr>
<tr>
<td>Thromboplastin time, partial (PTT) plasma or whole blood</td>
</tr>
<tr>
<td>Heterophile antibodies; screening</td>
</tr>
<tr>
<td>Immunoassay for infectious agent antibody, quantitative, not elsewhere specified</td>
</tr>
<tr>
<td>Particle agglutination, antibody (rapid strep screen)</td>
</tr>
<tr>
<td>Skin test, tuberculosis, intradermal</td>
</tr>
<tr>
<td>Culture, bacterial, definitive (throat or nose)</td>
</tr>
<tr>
<td>Culture, bacterial, screening only for single organisms</td>
</tr>
<tr>
<td>Culture, presumptive, pathogenic organism, screening only by commercial kit, with colony est from density chart</td>
</tr>
<tr>
<td>Culture, bacteria, urine, quantitative, colony count</td>
</tr>
<tr>
<td>Culture, bacterial, urine, commercial kit</td>
</tr>
<tr>
<td>Smear, primary source, with interpretation, wet and dry mount, for ova and parasites</td>
</tr>
<tr>
<td>Sensitivity study, antibiotic, disk method, per plate (12 or fewer disks)</td>
</tr>
<tr>
<td>Smear, primary source, with interpretation, routine stain for bacteria, fungi, or cell types</td>
</tr>
<tr>
<td>Smear, primary source, with interpretation, wet mount with simple stain, for bacterial, fungi, ova and/or parasites</td>
</tr>
<tr>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Streptococcus, group A</td>
</tr>
<tr>
<td>Leukocyte Count, Fecal</td>
</tr>
<tr>
<td>Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group A</td>
</tr>
<tr>
<td>Infectious agent antigen detection by immunoassay with direct optical observation; Influenza</td>
</tr>
<tr>
<td>Sweat collection by iontophoresis</td>
</tr>
</tbody>
</table>
### Specialty specific and outpatient facility laboratory procedure list II

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hematology</strong></td>
<td>Blood smear, microscopic examination with manual differential WBC count</td>
</tr>
<tr>
<td></td>
<td>Automated CBC/platelet/complete differential</td>
</tr>
<tr>
<td></td>
<td>Automated hemogram and platelet count</td>
</tr>
<tr>
<td></td>
<td>Blood smear, peripheral</td>
</tr>
<tr>
<td></td>
<td>Infectious Agent Antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; Streptococcus group A</td>
</tr>
<tr>
<td></td>
<td>Sweat collection by iontophoresis</td>
</tr>
<tr>
<td></td>
<td>Bone marrow, aspiration only</td>
</tr>
<tr>
<td></td>
<td>Bone marrow, smear interpretation only, with or without differential cell count</td>
</tr>
<tr>
<td></td>
<td>Bone marrow biopsy, needle or trocar</td>
</tr>
<tr>
<td></td>
<td>Complete CBC, automated (HG B, HCT, RBC, WBC w/o platelet count)</td>
</tr>
<tr>
<td></td>
<td>Complete CBC, automated (HG B, HCT, RBC, WBC)</td>
</tr>
<tr>
<td><strong>Urology/Infertility</strong></td>
<td><strong>Semen Analysis:</strong></td>
</tr>
<tr>
<td></td>
<td>Sperm identification from aspiration (other than seminal fluid)</td>
</tr>
<tr>
<td></td>
<td>Sperm isolation: simple prep (e.g., Sperm Wash and swim-up) for insemination or diagnosis with semen analysis</td>
</tr>
<tr>
<td></td>
<td>Sperm isolation, complex prep</td>
</tr>
<tr>
<td></td>
<td>Presence and/or motility of sperm including Huhner test (post-coital)</td>
</tr>
<tr>
<td></td>
<td>Motility and count</td>
</tr>
<tr>
<td></td>
<td>Complete (volume, count, motility and differential)</td>
</tr>
<tr>
<td></td>
<td>Sperm antibodies</td>
</tr>
<tr>
<td><strong>Rheumatology</strong></td>
<td>Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)</td>
</tr>
<tr>
<td></td>
<td>Sedimentation rate, erythrocyte: non-automated</td>
</tr>
<tr>
<td><strong>Infectious Disease</strong></td>
<td>Sedimentation rate automated</td>
</tr>
<tr>
<td><strong>OB/GYN</strong></td>
<td>Chlamydia culture</td>
</tr>
<tr>
<td></td>
<td>Sperm evaluations cervical mucus penetration, with or without Spinnbarkeit test</td>
</tr>
<tr>
<td><strong>General Surgery/Radiology/Endocrinology</strong></td>
<td>Fine needle aspiration with or without preparation of smears:</td>
</tr>
<tr>
<td></td>
<td>Superficial tissue (e.g., thyroid, breast, prostate)</td>
</tr>
<tr>
<td></td>
<td>Deep tissue under radiologic guidance</td>
</tr>
<tr>
<td><strong>All Outpatient Facilities</strong></td>
<td><strong>Bilirubin, total</strong> (for Customers under 30 days old, if LabCorp, Inc unable to draw)</td>
</tr>
<tr>
<td></td>
<td><strong>Bilirubin, direct</strong> (for Customers under 30 days old, if LabCorp, Inc unable to draw)</td>
</tr>
<tr>
<td></td>
<td><strong>Blood gases (ABG) X pH only</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Blood gases (any combination of pH, pCO2, pO2, C02, HCO3)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>With oxygen saturation, by direct measurement, except pulse oximetry</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Bloodgases, oxygen saturation only</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Hemoglobin X oxygen affinity (pO2 for 50% saturation with oxygen)</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Antibody elution (RBC), each elution</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Antibody identification RBC antibodies, each panel for each serum technique</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Blood typing, ABO</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Blood typing (Rh)</strong></td>
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<tr>
<td></td>
<td><strong>Antigen screening for compatible blood unit using patient serum, per unit screened</strong></td>
</tr>
<tr>
<td></td>
<td><strong>RBC antigens, other than ABO or Rh (D), each</strong></td>
</tr>
<tr>
<td></td>
<td><strong>RH phenotyping complete</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Microbiology, any other source</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; Streptococcus, group A</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Nasal smear for eosinophils</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Sweat collection by iontophoresis</strong></td>
</tr>
<tr>
<td><strong>Hematology/Oncology/Neurology/Pediatrics</strong></td>
<td><strong>Lumbar puncture:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Glucose, quantitative</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Protein, total, except refractometry</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Blood count, manual differential WBC count</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Cell count, miscellaneous body fluids, except blood</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Glucose; quantitative, blood (except regent strip)</strong></td>
</tr>
<tr>
<td><strong>Cardiology/Cardiovascular/Thoracic Surgery</strong></td>
<td><strong>Prothrombin time</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Thromboplastin time, partial (PTT), plasma or whole blood</strong></td>
</tr>
<tr>
<td><strong>Pediatrics &amp; Family Medicine</strong></td>
<td><strong>Bilirubin, total</strong> (for Customers under 30 days old)**</td>
</tr>
<tr>
<td></td>
<td><strong>Bilirubin, direct</strong> (for Customers under 30 days old)**</td>
</tr>
</tbody>
</table>
Use of non-participating laboratory services

This protocol applies to all Participating Providers, and it applies to all laboratory services, clinical and anatomic, ordered by any practitioner.

This protocol does not apply to laboratory services that are approved to be provided by physicians in their offices (as described above) or hospitals (as described above). Participating Providers are required to refer laboratory services to participating laboratories, except as otherwise authorized by NHP. To get more information on participating laboratories, you can:

- Go to myNHP.com to view a complete list of participating laboratories; or
- Go to LabCorp.com or call (888) LABCORP (522-2677), option #3 to determine how to conveniently access their services.
- Call Customer Care at (877) 972-8845.

In the unusual circumstance that you require a specific laboratory test for which you believe no participating laboratory is available, please contact NHP UM at (800) 550-5568. LabCorp requires the following to make sure accurate testing and billing:

- Customer’s NHP health care ID number
- LabCorp requisition forms with all required fields completed specific test orders using test codes
- Diagnosis codes

Administrative actions for non-participating laboratory services referrals

If NHP determines an ongoing and material practice of Referrals to non-participating laboratory service providers, NHP will promptly notify the responsible Participating Provider of the issue and remind him/her of his or her contractual requirements. Moreover, while it is our expectation that these actions will rarely be necessary, please note that continued Referrals to non-participating laboratories may, after appropriate notice, subject the referring Participating Provider to:

- A decreased fee schedule or
- Termination of network participation, as provided in the participation agreement.

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

Drug Prior Authorization

In order to promote appropriate utilization, NHP requires a Prior Authorization (PA) for certain medications dispensed through the pharmacy (prescription drug benefit) and/or incident to a physician’s service (medical benefit) to be eligible for coverage. For a plan Customer to receive coverage for a medication requiring PA, the Participating Provider must provide clinical information to OptumRx (if the medication is to be dispensed by a participating pharmacy), or to NHP UM (if the medication is to be provided incidental to a physician’s service). PA does not guarantee coverage.

<table>
<thead>
<tr>
<th>Pharmacy Drug PA Requests OptumRx</th>
<th>NHP Medical Drug PA Requests</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone: (800) 711-4555</td>
<td>Phone: (877) 488-5576</td>
</tr>
<tr>
<td>OptumRx Fax (non-specialty meds): (800) 527-0531</td>
<td>Fax: (800) 731-6984</td>
</tr>
<tr>
<td>OptumRx Fax (specialty meds): (800) 853-3844</td>
<td></td>
</tr>
</tbody>
</table>

For a full description of our clinical programs on medications dispensed through the outpatient pharmacy benefit, please refer to UnitedHealthcareOnline.com → Tools & Resources → Pharmacy Resources → Clinical and Specialty Programs. To determine medications available through the Pharmacy benefit and check PA requirements, please consult the NHP Prescription Drug List Consumer Reference Guide at MyNHP.com → Members → Pharmacy → Prescription Drug List (PDL).

All infusions and chemotherapeutic agents administered through the medical benefit require Prior Authorization, regardless of the indication. In addition, for the most current and complete list of medical drugs requiring PA for NHP Customers as well as the requirements for the outpatient medications listed above, go to myNHP.com → Providers → Pharmacy → Prior Authorization Requests.
General Administrative Requirements

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

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

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

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

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

Note: Not intended as claims coverage guidelines

Claims inquiries and appeals

Claim reconsideration inquiry:
Please refer to Claim reconsideration, appeals process and resolving disputes section located in the main part of the Guide under Our claims process for detailed information about the reconsideration process.

How to contact us: Customer Care at (877) 972-8845 or submit your request online at myNHP.com. (Documentation should clearly explain the nature of the review request.)

Claim appeal:
Please refer to Claim reconsideration, appeals process and resolving disputes section located in the main part of the Guide under Our claims process for detailed information about the appeal process.

How: Claim appeals must be requested in writing. Please use the Provider Appeal Request Form available on myNHP.com.

Where: Claim appeal forms, along with all accompanying documentation, should be mailed to:

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

When: You have 1 year from the date of occurrence to file an appeal with the Plan. You will receive a decision in writing, within 60 calendar days from the date appeal is received by NHP.
Important Information Regarding use of this Supplement

OneNet PPO, LLC (OneNet) is a wholly owned subsidiary of UnitedHealthcare Insurance Company, a part of UnitedHealth Group, Incorporated. The OneNet Physician, Health Care Practitioner, Hospital and Facility Supplement (OneNet Supplement) is a supplement to this UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (UnitedHealthcare Guide), both of which must be followed by OneNet Providers. The OneNet Supplement may also be referred to as the OneNet Physician, Health Care Practitioner, Hospital and Facility Manual or the “OneNet Manual”. OneNet Providers are providers whose agreement with UnitedHealthcare includes participation in networks offered by OneNet, including but not limited to, the OneNet PPO Network and the OneNet Workers’ Compensation Network. This may include providers within the OneNet service area, as well as providers in other areas such as providers in states adjacent to our service area, and those in any future OneNet network expansion areas.

The OneNet Supplement describes operational procedures and information that specifically apply to services provided to OneNet Customers and OneNet Clients. In the event of a conflict or inconsistency between your UnitedHealthcare agreement and the provisions outlined in the OneNet Supplement with regard to services rendered to OneNet Customers, the OneNet Supplement will control.

Because OneNet is not a payer but a preferred Provider network only, certain provisions of the UnitedHealthcare Guide will apply to OneNet, but with some variation. The OneNet Supplement identifies the principal variations and in the event of a conflict between the OneNet Supplement and the UnitedHealthcare Guide, the OneNet Supplement will control.

The OneNet service area includes Delaware, Maryland, North Carolina, Pennsylvania, Virginia, Washington D.C., and West Virginia with additional providers in Florida, Georgia, South Carolina and Tennessee. OneNet is based in Rockville, Maryland.

Terms Used in the OneNet Supplement

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

OneNet Customer: A OneNet Customer is a person authorized by OneNet PPO, LLC to access OneNet participating physicians, health care practitioners, hospitals and facilities under the terms of the physician, health care practitioner, hospital or facility’s agreement. If your UnitedHealthcare contract has the definition of “Customer” or “Member”, the term OneNet Customer as used by OneNet and as used in the OneNet Supplement is intended to have the same meaning. OneNet Customers include:

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

OneNet Payer: A OneNet Payer is a person or entity that has an obligation to pay for services rendered by a OneNet participating physician, health care practitioner, hospital or facility to a OneNet Customer. OneNet Payers may include insurance carriers, workers’ compensation carriers, self-funded health plans and others. OneNet Payers may use the services of a TPA or other entity to provide administrative services, including verifying eligibility and adjudicating and issuing claims payment on behalf of OneNet Payers. References in the physician, health care practitioner, and hospital or facility agreement to “participating entity”, “Payer” or “Payor” also apply to OneNet Payers. Neither OneNet nor UnitedHealthcare and its affiliates are OneNet Payers.

Claim Pricing or Repricing: The process of applying the OneNet contracted rates to claims submitted by participating providers. This process includes the application of clinical edits, reimbursement policies and standard coding practices. In the case of workers’ compensation, it includes the application of state or federal fee schedule rates, when applicable. The terms “claim pricing” and “repricing” are used interchangeably.
About OneNet PPO

OneNet PPO maintains a large network of physicians, health care practitioners, hospitals and other facilities offering medical, behavioral health, dental and workers’ compensation services, which are accessed by OneNet Clients and their Participants.

While OneNet administers the network and performs claim pricing for participating providers using contracted rates, and clients are responsible for the administration of the health plan accessing the OneNet network. The following provides a summary of the key roles and responsibilities of OneNet and its clients:

<table>
<thead>
<tr>
<th>What OneNet Does</th>
<th>What OneNet Clients Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ensures network adequacy</td>
<td>• Designs and administers health plans</td>
</tr>
<tr>
<td>• Ensures OneNet Clients comply with contractual agreements</td>
<td>• Establishes and maintains benefits and eligibility information of health plan</td>
</tr>
<tr>
<td>• Assists providers in resolving issues between them and our clients</td>
<td>• Participants (OneNet does not receive this information)</td>
</tr>
<tr>
<td>• Reviews and approves client health care ID cards</td>
<td>• Provides Participant health care ID cards (health care ID cards are not used for workers’ compensation)</td>
</tr>
<tr>
<td>• Performs Claim Pricing</td>
<td>• Adjudicates claims</td>
</tr>
<tr>
<td></td>
<td>• Pays claims according to health plan benefits</td>
</tr>
</tbody>
</table>

If you need assistance or have any questions, OneNet Customer Care is available by calling (800) 342-3289, or you may email us at maprofessionalservices@uhc.com. You may also access our website at onenetppo.com to view our network directories and find more information about OneNet.

How to Contact Us

OneNet Customer Care is available to assist you should you have questions. When you call OneNet Customer Care you will be connected to our voice-activated telephone system. Representatives can assist you in checking claim pricing status, verifying OneNet Payer information and more. You will need your Federal Tax Identification Number. If you have questions about your UnitedHealthcare contract, please contact your UnitedHealthcare Provider representative.

<table>
<thead>
<tr>
<th>OneNet Corporate Offices</th>
<th>800 King Farm Blvd 6th Floor  Rockville, MD 20850</th>
</tr>
</thead>
<tbody>
<tr>
<td>OneNet Customer Care</td>
<td>(800) 342-3289 email: <a href="mailto:maprofessionalservices@uhc.com">maprofessionalservices@uhc.com</a></td>
</tr>
<tr>
<td>Website:</td>
<td>onenetppo.com or UnitedHealthcareOnline.com</td>
</tr>
<tr>
<td>Claim Submission</td>
<td>Claims may be submitted through Electronic Data Interchange or on paper: For EDI claims, our payer number is: 52149 \ For claims submitted by mail: Please use the OneNet claims address listed on the Participant’s health care ID card.</td>
</tr>
<tr>
<td>Our Standard Claims Mailing Address</td>
<td>OneNet PPO/MAPS1 Claims P.O. Box 934 Frederick, MD 21705-0934</td>
</tr>
<tr>
<td>Fee Schedule Appeals</td>
<td>OneNet Appeals Attention: CRA P.O. Box 934 Frederick, MD 21705-0934</td>
</tr>
<tr>
<td>Claim Payment Appeals</td>
<td>OneNet does not adjudicate or pay claims. Please direct payment appeals to the OneNet Client at the telephone number found on the Participant’s health care ID card or on the OneNet Client’s EOB.</td>
</tr>
<tr>
<td>Questions About Your UnitedHealthcare Contract</td>
<td>Please contact your UnitedHealthcare Provider Representative.</td>
</tr>
</tbody>
</table>
Health Care ID Cards
Health care identification (ID) cards for OneNet Participants differ in appearance because each OneNet Client issues its own card. Health care ID cards for OneNet Participants are not produced by UnitedHealthcare, cannot be viewed online at UnitedHealthcareOnline.com, and do not use the swipe/bar code technology used for health care ID cards produced under other UnitedHealthcare commercial plans.

Sample health care ID card only: Actual cards will vary in design and appearance, but will include essential information for providing services and submitting claims.

OneNet requires OneNet Clients to provide information needed for providers to check eligibility and benefits follow applicable UM requirements, and submit claims. OneNet reviews and approves the card designs of OneNet Clients to help make sure key information is provided.

At a minimum, the health care ID card will have the following information:

- OneNet name and/or logo
- Group number
- Claims address
- Eligibility and/or benefits telephone number
- Group/Payer name
- UM information (if applicable)

The Participant’s health care ID card may list copayments (if any). Participants in the OneNet PPO Network must show a health plan ID card with the OneNet name and/or logo at the time of service.

The exception to this health care ID card requirement is services provided to Participants accessing providers through the OneNet PPO Workers’ Compensation Network. Health care ID cards are not issued or used for OneNet workers’ compensation Participants.

You should not expect Participants accessing the OneNet PPO Workers’ Compensation Network to present a health care ID card. Workers’ compensation insurers, workers’ compensation administrators and employers of the injured worker are instructed to advise you of network access when you call to verify employment. You may wish to ask if the injured worker is accessing you through a workers’ compensation network when you call the employer to verify employment. Please see Claim Submission section of this Supplement for additional information on handling of workers’ compensation claims.

All OneNet Clients must utilize the OneNet network as their primary network subject to the following exception. Under certain rare circumstances, due to contractual or other Benefit Plan requirements, OneNet may be utilized as a secondary network by a OneNet Client; provided however such utilization requires the express written authorization and approval of OneNet. If approval is given by OneNet, it will be clearly indicated on the health care ID card when OneNet is used as a secondary network.
Verifying eligibility and benefits of OneNet Customers

OneNet does not maintain benefits and eligibility information for OneNet Customers. This information must be obtained directly from the appropriate OneNet Client. Call the number on the Participant’s health care ID card to verify eligibility for coverage or to inquire about specific benefits and payments. In addition to providing a telephone number for verifying benefits and eligibility, some OneNet Clients may also maintain independent websites for verifying benefits and eligibility for their Participants.

If you are unclear about any information that was provided when calling the telephone contact on the Participant’s health care ID card, call our Customer Care Department at (800) 342-3289 and we will assist you in obtaining clarification from the OneNet Payer.

Online Services at onenetppo.com

The OneNet PPO website, onenetppo.com includes information for providers about OneNet. Our site also includes links to UnitedHealthcareOnline.com, where you can view your OneNet claims claim re-pricing.

Because OneNet does not pay claims and does not have an obligation to pay for services rendered by a OneNet provider, and because neither OneNet nor its parent company, UnitedHealthcare, maintains maintain benefits and eligibility information of OneNet Clients, many of the web tools available at UnitedHealthcareOnline.com for other Commercial products cannot be used for OneNet Customers. These include, but are not limited. Examples of tools that are not available include to:

- Review of eligibility, benefits or HRA balances for OneNet Customers
- View patient personal health records
- Submit Advance Notifications
- View your OneNet fee schedule
- Claim Estimator
- Claim submission
- Reprint EOBs
- Electronic Payments and Statements

Similar limitations exist for other UnitedHealthcare automated systems designed to utilize or verify benefits and eligibility information, such as the Enterprise Voice Portal.

Referrals to other OneNet providers

Use the “Find a Provider” feature at onenetppo.com to identify other OneNet participating providers. Directory information is updated weekly. For assistance locating participating physicians, health care practitioners, hospitals and facilities not identified in the online directory, such as hospital-based physician groups, please call our Customer Care department.

When referring a OneNet Participant, please use your best efforts to refer the Participant to a physician, health care practitioner, hospital, laboratory or other facility that also participates in the OneNet PPO Network. Please advise the OneNet Participant if a OneNet participating Provider is not available in the referring specialty and you are referring them to a Provider who does not participate in the OneNet PPO Network, as services from a non-participating Provider could result in higher out-of-pocket costs for the Participant.

Laboratory services

OneNet maintains a robust network of national, regional and local providers of laboratory services. Participants receiving services from out-of-network laboratories may incur increased financial liability and therefore higher out-of-pocket expenses. While it is ultimately the Participant’s responsibility to make sure they are utilizing participating providers, you are required to use your best efforts to refer laboratory services to a laboratory Provider participating in the OneNet network, except as otherwise authorized by OneNet or a OneNet Payer. Participating laboratory providers can be found in the OneNet online directory of physicians, health care practitioners, hospitals and facilities available at onenetppo.com, or by calling OneNet Customer Care at (800) 342-3289. In the event you require a specific laboratory test for which you believe no participating laboratory is available, please contact OneNet Customer Care to confirm the test cannot be performed by a participating OneNet provider.

If OneNet determines that you are consistently referring OneNet Participants to non-participating laboratories, we may contact you to discuss your reasons for doing so and to determine if participating laboratories can be used for future referrals.

OneNet does not participate in the UnitedHealthcare Laboratory Benefit Management program administered by Beacon LBS™.
Pharmacy Services
The OneNet network does not include a pharmacy network. OneNet Payers may choose to use a pharmacy network for administration of pharmacy benefits. The name of the pharmacy network may appear on the Participant’s health care ID card. Please contact the health plan at the benefits and eligibility number listed on the health care ID card if you have questions regarding coverage of certain drugs.

Specialty Pharmacy and Home Infusion
OneNet does not have a specific requirement that certain medications must be obtained from a participating specialty pharmacy or that a network Provider must be used. However, please remember that OneNet Participants may incur higher out-of-pocket costs for specialty pharmacy that is provided by out-of-network providers. Whenever possible, you should use your best efforts to use participating specialty pharmacy providers for the medications identified in the Specialty pharmacy requirements for procurement of certain Specialty medications section of the UnitedHealthcare Guide.

OneNet Payers may have pre-authorization requirements related to certain specialty drugs. Please verify any pre-authorization requirements related to specialty drugs by calling the utilization management number listed on the Participant’s health plan ID card prior to providing services. Failure to pre-authorize may result in higher out-of-pocket costs for the Participant.

Participating Specialty Pharmacy and Home Infusion providers providing services to OneNet Participants follow UnitedHealthcare’s protocol on the Prohibition of Provision of Non-contracted Services.

Behavioral Health Services
OneNet’s MAPSI Behavioral Health Network (MAPSI) is a network of behavioral health physicians, psychologists, and other behavioral health professionals and facilities. OneNet Clients may access the MAPSI network, the United Behavioral Health Network, or another behavioral health network. The word “MAPSI” will appear on the health care ID card if the Participant has access to the MAPSI network. If you believe a Participant requires behavioral health services and would like to refer a Participant to a behavioral health provider, you should use your best efforts to refer the Participant to providers participating in the behavioral health network the Participant accesses, if any.

Claim Submission
OneNet does not pay claims and does not have an obligation to pay for services rendered by a OneNet provider. OneNet reviews claims for completeness and accuracy, and applies claim pricing in accordance with your contracted fee schedule. OneNet then forwards the pricing to the appropriate OneNet Client for adjudication and payment determination.

Claims must be submitted within the time frame identified in your contract and in accordance with any applicable state laws. Failure to submit claims correctly will result in the rejection and return of claims.

A physician, health care practitioner, hospital or facility may bill Participants for applicable copayments, deductibles, coinsurance and non-covered services.

A physician, health care practitioner, hospital or facility may not bill Participants for non-professional services including, but not limited to, charges for overhead, administration fees, malpractice surcharges, membership fees, fees for referrals, or fees for completing claim forms or submitting additional information. If OneNet rejects or denies a claim because a physician, health care practitioner, hospital or facility failed to follow policies and procedures, the Participant may not be billed.

For all covered services, except for workers’ compensation related services, the Participant is responsible for payment of copayments, deductibles or coinsurance as described in the Participant’s health benefit plan. You are required to accept the OneNet contracted amount as payment in full for covered services, with the exception of the participating provider’s right to collect from the Participant any applicable copayment, deductible, or fee for any services that are deemed to be non-covered services under the participant’s health plan. You are prohibited from balance billing OneNet Participants for services covered by the OneNet Payer’s health plan and for amounts in excess of their copayments, deductibles, or coinsurances as described in their health benefit plan. For workers’ compensation related services, there are no copayments, deductibles, or coinsurances and balance billing is prohibited for all services covered by a workers’ compensation benefit plan.
OneNet Clients are required to adjudicate and pay clean claims within 30 days of receipt, or within applicable state or federal guidelines. If a OneNet Payer fails to adjudicate and pay a claim within this time period, the Provider may, at their discretion, request full billed charges. In these instances, the OneNet Payer will pay the claim as it was re-priced by OneNet. After receiving payment, the Provider must notify the OneNet Payer that payment of full billed charges is requested due to late claim payment. Exceptions to the right to request full billed charges for failing to offer timely payment is as follows:

- When OneNet notifies the Provider after receipt of the claim but prior to the expiration of the applicable claim payment time limit that the claim is denied, missing required information or is deficient in some way.
- When a OneNet Client notifies the Provider after receipt of the claim but prior to the expiration of the applicable claim payment time limit that the claim is denied or deficient.

Claims payments are subject to health plan limitations and applicable deductible, co-insurance and co-pays.

The OneNet Client must send you an Explanation of Benefits (EOB) with itemized explanations of reimbursement amounts for services. The EOB will outline: the billed charges for services rendered; Participant payment responsibility, such as applicable copayments, deductibles and/or coinsurance; the OneNet contracted amount; the reimbursement amount; and the amount that was adjusted based on the contract or benefit plan.

**Pricing of OneNet PPO Claims**
Reimbursement to you by the applicable OneNet Client for covered services rendered to OneNet Customers pursuant to a OneNet PPO, LLC benefit program (other than a OneNet PPO Workers’ Compensation benefit program), shall be the lesser of: (i) OneNet PPO, LLC payment rate as set forth in your agreement; or (ii) your billed charges for such services.

**Pricing of OneNet PPO Workers’ Compensation Claims**
Reimbursement to you by the applicable OneNet Client for covered services rendered to OneNet Customers pursuant to a OneNet PPO, LLC workers’ compensation benefit program, shall be the lesser of: (i) OneNet PPO, LLC payment rate set forth in your agreement; (ii) your billed charges for such services; or (iii) (a) the applicable state’s workers’ compensation fee schedule (b) the applicable federal workers’ compensation schedule or (c), other state, federal or government authorized methodology or schedule.

**Workers’ Compensation Claims Subject to Claim Edits**
For workers’ compensation 837P and CMS-1500 (formerly HCFA-1500) claims that are subject to code edits or line bundling and unbundling, the claim pricing resulting from these edits will be allocated back to the original submitted claim lines and codes. Priced claims do not display the lines or codes added or deleted by these claim edits. This is intended to assist physicians and OneNet’s workers’ compensation clients in claims reconciliation by having priced claims match originally submitted claims.

**Allocation of Global Pricing to the Claim Line Level**
Certain claims are subject to global pricing, including, but not limited to, case rates, flat rates and per diems. In these cases, the global contracted rate may be allocated proportionately to the applicable lines of the claim. How the contracted rate is distributed across claim lines will depend on the type of global rate and the payment methodology. In some cases, a fixed percentage of the global contracted rate may be applied to each line (Example 1).

**Example 1: Percentage of Global Pricing Distributed Across Lines**
Provider has billed lines totaling $100 that is subject to a global rate of $70. A portion of the global contracted rate is allocated to each line.

<table>
<thead>
<tr>
<th></th>
<th>Billed Charges</th>
<th>Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Line 1</td>
<td>$50.00</td>
<td>$35.00</td>
</tr>
<tr>
<td>Line 2</td>
<td>$25.00</td>
<td>$17.50</td>
</tr>
<tr>
<td>Line 3</td>
<td>$25.00</td>
<td>$17.50</td>
</tr>
<tr>
<td>Total</td>
<td>$100.00</td>
<td>$70.00</td>
</tr>
</tbody>
</table>

For other situations, distribution may occur by allowing up to the billed amount (or up to the state fee, as applicable, in the case of workers’ compensation claims) on each applicable line until the total global pricing amount is reached.
Subsequent lines subject to the global pricing will show a zero allowed amount (Example 2). This approach is most commonly used on workers’ compensation claims, as allocating a fixed percentage of the global rate can result in underpayment to a Provider if the state fee for an applicable line is less than the portion of the global rate applied to the line.

**Example 2: Global Pricing Allowed Up to the Billed Charge until Global Contracted Rate is Reached**

Provider has billed lines totaling $100 that is subject to a global rate of $70. Full billed charges are allowed on each line until the $70 rate is met. Subsequent lines show allowed amount of $0; this is because the $70 contracted rate is already accounted for in previous lines, not because these lines are denied.

<table>
<thead>
<tr>
<th>Line 1</th>
<th>Billed Charges</th>
<th>Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$50.00</td>
<td>$50.00</td>
</tr>
<tr>
<td>Line 2</td>
<td>$25.00</td>
<td>$20.00</td>
</tr>
<tr>
<td>Line 3</td>
<td>$25.00</td>
<td>$0.00</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>$100.00</strong></td>
<td><strong>$70.00</strong></td>
</tr>
</tbody>
</table>

Other distributions may also be used to ensure that line level allowed amounts add up to the correct global level pricing. When such allocations occur, OneNet Clients are instructed that individual lines where global pricing has been distributed cannot be processed separately. Remark codes on the claim indicate when individual lines of a claim-level rate cannot be processed separately.

**Complete claims**

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

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

If you have questions about submitting claims to us, please contact OneNet Customer Care.

For questions specific to electronic submission of claims, please call (866) 842-3278.

Obtain the following from the Participant:

- Name, address, date of birth and Social Security Number or Unique Identifier Number
- Primary Participant’s name, address and Social Security Number or Unique Identifier Number
- Group name and group number from the health care ID card

**Complete claims requirements**

Your claim may not be processed if you omit any of the following:

- Items identified under the *Complete claims and encounter data submissions* section of the UnitedHealthcare Guide
- Taxonomy Code (EDI Claims)
- Description of service (Paper claims)

Additional requirements for the CMS 1450 form:

- Items identified under the Additional information needed for a complete UB-04 or CMS-1450 form section the UnitedHealthcare Guide.
- When billing late charges, bill type 115 or 117 (inpatient), or 135 or 137 (outpatient), should be indicated in form locator 4 of the CMS-1450/UB-04.
- Bill all outpatient surgeries with the appropriate revenue and CPT codes if reimbursed according to ambulatory surgery groupings.
Submit all claims for professional services or facility services to OneNet on a CMS-1500 or CMS-1450/UB-04 claim form or their electronic equivalents and include all standard code sets that apply.

Participating physicians, health care practitioners, hospitals and facilities must mark all claims “OneNet PPO” (physician and health care practitioners use Box 9D on CMS-1500; hospitals and facilities use Box 9D on CMS-1500 or Box 50 on CMS-1450/UB-04).

Non-workers’ compensation claims should be sent to OneNet by EDI (see Electronic Data Interchange section of this Supplement) or mailed to the OneNet claims address listed on the Participant’s health care ID card. OneNet claims should not be submitted using UnitedHealthcare’s Connectivity Directory available at or Provider websites UnitedHealthcareOnline.com; this will cause claims to be rejected. All workers’ compensation claims should be sent directly to the applicable employer, workers’ compensation administrator or insurance carrier.

Remember to have the Participant assign the claim. This is essential for the OneNet Payer to reimburse you properly. When submitting hospital or facility claims to OneNet:

- Inpatient stays usually require prior approval from the OneNet Payer’s utilization management company and notification by the hospital by the next business day following admission to be considered for payment.

- OneNet may request copies of medical records in order to comply with audits required by external accreditation agencies, the state, OneNet Clients, or for cause. OneNet Payers and OneNet Clients may conduct independent hospital or facility claims audits and may also request copies of medical records as part of the process of ensuring quality care. You must provide medical records when requested by OneNet or OneNet Clients at no cost to OneNet, the OneNet Client, or the Participant. UnitedHealthcare’s Hospital Bill Audit Protocol does not apply to such audits or requests for medical records.

Electronic Data Interchange
OneNet can accept professional and institutional claims through our Electronic Data Interchange (EDI) program. OneNet’s Electronic Data Interchange payer code is: 52149

OneNet can accept 837 format claims through OptumInsight and other EDI clearinghouses. If you have a question about submitting using EDI, please call OneNet Customer Care at (800) 342-3289.

Be sure all EDI claims include the data indicated in the complete claim requirements listed in this Supplement.

Claim Resubmission
Allow enough time for your claims to process and check the status online before sending second submission or contacting the OneNet Client regarding payment. If you do need to submit a second submission of the same claim you have previously submitted, be sure to submit it no sooner than 45 days after original submission.

If OneNet returns a claim for additional information, the claim must be resubmitted within the time frame identified in your contract and in accordance with applicable state laws.

Claim Review Procedures
OneNet reviews claims to identify and correct coding errors. Our coding review procedures allow corrections of coding errors and coding irregularities, and facilitate consistency in our claims processing.

Claim Scanning Process
OneNet uses imaging and optical character recognition technology to efficiently handle paper claim submissions. For claims to be scanned, the claim form and any attachments must be legible and properly aligned. When a claim cannot be scanned, there is a delay in the adjudication process.

Other tips to expedite claim processing:
- Always include the Participant’s group name and number on the claim form. Do not submit a claim that only includes the Participant’s Social Security Number or Unique Identifier Number. OneNet cannot price a claim without the group number.

- OneNet claims cannot be estimated using the UnitedHealthcareOnline.com Claim Estimator. To estimate the claim pricing of a claim, please contact OneNet Customer Care. Eligibility and benefits are not considered in claim pricing estimates and are therefore not a guarantee of payment or coverage of a specific amount.
• Submit claims on a red CMS-1500 or a CMS-1450/UB-04 form, using 11 or 12 point font size and black laser jet ink.
• Do not use a highlighter on the claim form or any attachments.
• Line up forms to print in the appropriate boxes.
• Submit claims on original forms, not photocopies.
• Complete all required fields on standard claim forms.
• Make sure attachments are complete and legible.
• Make sure information such as Provider name, telephone number, NPI, and other information is accurate.
• Remember to sign and date all necessary forms; an electronic signature is acceptable.

Claim Inquiries
OneNet can only verify the receipt, pricing, and mail date of a claim from participating physicians, health care practitioners, hospitals and facilities. Other claims inquires, including those about adjudication or payment status, should be made directly to the applicable OneNet Payer or OneNet Client.

The fastest way to check for a claim pricing sheet is through UnitedHealthcareOnline.com, the Providers section of our website at onenetppo.com. The link “View Your OneNet Claim Pricing Sheets” will connect you to UnitedHealthcareOnline.com, where OneNet claims can be viewed and printed using the site’s claim status tool under Claims & Payment → Claim Status → OneNet PPO Pricing Status. Pricing sheets show the allowed amount of your claims after the application of OneNet claim pricing. Pricing sheets do not show the final claim adjudication by the OneNet Payer and may include billed charges that the OneNet Payer will determine to be ineligible or the Participant’s responsibility. Any charges that are determined ineligible or the Participant’s responsibility will be detailed on the OneNet Payer’s EOB or Remittance Advice.

If you do not have Internet access, or if you cannot find the claim information you need on our website, please call OneNet Customer Care at (800) 342-3289. Be prepared to provide the following information:

• Tax Identification Number and National Provider Identifier
• Participant Identification number, Social Security Number or Unique Identifier Number
• Date(s) of service for the claim

Please direct your inquiries about claims payment to the applicable OneNet Client. To do so, you may be asked to provide the Social Security Number (or Unique Identifier) and group number of the OneNet Participant.

Claim Appeals
OneNet claims appeals cannot be submitted for reconsideration using the UnitedHealthcareOnline.com Claim Reconsideration tool Provider website. Procedures for claim appeals with regard to OneNet claims are detailed in the following sections.

Payment Appeal Procedures
OneNet PPO is not a OneNet Payer and does not pay claims. Direct appeals regarding payment to the appropriate OneNet Client at the telephone number listed on the Participant’s health care ID card or at the contact information listed on the OneNet Client’s EOB. You may also call OneNet Customer Care for assistance identifying the appropriate client.

When resubmitting information, include all applicable documentation, including any additional information requested and a copy of the EOB.

Overpayments
All questions or refunds of overpayments should be directed to the applicable OneNet Client at the phone number listed on the OneNet Participant’s health care ID card, or contact information listed on the OneNet Client’s EOB or Remittance Advice.

If you identify a claim for which you were overpaid by a OneNet Payer, or if OneNet or one of our OneNet Payers informs you in writing or electronically of an overpaid claim that you do not dispute, you must send the OneNet Payer
the overpayment within 30 calendar days (or as required by law or your participation agreement), from the date of your identification of the overpayment or our request.

Please include appropriate documentation that outlines the overpayment, including Participant’s name, health care ID number, date of service, and amount paid. If possible, please also include a copy of the EOB that corresponds with the payment.

If you disagree with a request for an overpayment refund, you should notify the OneNet Payer in writing as to why you do not believe overpayment occurred and why a refund is not merited.

If a OneNet Participant pays you more than the amount indicated on the EOB or Remittance Advice, you are responsible for promptly refunding the difference to the OneNet Participant within 30 days of identifying the overpayment, or within applicable state and federal timeframes.

**Claim Pricing Appeals**

Send all appeals regarding claim pricing in writing to:

OneNet Appeals  
P.O. Box 934  
Frederick, MD 21705-0934  
Attention: OneNet CRA

Please include all applicable documentation, including a copy of the original claim and EOB. If appropriate, be sure to submit office/clinical notes and the corrected claim. Always include a clear explanation of the reason for the appeal. Claim pricing appeals must be submitted within 12 months of the date of the EOB, or within applicable state and federal timeframes.

**Claim Pricing Adjustments of $5.00 or Less**

OneNet strives to accurately re-price all claims, and will gladly make adjustments when a claim that has been re-priced inaccurately results in significant underpayment or overpayment for services.

To ensure administrative costs for our physicians, health care practitioners, hospital, facilities, OneNet Clients and OneNet do not exceed the amount being appealed, claim pricing that resulted in either an overpayment or underpayment of 5 dollars ($5.00) or less will not be adjusted.

**Resolving Disputes**

If you have a concern or complaint about a OneNet Client, please use your best efforts to resolve the issue directly with the OneNet Client.

If the issue is not resolved to your satisfaction, please follow the resolution processes outlined in *Resolving disputes - concern or complaint* section of the UnitedHealthcare Guide.

**Compensation**

Follow UnitedHealthcare’s protocols on Compensation with regard to care provided to OneNet Participants with the following exceptions:

- Under processes for Charging Customers for non-covered services, in cases where you know services may not be covered, the Participant’s written consent should include a statement that the OneNet Payer has determined the services are not covered and the Participant, with knowledge of the Payer’s determination, agrees to be responsible for those charges.

- Coverage of services is determined by the Participant’s health plan. OneNet Client health plans may cover services that are not covered under UnitedHealthcare health plans, and vice versa. Always confirm benefits and eligibility directly with the OneNet Payer.

- Under processes related to Customer financial responsibility, you may request estimates for treatment for OneNet Participants by contacting OneNet Customer Care. The online Claim Estimator available on UnitedHealthcareOnline.com cannot be used to estimate OneNet claims. Likewise, OneNet claims cannot be submitted for real time processing through our website the claim submission feature on UnitedHealthcareOnline.com.
• With regard to Hospital Audit Services, OneNet or OneNet Clients may conduct their own reasonable audits of hospital claims and may follow their own procedures, subject to mutual agreement of the OneNet Client and the audited facility. These procedures may vary from those of UnitedHealthcare’s Hospital Audit Service Department. OneNet Payers must pay the claims first before requesting an audit.

**Clinical Care Coordination (Utilization Management)**

OneNet Clients use the services of different UM firms for clinical care coordination services. These can include third party UM services, or the OneNet Client’s own internal capabilities.

You are required to use your best efforts to comply with the UM guidelines of the OneNet Clients. Make sure you understand the required guidelines by calling the utilization management telephone number on the Participant’s health care ID card.

UM programs may require prior approval for planned or elective hospital admissions and durable medical equipment, and/or medical necessity approval for certain designated procedures and services. Obtaining this approval is not a guarantee of payment.

You should recommend physicians, health care practitioners, and facilities within the OneNet network to OneNet Participants. Always check the Participant’s health care ID card for the number to call for UM approvals.

In non-emergency situations, follow this checklist before hospitalizing any OneNet Participant:

• Determine whether the services require hospitalization or if they can be performed on an outpatient basis. Some OneNet Clients may require prior approval for outpatient surgery.

• Check for applicable UM requirements by calling the UM telephone number or benefit and eligibility number listed on the Participant’s health care ID card.

• If you are unable to recommend a OneNet participating provider, please ask the Participant their preference before suggesting a non-participating physician, health care practitioner, hospital or facility, as the Participant may be responsible for a greater share of the costs when non-participating providers are used.

When calling the utilization management company for approval, have the following information available:

• Primary Participant and/or patient name, Social Security Number or Unique Identifier Number

• Group name and number

• Admitting physician’s telephone number and physician Tax ID number and/or NPI

• Name of the hospital and the expected admission date

• Diagnosis or reason for admission

• Planned surgery or other procedures

• Clinical information related to the proposed procedure

• Additional information may be required for some procedures

While you are required to use your best efforts to comply with the UM guidelines of OneNet Clients, it is ultimately the obligation of the Participant to follow UM guidelines established by the health benefits plan. If the Participant fails to do so and a financial non-compliance penalty applies, you may seek payment directly from the Participant.

**UnitedHealthcare Health Management and Quality Management Programs**

The following exceptions apply to the Health Management and Quality Management Program Information section of the UnitedHealthcare Guide in how they apply to OneNet and OneNet Participants:

• UnitedHealthcare Complex Case and Disease Management programs do not apply to OneNet, unless the OneNet Client has arranged to access these programs through a separate agreement with UnitedHealthcare.

• Programs described under Additional Care, Wellness and Behavioral Health Programs do not apply to OneNet unless the OneNet Client has arranged to access these programs through a separate agreement with UnitedHealthcare.

• OneNet directories may not display UnitedHealth Premium Designation Program indicators, and OneNet Participant experience is not included in Premium Designation evaluations.
• OneNet Participant information should not be reported to the UnitedHealthcare Cancer Registry.

• OneNet encourages the use of the Clinical and Preventive Health Guidelines published by UnitedHealthcare when treating OneNet Participants.

• OneNet encourages the use of resources available at UnitedHealthcareOnline.com related to depression, alcohol and drug abuse and addiction and attention deficit hyperactivity disorder.

• Contact the OneNet Client to confirm benefits if you would like to arrange a psychiatric consultation for a Participant in a medical bed. Please use your best efforts to obtain a consultation from a behavioral health physician or health care professional that participates in the OneNet network or the Participant’s behavioral health network, if any.

**Coordination of Benefits**

If a OneNet Payer is a secondary payer under state or federal regulations, the OneNet Payer’s obligation (subject to any adjustments due to the contract or benefit plan) is limited to the amount by which the OneNet contracted amount exceeds the amount paid by the primary payer. It is the responsibility of the physician, health care practitioner, hospital or facility to obtain payment from the primary payer. When billing the primary payer, if the primary payer is not a OneNet Payer, the physician, health care practitioner, hospital or facility is not limited by the OneNet contracted amount. The OneNet Payer is not required to pay its portion of the claim until an EOB is received from the primary payer.

**OneNet General Administrative Requirements**

OneNet providers follow the general administrative requirements provided in the UnitedHealthcare Guide with the noted exceptions:

• When arranging substitute care, participating providers can go to onenetppo.com for a current directory of OneNet participating physicians, health care practitioners, hospitals and facilities.

• As part of transitions under continuity of Customer Care, participating providers should notify current patients who are OneNet Participants of an effective date of termination of their participation agreement at least 30 calendar days prior, or as required under applicable laws. OneNet does not maintain Participant names and addresses and cannot notify Participants on your behalf.

• A copy of current OneNet Participant Rights and Responsibilities, which vary from UnitedHealthcare’s Customer Rights and Responsibilities, can be obtained by calling OneNet Customer Care.

• OneNet does not produce benefit materials for OneNet Participants and cannot inform OneNet Participants of state laws on advance directives.

• Requirements regarding Access to Records extend to OneNet.
Oxford Commercial Supplement

Important Information Regarding the Use of this Supplement
This Supplement applies to all covered services which you provide to Customers insured by or receiving administrative services from UnitedHealthcare Oxford. Oxford offers Commercial Products under the names of Freedom, Liberty, Metro, and Garden State, as follows:

- Freedom products are offered in Connecticut, New Jersey and New York
- Liberty products are offered in New Jersey and New York
- Metro Products are only offered in the New York state counties of: Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester. The service area is limited to those New York State counties listed (except for emergency services).
- Garden State Products are only offered in New Jersey. The service area is limited to New Jersey (except for emergency services).

For services provided to Customers enrolled in the UnitedHealthcare Medicare Advantage plans offered under the AARP® MedicareComplete®, AARP® MedicareComplete® Mosaic, and UnitedHealthcare Medicare Advantage brands on the Oxford Health Plan platform, please refer to the UnitedHealthcare Administrative Guide located previous to this Supplement.

For important contact information see the How to contact Oxford Commercial section that follows. They include telephone and fax numbers, as well as websites and mailing addresses.

The term “Prior Authorization” referenced in this Supplement is also referred to as “Precertification”. You will notice both terms used throughout this Supplement, both are the same.

Medical and administrative policies
A complete library of Oxford’s Clinical, Administrative and Reimbursement Policies is available for your reference at OxfordHealth.com → Providers or Facilities → Tools & Resources → Medical Information → Medical and Administrative Policies → Medical & Administrative Policy Index. You can also request a paper copy of a Clinical, Administrative or Reimbursement Policy by writing to:

Oxford Policy Requests and Information
4 Research Drive
Shelton, CT 06484

Policy Update Bulletin
Oxford publishes monthly editions of the “Policy Update Bulletin”, a user-friendly online resource that provides notice to our network physicians and facilities of any changes to our Clinical, Administrative and Reimbursement Policies. The Policy Update Bulletin is posted on the first calendar day of every month and is accessible online at OxfordHealth.com → Providers → Tools & Resources → Medical Information → Medical and Administrative Policies → Policy Update Bulletin. As a supplemental reminder to the detailed policy update summaries announced in the Policy Update Bulletin, a list of recently approved, revised and/or retired Clinical, Administrative and Reimbursement Policies is also provided in the monthly Network Bulletin available at UnitedHealthcareOnline.com → Quick Links → Network Bulletin.
# How to contact Oxford Commercial

## Contact information and resources

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<td><strong>Administrative Appeals</strong></td>
<td>Mail: UnitedHealthcare Grievance Review Board P.O. Box 29134 Hot Springs, AR 71903</td>
<td>• File an appeal on a claim determination</td>
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<td><strong>Voice Portal</strong></td>
<td>Phone: (800) 666-1353 In most cases, you will be required to enter the physician’s or facility’s Oxford Provider ID number. Online: For a Quick Reference guide, go to OxfordHealth.com ➔ Providers or Facilities ➔ Tools &amp; Resources ➔ Administrative Tools &amp; Information ➔ Voice Portal Quick Reference.</td>
<td>• Check patient eligibility and benefits • Submit referrals • Check the status of referrals and Prior Authorization requests • Check the status of claims</td>
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<td><strong>Behavioral Health Department</strong></td>
<td>Phone: (800) 201-6991</td>
<td>• Prior Authorization for services • Obtain referrals for mental health and substance abuse services</td>
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<tr>
<td><strong>Cardiac Catheterization Prior Authorization</strong></td>
<td>Phone: (877) PREAUTH / (877) 773-2884 (Mon - Fri., 7 a.m. to 7 p.m. ET) Online: CareCoreNational.com 24 hours a day 7 days a week Medical policy: OxfordHealth.com ➔ Medical and Administrative Policies ➔ Cardiology Procedures Requiring Precertification for eviCore Healthcare Arrangement</td>
<td>• Request Prior Authorization</td>
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<tr>
<td><strong>Cardiology Utilization Review/Medical Necessity Review</strong></td>
<td>Phone: (877) PREAUTH / (877) 773-2884 (Mon - Fri., 7 a.m. to 7 p.m. ET) Online: CareCoreNational.com 24 hours a day 7 days a week Medical policy: OxfordHealth.com ➔ Provider ➔ Tools &amp; Resources ➔ Medical Information ➔ Medical and Administrative Policies ➔ Medical &amp; Administrative Policy Index ➔ Cardiology Procedures Requiring Precertification for eviCore Healthcare Arrangement</td>
<td>• Request Utilization/Medical Necessity review • Check procedures requiring Prior Authorization</td>
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<tr>
<td><strong>Centers for Disease Control (CDC) National AIDS hotline</strong></td>
<td>Phone: (800) 232-4636</td>
<td>• Anonymous counseling and HIV testing program information</td>
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<tr>
<td><strong>Chiropractic Services — OptumHealth</strong></td>
<td>Provider Services/Claims Phone: (800) 985-3293 Online: myoptumhealthphysicalhealth.com</td>
<td>• Physician claim/authorization questions as well as: • Inquiries about claims status, claims payment, authorization status, first level appeals • Submit Prior Authorization requests</td>
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<td><strong>Claim submission</strong></td>
<td>Electronic Claims: Commercial Claims Payer ID: 061111 Online: Learn more on OxfordHealth.com ➔ Providers or Facilities ➔ Tools &amp; Resources ➔ Administrative Tools &amp; Information ➔ Electronic Data Interchange (EDI) You can also visit post-n-track.com ➔ Customers ➔ Providers, to learn about a free submission tool that doesn’t require practice management software. Paper Claims: UnitedHealthcare Attn: Claims Department P.O. Box 29130 Hot Springs, AR 71903</td>
<td>• Submit claims electronically or on paper • Learn about electronic data interchange (EDI)</td>
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<td><strong>Claim Corrections &amp; Reconsiderations</strong></td>
<td>EDI: Submit facility claim corrections electronically. Online: Use the Claim Reconsideration application on Link Paper: <a href="http://OxfordHealth.com">OxfordHealth.com</a> ➞ Providers or Facilities ➞ Tools &amp; Resources ➞ Network Information ➞ Forms • Claim Review Request (1-19 claims) • Claim Research Project (20 or more claims) • New Jersey Provider Claim Appeal Form</td>
<td>• Submit corrected claims and reconsideration requests</td>
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<tr>
<td><strong>Claim status</strong></td>
<td>Online: <a href="http://OxfordHealth.com">OxfordHealth.com</a> ➞ Providers or Facilities ➞ Transactions ➞ Check ➞ Claims. Electronic Data Interchange (EDI) Use your vendor or clearinghouse. Voice Portal and Provider Services: (800) 666-1353 and say “Claims” when prompted You can speak with a representative (Mon – Fri., 8 a.m. to 6 p.m. ET)</td>
<td>• Check claim status • Print an Explanation of Benefits (EOB)/ remittance advice online</td>
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<tr>
<td><strong>Clinical, Administrative and Reimbursement Policies</strong></td>
<td>Online: <a href="http://OxfordHealth.com">OxfordHealth.com</a> ➞ Providers or Facilities ➞ Tools &amp; Resources ➞ Medical Information ➞ Medical and Administrative Policies ➞ Medical &amp; Administrative Policy Index.</td>
<td>• Access the Medical &amp; Administrative Policy Index • View the monthly Policy Update Bulletin</td>
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<tr>
<td><strong>Clinical Appeals</strong></td>
<td>Fax (877) 220-7537 Mail: Oxford Clinical Appeals Department P.O. Box 29139 Hot Springs, AR 71903</td>
<td>• Submit appeal requests</td>
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<td><strong>Clinical Services Department</strong></td>
<td>Phone: (800) 666-1353 (Mon – Fri., 8 a.m. – 6 p.m. ET)</td>
<td>• Medical directors are available to discuss their decisions with you.</td>
</tr>
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<td><strong>Credentialing and Recredentialing (Member of the Council for Affordable Quality Healthcare (CAQH))</strong></td>
<td>Phone: United Voice Portal at (877) 842-3210 Online: <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a> ➞ Tools &amp; Resources ➞ Policies, Protocols and Guides ➞ Credentialing &amp; Recredentialing Plan. New Jersey only: Online: <a href="http://state.nj.us/health">state.nj.us/health</a> or <a href="http://caqh.org/cred">caqh.org/cred</a> Phone: Provider Services at (800) 666-1353 or CAQH Support at (888) 599-1771</td>
<td>• Review the information submitted to support your credentialing application; • To correct erroneous information; and • Check on status of your credentialing or recredentialing application</td>
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<td><strong>Crisis Intervention Hotline – Connecticut</strong></td>
<td>Phone: (800) 203-1234</td>
<td>• Provides referrals to all Connecticut local hotlines and resources.</td>
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<tr>
<td><strong>Crisis Intervention Hotline – New Jersey</strong></td>
<td>Phone: within New Jersey (800) 624-2377</td>
<td>• Available 24 hours a day, 7 days a week, toll-free phone number is only accessible when calling from New Jersey</td>
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<td><strong>Crisis Intervention Hotline – New York</strong></td>
<td>State of New York and New York City information: (800) 541-2437 Spanish/bilingual information: (800) 233-7432 TTY/TDD (for the hearing-impaired): (800) 369-2437 Department of Health Testing Hotline: (800) 825-5448</td>
<td>• Pretesting counseling is conducted over the phone, and appointments are made for callers at testing centers throughout the 5 boroughs • This service is linked to a crisis intervention hotline</td>
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<tr>
<td><strong>Echocardiogram and Stress Echocardiogram</strong></td>
<td>Phone: (877) PREAUTH / (877) 773-2884 (Mon - Fri., 7 a.m. to 7 p.m. ET) Fax: (888) 622-7369 Online: <a href="http://CareCoreNational.com">CareCoreNational.com</a> 24 hours a day 7 days a week Medical policy: <a href="http://OxfordHealth.com">OxfordHealth.com</a> ➞ Medical and Administrative Policies ➞ Cardiology Procedures Requiring Precertification for eviCore Healthcare Arrangement</td>
<td>• Request Prior Authorization for cardiology procedures • Check procedures requiring Prior Authorization</td>
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<td>**Electronic Payments &amp;</td>
<td>Information and Enrollment:  WelcometoEPS.com</td>
<td>• Learn about our solution for electronic funds transfer (EFT) and electronic remittance advice (ERA).</td>
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<td>Statements (EPS)</td>
<td>Refer to the UnitedHealthcare Admin Guide for information about Virtual Card Payments (VCP)</td>
<td>• Enroll in EPS.</td>
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<td></td>
<td>Logon: Optumhealthfinancial.com → Customer Login → Health Care Professional → Log in</td>
<td>• Access online explanation of benefits (EOBs)/remittance advice, 835 files and information about direct deposit payments.</td>
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<td>Helpdesk: (866) 842-3278, Option 5</td>
<td>• Call for questions about EPS.</td>
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<td><strong>Electronic Data Interchange</strong></td>
<td>Payer ID: 06111&lt;br&gt;EDI Support: &lt;br&gt;Phone: (800) 599-4334 or UnitedHealthcareOnline.com → Contact Us → Electronic Data Interchange (EDI) Claims → EDI Transaction Support Form.</td>
<td>• Call or submit online form for questions or to resolve problems with your practice management vendor/clearinghouse or for help understanding your electronic claims tracking reports.</td>
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<td>(EDI)</td>
<td>Online Information: &lt;br&gt;OxfordHealth.com → Providers or Facilities → Tools &amp; Resources → Administrative Tools &amp; Information → Electronic Data Interchange UnitedHealthcareOnline.com → Tools &amp; Resources → EDI Education for Electronic Transactions.</td>
<td>• Learn about the benefits of electronic transactions and submission options:&lt;br&gt; › Claim Submission (837)&lt;br&gt; › Eligibility Benefit Inquiry &amp; Response (270/271)&lt;br&gt; › Claim Status Request &amp; Response (276/277)&lt;br&gt; › Admission Notification (278N)&lt;br&gt; › Authorization and Notification Inquiries (278I)&lt;br&gt; › Pre-Authorization and Advance Notifications (278A)&lt;br&gt; › Electronic Remittance Advice (835)&lt;br&gt; • Obtain Payer IDs for UnitedHealthcare, Affiliates, and Strategic Alliances.&lt;br&gt; • Access companion guides.</td>
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<td><strong>Eligibility and Benefits</strong></td>
<td>Online: OxfordHealth.com → Providers or Facilities → Transactions → Check → Eligibility and Benefits. &lt;br&gt;Electronic Data Interchange (EDI): Use your vendor or clearinghouse. &lt;br&gt;Voice Portal and Provider Services: (800) 666-1353 (Say “Benefits and Eligibility” when prompted.) You can speak with a representative (Mon - Fri., 8 a.m. to 6 p.m. ET.)</td>
<td>• Check patient eligibility and benefits</td>
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<td><strong>Fraud Hotline</strong></td>
<td>Phone: (866) 242-7727</td>
<td>• Report fraudulent activity</td>
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<td><strong>HIPAA compliance and security</strong></td>
<td>Online: uhnational.com → HIPAA and EDI → security</td>
<td>• Standards on confidentiality of electronic records&lt;br&gt; • Examples of safeguard areas</td>
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<td>**Infertility Services –</td>
<td>Phone: (877) 512-9340&lt;br&gt;Fax: (855) 536-0491</td>
<td>• Prior Authorization for all outpatient services</td>
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<td>OptumHealth**</td>
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<td><strong>Inpatient admission</strong></td>
<td>Online: OxfordHealth.com → Providers or Facilities → Transactions → Submit → Precert Requests &lt;br&gt;Electronic Data Interchange (EDI) Phone: (800) 666-1353 &lt;br&gt;Fax: (800) 303-9902</td>
<td>• Submit Admission Notifications and Prior Authorization requests</td>
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| Inpatient and Outpatient-Clinical Services    | Phone: (800) 666-1353                                                      | • Inpatient admissions and Outpatient procedures  
• Services for which review is delegated in whole or in part to a vendor, including eviCore Healthcare, OrthoNet and OptumHealth Care Solutions  
• Urgent services or Prior Authorization requested on a retroactive basis  
• Requests for clinical trial, experimental treatment, new technology, or a therapeutic abortion |
| Intensity Modulated Radiation Therapy(IMRT)   | Fax: (888) 242-9058 Phone: (800) 747-1446 Ext: 65212                     | • Fax completed IMRT form for Prior Authorization for services                                                                                                                                                           |
| Internal appeals-Claims payment disputes      | Forms: OxfordHealth.com ➔ Providers or Facilities ➔ Tools & Resources ➔ Network Information ➔ Forms  
• Claim(s) Review Request (1-19 claims)  
• Claims Research Project (20 or more claims)  
• New Jersey Provider Claim Appeal Form | • Dispute the payment of a claim                                                                                                                                                                                       |
| Laboratory information: Laboratory Corporation of America (LabCorp) Client services | Locate participating laboratories by:  
Phone: Patient service center locator number for Customers (888) LABCORP (522-2677)  
• North New Jersey (800) 223-0631  
• South New Jersey (800) 633-5221  
• New York (800) 223-0631  
• Connecticut (800) 631-5250  
Online: OxfordHealth.com ➔ Providers or Facilities ➔ Search ➔ Laboratories | • List of available laboratories  
• Inventory of patient service centers                                                                                                                                                                                |
| Customer Appeals (Commercial Products)       | OxfordHealth.com ➔ Providers or Facilities ➔ Tools & Resources ➔ Network Information ➔ Forms  
• Claim(s) Review Request Form  
• Member Authorization for a Designated Representative | • File appeal on Customer's behalf                                                                                                                                                                                      |
| Medical Necessity Appeals Commercial Products | Mail: Oxford Clinical Appeals Department P.O. Box 29139 Hot Springs, AR 71903 | • File a standard medical necessity appeal                                                                                                                                                                              |
| Network Bulletin                              | View or sign up to receive the bulletin via email.  
Online: OxfordHealth.com ➔ Tools & Resources ➔ Network Information ➔ Network Bulletin | • Important information on Oxford protocol and policy changes is included in the Affiliates section of this monthly online publication.                                                                                     |
| Oxford On-Call® (Urgent and non-urgent care)  | Phone: (800) 201-4911                                                      | • Available 24 hours a day, 365 days a year  
• Staffed by registered nurses  
• Assistance for urgent and non-urgent medical problems recommend an appropriate site of care                                                                                                                                 |
| Pharmacy customer service                     | Phone: (800) 788-4863 TTY/TDD: (800) 498-5428  
Available 24 hours per day, 7 days per week including holidays | • Obtain information pertaining to prescription benefits                                                                                                                                                                   |
| Pharmacy Prior Authorization                  | Phone: (800) 711-4555  
Available 24 hours per day, 7 days per week including holidays | • Obtain medication Prior Authorization for Customers                                                                                                                                                                  |
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| Physical and occupational therapy | Provider services: (877) 369-7564  
Online: myoptumhealthphysicalhealth.com | • Obtain new Patient Summary Forms  
• Submit initial and follow-up Patient Summary  
• Physician authorization questions  
• Utilization review  
• Inquire about authorizations, Network Exceptions, First Level UM Appeals |
| Physical and occupational therapy – OptumHealth Claims Submission and Inquiry | For claims submitted electronically: Payer ID 06111  
For paper claims, please mail to:  
UnitedHealthcare  
Attn: Claims Department  
P.O. Box 29130  
Hot Springs, AR 71903  
Claims inquiry: (800) 666-1353 | • Check claim status  
• Submit claims |
| Prescription Mail Order | OptumRx  
P.O. Box 2975  
Mission, KS 66201 | • 90-day supply of certain medications |
| Primary Care or Specialist physician change | Phone: Member Customer Service: (800) 444-6222  
Online: OxfordHealth.com ➔ Members ➔ Find a Physician or Facility | • Customers can change primary care physician |
| Prior Authorization Submission | Phone: Provider Services (800) 666-1353 (Mon - Fri., 8 a.m. - 6 p.m. ET)  
Online: OxfordHealth.com ➔ Providers or Facilities ➔ Transactions ➔ Submit ➔ Precert Requests  
Fax: You may submit our form, which can be found on OxfordHealth.com ➔ Providers or Facilities ➔ Tools & Resources ➔ Network Information ➔ Forms  
Electronic Data Interchange (EDI): Use your vendor or clearinghouse | • Submit Prior Authorization requests |
| Prior Authorization Verification | Phone: Provider Services or Voice Portal:  
(800) 666-1353 (Mon - Fri., 8 a.m. - 6 p.m. ET)  
Say “Precertification” when prompted.  
Online: OxfordHealth.com ➔ Providers or Facilities ➔ Transactions ➔ Check ➔ Precert Status. Electronic Data Interchange (EDI) | • Verify Prior Authorization status |
| Quality Management Programs | Online: OxfordHealth.com ➔ Tools & Resources ➔ Network Information ➔ Network Bulletin. | • Oxford Quality Management Program information is included in this monthly Network Bulletin publication |
| Radiology and Radiation Therapy Prior Authorization | Phone: (877) PREAUTH/(877) 773-2884) (Mon - Fri., 7 a.m. to 7 p.m. ET)  
Online: CareCoreNational.com 24 hours a day 7 days a week  
Medical policy: OxfordHealth.com ➔ Providers or Facilities ➔ Tools & Resources ➔ Medical Information ➔ Radiology & Radiation Therapy Information. | • Request Prior Authorization for radiology and radiation therapy procedures  
• Check procedures requiring Prior Authorization |
| Radiology and Radiation Therapy Utilization Review, Medical Necessity Review | Phone: (877) PREAUTH/(877) 773-2884 (Mon - Fri., 7 a.m. to 7 p.m. ET)  
Online: CareCoreNational.com 24 hours a day 7 days a week  
Medical policy: OxfordHealth.com Tools & Resources ➔ Medical Information ➔ Radiology & Radiation Procedures Therapy Information | • Request Utilization/Medical Necessity review |
| Referral Submission | Online: OxfordHealth.com ➔ Providers ➔ Transactions ➔ Submit Referrals.  
Phone: Provider Services or Voice Portal: (800) 666-1353 (Mon - Fri., 8 a.m. - 6 p.m. ET) Say "referral" when prompted.  
Electronic Data Interchange (EDI): Use your clearinghouse or vendor | • Submit referral requests |
### Commercial Products

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| **Referral Verification** | Online: OxfordHealth.com ➔ Providers ➔ Transactions ➔ Check Referrals  
Phone: Provider Services or Voice Portal: (800) 666-1353 (Mon - Fri., 8 a.m. - 6 p.m. ET). Say “referral” when prompted.  
Electronic Data Interchange (EDI): Use your clearinghouse or vendor | • Verify referral status  
• Note: Submitted referrals are available immediately for inquiry; this includes those submitted electronically and those initiated by Oxford On-Call*. |
| **Roster of Participating Physicians, Other Health Care Professionals and Facilities** | Phone: (800) 666-1353  
Online: OxfordHealth.com ➔ Providers or Facilities ➔ Search:  
  • Doctor  
  • Hospital  
  • Laboratories | • Locate a participating PCP, Specialist or facility  
• Note: PCPs who have contracted with us as Specialists may provide specialty care services to their patients on a network basis. |
| **Second Level Customer Appeals** | Mail: UnitedHealthcare Grievance Review Board  
P.O. Box 29134  
Hot Springs, AR 71903 | • File a second level Customer appeal |
| **Termination Requests** | Phone: (800) 666-1353  
Physicians and other Healthcare professionals  
Mail: UnitedHealthcare Network Contract Support  
Mail Route: TX023-1000  
1311 W President George Bush Highway, Suite 100  
Richardson, TX 75080-9870  
Behavioral health providers only: Phone: (877) 614-0484 | • Hospital and Ancillary termination requests please refer to the address in your contract for termination notice.  
• Both will treat termination notices as “received” on the third business day after they are sent |
| **Website Commercial** | OxfordHealth.com  
Registration for physicians:  
Go to OxfordHealth.com ➔ Providers ➔ Need to Register? and fill in the requested information (including SSN/TIN and physician date of birth)  
Registration for facilities:  
You can start the process online or call our Web Help Desk at (800) 811-0881.  
Assistance:  
For step-by-step instructions to using our website transactions, go to OxfordHealth.com ➔ Providers or Facilities ➔ Tools & Resources ➔ Administrative Tools & Information ➔ OxfordHealth.com Quick Reference  
View the schedule of instructor-led webcast training sessions at UnitedHealthcareOnline.com ➔ Quick Links ➔ Training & Education ➔ OxfordHealth.com Overview  
Web Help Desk at: (800) 811-0881 | • Determine whether a CPT code requires Prior Authorization (up to 12 codes at one time)  
• Submit and check referrals (physicians only) and Prior Authorization  
• Check claim status and print an Explanation of Benefits (EOB)/remittance advice  
• Submit notifications of inpatient admissions (facilities only)  
• Check patient benefits and eligibility  
• Change your address (physicians only), email, username, password, and referral fax number  
• Keep apprised of news in the Messages section  
• Request materials  
• Search for a physician, laboratory or hospital  
• View radiology and laboratory program information  
• View our prescription drug information  
• View our medical and administrative policies  
• View our clinical and preventive practice guidelines  
• View our disease management initiatives |

### Customer Eligibility and Benefits

**Customer health care identification (ID) cards**

Each Customer is given a health care ID card that is for identification only and does not establish eligibility for coverage. The Customer should present his/her card when requesting any type of covered health care service. We suggest that
each time you check a Customer’s health care ID card; you also request a photo identification to minimize any risk of an unauthorized use of the Customer’s card.

For more detailed information on ID cards and to see a sample health care ID card, please refer to the Commercial health care ID card section of this guide.

Confirming eligibility and benefits
Checking the Customer’s eligibility and benefits prior to rendering services will ensure that you submit the claim to the correct payer, allow you to collect copayments, determine if a referral is required and reduce denials for non-coverage. To check eligibility and benefits, use any of the following methods:

- **Online**: OxfordHealth.com → Providers or Facilities → Transactions → Check → Eligibility and Benefits.
- **Provider Services or Voice Portal**: Call (800) 666-1353, and say “benefits and eligibility” when prompted. (Mon. - Fri., 8 a.m. - 6 p.m. ET).
- **Electronic Data Interchange (EDI)**

For additional assistance with Web, Voice Portal and EDI solutions, please refer to OxfordHealth.com → Providers or Facilities → Tools & Resources → Administrative Tools & Information. There you will find quick reference guides and instructions to assist you.

Oxford Commercial Product Overview
Oxford offers Commercial products that can be either gated or non-gated products as described below.

**Gated products** – These are products in which all covered services* performed by network Physicians and/or other network Health Care Professionals, other than those covered services performed by the Customer’s PCP or OB/GYN, require: (a) a referral from the Customer’s PCP to a network Provider; or (b) Prior Authorization from the plan, obtained by the Customer’s PCP, approving a network exception,** for the Customer to receive covered services from an out-of-network provider at the Customer’s network level of benefits. Customers of gated plans will have “In-Network Referral Required” printed on the back of their health care ID card.

- For gated plans with network only benefits, covered services obtained without the required referral or in-network exception* will be denied.
- For gated plans with out-of-network benefits, covered services obtained without the required referral or in-network exception* will be covered, but subject to the Customer’s out-of-network benefits and cost sharing requirements.

**Non-gated plans** – These are plans in which all covered services* performed by network Physicians and/or other network Health Care Professionals do not require a referral from the Customer’s PCP to a network Provider, but do require Prior Authorization from the plan, obtained by the Customer’s PCP, approving an in-network exception,** for the Customer to receive covered services from an out-of-network provider at the Customer’s network level of benefits. Customers of non-gated plans will have “No Referral Required” printed on the back of their health care ID card.

- For non-gated plans with network only benefits, covered services obtained from an out-of-network provider without an approved in-network exception will be denied.
- For non-gated plans with out-of-network benefits, covered services obtained from an out-of-network provider without an approved in-network exception will be covered, but subject to the Customer’s out-of-network benefits and cost sharing requirements.

Determining the primary payer among Commercial plans
When a Customer has more than one Commercial health insurance policy, primacy is determined based upon model regulations established by the National Association of Insurance Commissioners (NAIC).

1. **COB provision rule**: The plan without a COB provision is primary.

2. **Dependent/non-dependent rule**: The plan that covers the individual as an employee, Customer or subscriber or retiree is primary over the plan that covers the individual as a dependent.

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* Emergency services and urgent care services never require a PCP referral or Prior Authorization.

** Please see Referrals and Prior Authorization section for additional. Information regarding the in-network exception process for circumstances where the plan does not have an network Provider available to provide covered services to a Customer.
3. **Birthday rule:** The “birthday rule” applies to dependent children covered by parents who are not separated or divorced. The coverage of the parent whose birthday falls first in the calendar year is the primary carrier for the dependent(s).

4. **Custody/divorce decree rule:** If the parents are divorced or separated, the terms of a court decree will determine which plan is primary.

5. **Active or inactive coverage rule:** The plan that covers an individual as an employee (not laid off or retired) or as that employee’s dependent is primary over the plan covering that same individual as a laid off or retired employee or as that employee’s dependent.

6. **Longer/shorter length of coverage rule:** If the preceding rules do not determine the order of benefits, the plan that has covered the person for the longer period of time is primary.

### Coordinating with Medicare plans

We will coordinate benefits for Customers who are Medicare beneficiaries according to federal Medicare program guidelines.

We have primary responsibility if the Customer is:

- 65 or older, actively working and his/her coverage is sponsored by an employer with 20 or more employees;
- Disabled, actively working and his/her coverage is sponsored by an employer with 100 or more employees; or
- Eligible for Medicare due to end stage renal disease (ESRD) and services are within 33 months of the first date of dialysis.

### Customer Rights and Responsibilities

For the entire list of Customer Rights and Responsibilities, go to OxfordHealth.com → Providers (or Facilities) → Tools & Resources → Medical Information → Medical and Administrative Policies → Managed Care Act Disclosure Materials → Member Handbook.

### PCP selection

All HMO products require Customers to select a PCP to provide primary care services and coordinate the Customer’s overall care. In addition, female Customers may also select an obstetrician/gynecologist (OB/GYN) whom that female Customer may see without a referral from her PCP.

Selection - Customers can only select a PCP within their network (e.g., a Liberty PlanSM Customer must select a Liberty Network participating PCP).

### Newly enrolled Customers who may need transitional care or continuity of care

When a new Customer enrolls with us, the Customer may qualify for coverage of transitional care services rendered by his/her non-participating physicians or other health care professionals. If the Customer has a life-threatening disease or condition, or a degenerative and disabling disease or condition, the transitional care period is 60 days.

If the Customer has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include the provision of postpartum care directly related to the delivery. Treatment by the non-participating physician or other health care professional must be determined to be medically necessary by our Medical Director. Transitional care is available only if the physician or other health care professional agrees to accept as payment our negotiated fees for such services. Further, the physician or other health care professional must agree to adhere to all of our Quality Management procedures as well as all other policies and procedures required by us regarding the delivery of covered services.

For more information about transitional care, Customers may call Customer Service at (800) 444-6222.

### Referrals and Prior Authorization

**Referral policies and guidelines**

Our physician contracts require referrals be issued to participating physicians and other health care professionals within the applicable network of providers available to the Member, for Customers with gated plans. The only exceptions to this are cases of emergency or when there are no participating physicians or other health care professionals who can treat
the Customer’s condition. If you would like to direct a Customer to non-participating physicians and other health care professionals, you must request an in-network exception from our Clinical Services department and receive approval before the service is rendered. If the Customer requests to see a Specialist and is unable to reach his/her PCP or OB/GYN (after-hours, weekends or holidays), the PCP may issue a referral up to 72 hours after services have been received.

**Note:** Participating Oxford Specialists can only issue referrals for certain types of covered services as outlined in the grid below:

<table>
<thead>
<tr>
<th>Provider Specialty</th>
<th>Referrals may be submitted for:</th>
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<tbody>
<tr>
<td>Any Participating Oxford Specialist</td>
<td>Any diagnostic procedure</td>
</tr>
<tr>
<td>A Participating Oxford PCP, General Surgeon, Gynecological Oncologist, Hematologist-Oncologist, Neurologist, Oncologist, Orthopedists, Pain Management Specialist, Physiatrist, Neurosurgeon, Rheumatologist, Chiropractor</td>
<td>Any diagnostic procedure, as well as therapeutic services, such as physical and occupational therapy</td>
</tr>
<tr>
<td>Pediatric General Surgeons, Pediatric Gynecological Oncologists, Pediatric Hematologist-Oncologists, Pediatric Neurologists, Oncologists, Pediatric Orthopedists, Pediatric Physiatrists, Pediatric Neurosurgeons, and Pediatric Rheumatologists</td>
<td>All Specialist care</td>
</tr>
</tbody>
</table>

A referral should be made only when, in your professional opinion, you believe it is medically appropriate and necessary. If you have:

- An existing provider/customer relationship and the Customer requests a referral and you believe the referral is appropriate, a referral may be generated without seeing the Customer. This is done entirely at your discretion.
- Never seen the patient before, you have the right to ask the patient to come in for an examination and diagnosis before issuing a referral. If you do not examine the patient on the day you issue a referral, you may not charge for any evaluation and management service at that time.

Referrals are issued for a defined time period and for a maximum quantity of services, as defined by you, the referring physician. Unless otherwise specified by you or the applicable Member certificate, a referral is valid for 1 visit within 180 days (6 months) of the date the referral was issued. The maximum number of visits for which a referral can be generated is 30 visits within 180 days (6 months). If more visits are necessary within this timeframe, another referral must be generated unless a standing referral has been approved (see below).

**Submitting and verifying referrals**

A PCP or OB/GYN can issue a referral to participating physicians and other health care professionals online, through our automated telephone system or through an electronic data interchange (EDI) vendor. Once the referral is entered, the referring physician or other health care professional will receive a reference number. For a complete list of submission and verification methods, please refer to the How to contact Oxford Commercial list in the beginning of this Supplement.

**Automated fax notification**

Upon submission of a referral, a fax will be sent to the referred-to-physician or other health care professional, usually within 24 hours of the submission. This fax serves as a confirmation notice of the referral.

**Note:** Physicians and other health care professionals have the option to update their referral fax number or decline the auto-fax notification feature on our website in the My Account section.

**Standing referrals**

Standing referrals to a participating Specialist or ancillary provider may be requested if a Customer requires ongoing Specialist treatment, has a life-threatening condition or disease, or a degenerative and disabling condition or disease. This referral is available only if the condition or disease requires specialized medical care over a prolonged period of time. Further, the participating Specialist or ancillary provider must have the necessary medical expertise and be properly accredited or designated (as required by state or federal law or a voluntary national health organization) to provide the medically necessary care required for the treatment of the condition or disease. The services to be provided will be covered only to the extent they are otherwise covered by the Customer’s Certificate of Coverage.

Our Medical Director will consult with the Customer’s PCP, and the participating Specialist or ancillary provider to determine if such a referral is appropriate. The referral will be provided pursuant to a treatment plan that will be developed
by the participating Specialist or ancillary provider and approved by our Medical Director. The Customer, PCP or participating network Specialist may call Clinical Services and request a standing referral.

**Medically necessary services**
Medically necessary services are services or supplies provided by a hospital, skilled nursing facility, physician or other health care professional which are required to identify or treat a Customer’s illness or injury, as determined by our Medical director. These services or supplies must be:

- Consistent with the symptoms or diagnosis and treatment of a Customer’s condition;
- Appropriate with regard to standards of good medical practice;
- Not solely for the Customer’s convenience or that of any physician or other health care professional; and
- The most appropriate supply or level of service which can safely be provided. For inpatient services, it further means that the Customer’s condition cannot safely be diagnosed or treated on an outpatient basis.

**Prior Authorization or Notification**
Prior Authorization should be submitted as far in advance of the planned service as possible to allow for review. Prior Authorization is required at least 14 business days prior to the planned service date (unless otherwise specified within the Prior Authorization List).

- Obstetrical admissions for normal delivery should be authorized as early as possible in the course of prenatal care, based on the expected date of delivery.
- Participating physicians and other health care professionals and facilities are responsible for contacting us for:
  - All procedures requiring Prior Authorization; however, an active referral* must also be on file for services to be covered in-network, depending on the Customer’s benefits.
  - Any change of treating physician or other health care professional, CPT codes or dates of service for the authorized service.
  - All Customer emergency admissions upon admission or on the day of admission. If the physician/facility is unable to determine on the day of admission that the patient is our Customer, the physician/facility will notify us as soon as possible after discovering that the patient has coverage with us.
- Participating physicians and other health care professionals will be notified of all determinations involving New York Customers by phone and in writing. All participating physicians and other health care professionals are responsible for calling the Customer the same day that the provider receives notification of our determination.
- Neither Prior Authorization nor referral is required for Customers to access a participating women’s health Specialist for routine and preventive health care services. Women’s health Specialists include, but are not limited, to gynecologists and/or certified nurse midwives. Routine and preventive health care services include breast exams, mammograms, and Pap tests.
- Customers are responsible for notifying us of emergency facility admissions to a non-participating facility.
- We may require that a Customer see a physician or other health care professional, selected by us, for a second opinion. We reserve the right to seek a second opinion for any surgical procedure; there is no formal list of procedures requiring second opinions; Customers may also seek a second opinion when appropriate.

**Determining services that require Prior Authorization**
1. You can log on to OxfordHealth.com to use the Precert Required Inquiry tool on the Transactions tab to check Prior Authorization requirements for up to 12 CPT codes at one time.
2. For a list of services requiring Prior Authorization, refer to OxfordHealth.com → Providers or Facilities → Tools & Resources → Medical Information → Medical and Administrative Policies → Medical &Administrative Policy Index → Services Requiring Prior Authorization.
A copy of the most current list can also be obtained by sending a written request to:

Oxford Policy Requests and Information
4 Research Drive
Shelton, CT 06484

Changes to the policies appearing on this list are announced at OxfordHealth.com → Providers or Facilities → Tools & Resources → Medical Information → Medical and Administrative Policies → Policy Update Bulletin (published monthly).

- Certain services may not be covered within an individual Customer’s benefit plan, regardless of whether Advance Notification is required.*
- In the event of a conflict or inconsistency between applicable regulations and the notification requirements in this Supplement, the notification process will be administered in accordance with applicable regulations.
- Prior Authorization requirements may differ by individual physicians, health care professionals and ancillary provider and facility. If additional Prior Authorization requirements apply, the physician or other health care professional will be notified in advance of the Prior Authorization rules being applied.

**Prescription medications requiring Prior Authorization**

Based on the Customer’s benefit plan design, select high-risk or high-cost medications may require advance notification in order to be eligible for coverage. This process is also known as Prior Authorization and requires that you submit a formal request and receive advance approval for coverage of certain prescription medications.

The list of prescription medications (including generic equivalents, if available) that require Prior Authorization is available for your reference at OxfordHealth.com → Providers or Facilities → Tools & Resources → Medical Information → Prescription Drug Information → Drugs Requiring Precertification.

**Prior Authorization and referral guidelines when coordinating benefits**

When it is determined that we are the secondary or tertiary carrier, normal requirements for Prior Authorization and referrals are modified as follows:

- Referral and Prior Authorization guidelines will be waived, deferring to the requirements of the primary carrier.
  
  **Note:** Other requirements are not waived (e.g., itemized bills, student verification, consent for Behavioral Health exchange, etc.).

- Exception: Referral and Prior Authorization guidelines will apply:
  - If the primary carrier does not cover a service or applies an authorization penalty.
  - When a motor vehicle accident or workers’ compensation is involved.

**Submitting and verifying Prior Authorization requests**

We recommend that physicians and other health care professionals perform a precertification status check first to determine if there is already a Prior Authorization on file. For a complete list of submission and verification methods, please refer to the How to contact Oxford Commercial list in the beginning of this Supplement.

**Using non-participating physicians, other health care professionals or facilities**

As a participating physician or other health care professional, you are required to utilize participating physicians, other health care professionals and facilities within the network (i.e., Liberty Network) applicable to the Customer’s plan. We have implemented a compliance program to identify participating physicians and other health care professionals who regularly use physicians and other health care professionals and facilities that do not participate in our network, and will take the appropriate measures to enforce compliance.

If you would like to direct a Customer to a non-participating physician or other health care professional because there are no participating physicians or other health care professionals able to perform the specific service in the area, then the PCP is responsible for obtaining Prior Authorization for an in-network exception on behalf of the Customer by calling (800) 666-1353. A referral cannot be made to a non-participating provider without our approval.

* Not required when a Customer is seeing their designated participating OB/GYN.
If a Customer asks you for a recommendation to a non-participating physician or other health care professional, you must tell the Customer that you may not refer to a non-participating provider, and the Customer must contact us to obtain the required Prior Authorization. The Customer may obtain all required Prior Authorizations by calling (800) 444-6222.

If you contact us for authorization to perform a non-emergency procedure at a non-participating facility for a Customer who has out-of-network benefits, the procedure will be authorized as out-of-network.

- This means that the reimbursement to the non-participating facility will be subject to the Customer’s out-of-network deductible and coinsurance obligations. Also, the non-participating facility’s charges are only eligible for coverage up to the reimbursement levels available under the Customer’s plan, using either a usual, customary and reasonable (UCR) fee schedule, or a Medicare reimbursement system (called the Out-of-Network Reimbursement Amount for our New York Customers).
- Customers will be responsible for paying their out-of-pocket cost as well as the difference between the UCR fee or other out-of-network reimbursement and the non-participating facility’s billed charges. Please remind the Customer that his/her expenses may be significantly higher when using a non-participating provider.

If you contact us for authorization to perform a non-emergency procedure at a non-participating facility on a Customer who does not have out-of-network benefits (HMO and EPO plan Customers), the services will be denied.

**Note:** Exceptions may be considered upon request only when our Medical Director determines in advance that our network does not have an appropriate participating network physician or other health care professional who can deliver the necessary care.

### Participating Gastroenterologists Using Non-Participating Anesthesiologists In-Office (New York Only)

Many of our participating gastroenterologists are performing endoscopy procedures with anesthesia in the office setting with the assistance of a non-participating anesthesiologist. While in-office endoscopy can be convenient for both physicians and patients, and can help promote high-quality, cost-effective care, the use of non-participating anesthesia providers often results in higher costs and financial liability for Customers.

Therefore, all non-emergent procedures being performed with anesthesia in the office setting in New York, including endoscopy and surgical suites, must be performed using a participating anesthesiologist unless:

1. After discussing a Customer’s referral options with them in advance of the service, the Customer explicitly agrees to receive services from a non-participating anesthesiologist by marking the appropriate box and signing Oxford’s Non-Participating Provider Consent Form and understands that the use of this provider will be out-of-network (OON).
   - For Customers with OON benefits, these non-participating anesthesiologist claims will be paid at the OON benefit level. OON cost shares and deductibles will apply.
   - For Customers with no OON benefits, there is no coverage for services provided by nonparticipating providers and Customer’s will therefore be responsible for the entire cost of the service, OR

2. An in-network exception has been requested and approved at least 14 days in advance of the service.

Providers are required to keep a signed copy of the Non-Participating Provider Consent Form on file in order to provide to us upon request. If the participating gastroenterologist cannot provide the signed Non-Participating Provider Consent Form, within 15 days of the request, we will administratively deny the participating gastroenterologist claim. Any payment previously made for the gastroenterology service will be subject to recovery. The participating gastroenterologist cannot balance bill the Customer for claims denied for administrative reasons.

For additional details and copies of the Non-Participating Provider Consent Form, please refer to the complete policy, at OxfordHealth.com → Providers → Tools & Resources → Medical Information → Medical and Administrative Policies → Medical & Administrative Policy Index → Participating Gastroenterologists Utilizing Non-Participating Anesthesiologists for In-Office Procedures.
Participating Mastectomy Surgeon Using a Non-Participating Breast Reconstruction Surgeon (New York Products Only)

If a participating mastectomy surgeon is recommending the use of a non-participating breast reconstruction surgeon (including but not limited to plastic surgeons, assistant surgeons, etc.), for a reconstruction that is being performed within the same surgical or different operative session as the mastectomy, prior to making a recommendation or scheduling services the participating mastectomy surgeon is required to:

1. **Verbally discuss options and financial impact with the Customer.** The discussion must explain participating and non-participating alternatives, provide the Customer with an understanding of all the providers involved in the Customer’s care (e.g.; plastic surgeon, assistant surgeon, etc.) and include a conversation explaining the financial impact of using a non-participating provider.

2. **Obtain a completed Non-Participating Provider Consent Form.** The Customer will need to either agree or disagree to receive out of network services, by signing, dating and returning the Non-Participating Provider Consent Form no less than 14 days before the scheduled date of the procedure.

3. **Coordinate the Customer’s care as directed by the Customer in the Non-Participating Provider Consent Form** (including, but not limited to, using a Participating breast reconstruction surgeon, plastic surgeons, assistant surgeons, etc., In-Network Exceptions and/or claim appeals).

You are required to keep a signed copy of the Non-Participating Provider Consent Form on file in order to provide to us upon request. If you cannot provide the signed Non-Participating Provider Consent Form within 15 days of the request, we will administratively deny your mastectomy surgery claim for failure to comply with this protocol. Any payment previously made for the mastectomy surgery service will be subject to recovery. You are prohibited from balance billing the Customer for claims denied for administrative reasons.

For additional details and/or to obtain a copy of the Non-Participating Provider Consent Form, refer to the complete policy at OxfordHealth.com → Providers → Tools & Resources → Medical Information → Medical and Administrative Policies → Medical & Administrative Policy Index → In-Network Exceptions for Breast Reconstruction Surgery Following Mastectomy.

**Urgent Care, Emergencies, Hospitalization, Inpatient, Outpatient and Behavioral Health Care Services**

**Urgent Care**

Urgent care is medical care for a condition that needs immediate attention to minimize severity and prevent complications but is not a medical emergency and does not otherwise fall under the definition of emergency care as defined below.

**Definition of a medical emergency**

**Emergency condition**

**Connecticut:** An “emergency condition” is defined as medical or behavioral condition, that manifests itself by symptoms of sufficient severity, including severe pain, and the absence of immediate medical attention to result in (i) placing the health of such person, or others in serious jeopardy, or (ii) serious impairment to such person’s bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; or (iv) serious disfigurement of such person.

**New Jersey:** An “emergency condition” is defined as a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse, and the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to affect a safe transfer of the woman or unborn child to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

**New York:** An “emergency condition” is defined as a medical or behavioral condition, that manifests itself by acute symptoms of sufficient severity, including severe pain, and the absence of immediate medical attention to result in (i) placing the health of such person, or others in serious jeopardy, or (ii) serious impairment to such person’s bodily functions; or (iii) serious dysfunction of any bodily organ or part of such person; (iv) serious disfigurement of such person; or a condition described in section 1867 (e)(1)(A) of the Social Security Act.
Emergency admission review
If your patient is admitted to a hospital as a result of an emergency (as defined above), we will review the hospital admission for medical necessity and determine the appropriate length of stay based on our approved criteria for concurrent review. Review begins when we become aware of the admission.

We must be notified of all emergency inpatient admissions (no later than 48 hours from the date of admission, or as soon as reasonably possible). If the Customer is admitted to a contracted hospital, we will use reasonable efforts to transmit a decision about the admission to the hospital (to the fax number and contact person designated by the hospital) within 24 hours of making the decision.

Emergency room visits
• Emergency room visits during which a patient is treated and released without admission do not require notice to us.
• If an ambulatory surgery occurs as a result of an emergency room or urgent care visit, the provider must also notify us within 24-48 hours of when the surgery is performed. Any and all follow-up needs related to such emergency services should be coordinated through the Customer’s PCP and are subject to the standard referral process.
• When a patient is unstable and not capable of providing coverage information, the facility should submit the concurrent authorization as soon as the information is known and communicate the extenuating circumstances.

In-area emergency services
You do not need to provide notification or obtain Authorization for in-area emergency room treatment and subsequent release. However, all emergency inpatient admissions and emergency outpatient admissions (i.e., for emergent ambulatory surgery, etc.) do require notification upon admission or on the day of admission (no later than 48 hours from the date of admission, or as soon as reasonably possible).

Out-of-area emergency services
Out-of-area coverage for emergency room (ER) services are limited to care for accidental injury, unanticipated emergency illness or other emergency conditions when circumstances prevent a Customer from using ER services within our service area.

Coverage
We cover emergency room services for medical emergencies. The Customer is responsible for paying the applicable copayment. Follow-up emergency room visits within our service areas are not covered. However, follow-up care, if appropriate, should be coordinated through the Customer’s PCP and is subject to the standard referral process.

Non-emergency hospitalization
Any hospitalization service that does not meet the criteria for an emergency or for urgent care requires Prior Authorization and is subject to medical necessity review.

Inpatient Maternity Stay and Subsequent Home Nursing
It is crucial that the Customer, or the Customer’s physician or other health care professional, notify us of a pregnancy as early as possible to ensure the proper application of benefits. Oxford abides by state mandates regarding the length of an inpatient maternity stay and the coverage of subsequent home nursing visits. Regulations vary by state as outlined below.

Inpatient Maternity Length of Stay
Oxford will cover inpatient maternity stays for both mother and newborn as follows:
• 48 hours following a vaginal delivery
• 96 hours following a cesarean delivery.

Post-Discharge Home Nursing Visits
• Connecticut: Oxford will approve two (2) home nursing visits if both mother and newborn are discharged before the mandated length of stay (48 hours following vaginal delivery and 96 hours following Cesarean delivery).
• New Jersey and New York Plans: Oxford will approve one (1) home nursing visit if both mother and newborn are discharged before the mandated length of stay (48 hours following vaginal delivery and 96 hours following Cesarean delivery).
Non-emergency maternity admissions should be authorized. Newborn coverage varies from plan to plan and state to state. For additional details, refer to OxfordHealth.com → Providers or Facilities → Transactions → Check Eligibility & Benefits.

**Hospital services, admissions and inpatient and outpatient procedures**

Facilities are responsible for providing Admission Notification and obtaining Prior Authorization (where applicable) for the following types of inpatient admissions:

- All planned/elective admissions for acute care
- All unplanned admissions for acute care (Admission Notification Only)
- All Skilled Nursing Facility (SNF) admissions
- All admissions following outpatient surgery and observation
- All newborns admitted to Neonatal Intensive Care Unit (NICU) and who remain hospitalized after the mother is discharged.
- Prior Authorization by the facility is required even if Prior Authorization was supplied by the physician and a pre-service approval is on file.

Physicians, health care professionals and ancillary providers are responsible for obtaining Prior Authorization for outpatient surgical and major diagnostic testing performed in an outpatient clinic or any ambulatory or freestanding surgical or diagnostic facility.

**Inpatient hospital copayment**

State regulations for Commercial plans determine when a Customer should be charged for subsequent inpatient hospital copayment(s) when readmitted into an inpatient setting. According to state laws, inpatient hospital copayments must be based on a “per continuous confinement” basis.

**Concurrent Review: Clinical Information**

Upon admission, Clinical Services will accept concurrent review information provided by the admitting physician or other health care professional and/or the hospital's Utilization Review department. Furthermore, if not already submitted, the hospital will provide us with the discharge plan on the day of admission. If a patient requires an extended length of stay or additional consultations, please call our Clinical Services department at (800) 666-1353 to update the Prior Authorization.

- For Behavioral Health, all calls related to inpatient Prior Authorization should be directed to (800) 201-6991.
- You must cooperate with all requests for information, documents or discussions for purposes of concurrent review and discharge. When available, provide clinical information via access to Electronic Medical Records (EMR).
- You must cooperate with all requests from the inpatient care management team and/or medical director to engage our Customers directly face-to-face or telephonically.
- You must return/respond to inquiries from our inpatient care management team and/or medical director. You must provide complete clinical information and/or documents as required within 4 hours if our request is received before 1:00 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1:00 p.m. local time (but no later than 12:00 p.m. the next business day).
- Oxford uses MCG™ Care Guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings.

**Neonatal Intensive Care Unit (NICU) level of care**

NICU bed levels are based on the intensity of services and identifiable interventions received by the neonate. The NICU bed levels of care are linked to a revenue code that is defined by the National Uniform Billing Committee. We will assign NICU levels for those facilities contracted with more than one level of NICU. Claims reimbursement is based on the pay codes and Bed Types (levels of care per contract).
**Hospital responsibilities**

The hospital is required to notify us of:

- Newborns admitted to Neonatal Intensive Care Unit (NICU) and who remain hospitalized after the mother is discharged.
- Concurrent inpatient stays (notification prior to discharge).
- Any patient that changes level of care. The Customer must be enrolled and effective with us on the date the service(s) are rendered. However, if CMS or an employer or group retroactively disenrolls the Customer up to 90 days following the date of service, then we may deny or reverse the claim.

The hospital must also:

- Provide daily inpatient census log by 10:00 a.m.; the daily inpatient census log will reflect all admits and discharges through midnight the day prior.
- Provide notification of all admissions of our Customers at the time of, or prior to, admission; the hospital must notify us of all emergencies (upon admission or on the day of admission); the hospital must also notify us of “rollovers” (i.e., any patient who is admitted immediately upon receiving a preauthorized outpatient service).
- Obtain Prior Authorization for any transfer admissions of Customers prior to the transfer unless the transfer is due to life-threatening medical emergency.
- Communicate necessary clinical information on a daily basis, or as requested by our Case Manager, at a specified hour that allows for timely generation of our End of Day Report (EDR).
- Verify the accuracy of the admission and discharge dates for our Customers listed on the EDR.

If the hospital does not provide the necessary clinical information, the day will be denied and reconsideration will be given only if clinical information is received within 48 hours (72 hours for New Jersey facilities).

If we conduct on-site utilization review, the hospital will provide our on-site utilization management personnel reasonable workspace and access to the hospital, including access to Customers and their medical records. It is the responsibility of all physicians and other health care professionals to deliver letters of non-coverage to the Customer before discharge; this includes hospitals, acute rehabilitation, skilled nursing facilities, and home care.

**Note:** Appeals will be considered if the hospital can demonstrate that the necessary clinical information was provided within 48 hours, but we failed to respond in a timely manner.

**Retrospective review of inpatient stays (notification of admission after discharge)**

Customers - Upon request from us, the hospital will provide the necessary clinical information to perform a medical necessity review within 45 days of discharge. If the hospital does not provide the necessary clinical information, the day will be denied and reconsideration will only be given if clinical information is received within 48 hours (72 hours for New Jersey Customers).

**Electronic Medical Records (EMR)**

EMR is any type of electronic concurrent medical information management system. This process improves efficiency and quality inpatient care through integrated decision support which allows for better information storage, retrieval and data sharing capabilities. EMR systems allow physicians, nurses and other health care staff to be able to access and share information smoothly and quickly, to enable them to work more efficiently and make better quality decisions.

**Our responsibilities**

- We will maintain a system for verifying Customer eligibility/status and use reasonable efforts to transmit a decision regarding an emergency/urgent admission to the hospital.
- We will request any necessary clinical information; failure by us to seek such information will result in our liability for that day’s services.
- We also agree to provide concurrent and prospective certification for all services via a daily EDR when the hospital provides timely necessary clinical information.
• We will assign a first day of review (FDOR) for all elective inpatient services, and all days up to and including the FDOR will be certified; coverage decisions for the next day will be given on the EDR.

• We will notify the hospital and attending physician or other health care professional either verbally or in writing of all denied days.

• We will perform clinical review of days that fall on the weekends and holidays for which we or the facility is closed, and days upon which there are unforeseen interruptions in business on the following business day; such reviews will be considered concurrent.

Note: We will not deny services retrospectively or reduce the level of payment for services that have been preauthorized or received concurrent review approval unless:

• The Customer is retroactively disenrolled.

• The certification or concurrent review approval was based on materially erroneous information.

• The services are not provided in accordance with the proposed plan of care.

• Hospital delays in providing an approved service to prolong the length of stay beyond what was approved.

Clinical process definitions

Acute hospital day
An acute hospital day (AHD) is any day when the severity of illness (clinical instability) and/or the intensity of service are sufficiently high and care cannot reasonably be provided safely in another setting.

Alternative level of care (ALC)*
We will determine that an inpatient ALC applies in any of the following scenarios:

• An acute clinical situation has stabilized.

• The intensity of services required can be provided at less than an acute level of care.

• An identified skilled nursing and/or skilled rehabilitative service is medically indicated.

• ALC is prescribed by the Customer’s physician or other health care professional.

• Inpatient ALC must meet the following criteria:**
  › The skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists are required; and
  › Such services must be provided directly by or under the general supervision of those skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

New technology
New technology refers to a service, product, device, or drug that is new to our service area or region. Any new technology must be reviewed and approved for coverage by the Medical Technology Assessment Committee or the Clinical Technology Assessment Committee for Behavioral Health technologies.

Potentially avoidable days
A potentially avoidable day (PAD) arises in the course of an inpatient stay when, for reasons not related to medical necessity, a delay in rendering a necessary service results in prolonging the hospital stay. PADs must be followed by a medically necessary service. There are several types of PADs:

• Approved potentially avoidable day (AOPAD): We caused delay in service; the day will be payable.

• Approved physician or other health care professional potentially avoidable day (APPAD): The physician or other health care professional caused delay in service; the day will be payable.

* ALC only applies if the facility has a contracted rate.

** Inpatient ALC must meet clinical criteria per clinical guidelines. Failure to satisfy these criteria can result in denial of coverage.
• **Approved mixed potentially avoidable day (AMPAD):** A delay due to mixed causes not solely attributable to us, the physician, other health care professional, or the hospital; the day will be payable.

• **Denied hospital potentially avoidable day (DHPAD):** The hospital caused the delay in service; DHPAD is a non-certification code, and the day is not payable.

We will not reverse any certified day unless the decision to certify was based on erroneous information supplied by the physician or other health care professional, or a potentially avoidable day was identified.

**Re-admissions**

When a Customer is readmitted to the hospital for the same clinical condition or diagnosis within 30 days of discharge, the second hospital admission will not be reimbursed when any of the following conditions apply:

- The Customer was admitted for surgery, but surgery was canceled due to an operating room scheduling problem.
- A particular surgical team was not available during the first admission.
- There was a delay in obtaining a specific piece of equipment.
- A pregnant woman was readmitted within 24 hours and delivered.
- The Customer was admitted for elective treatment for a particular condition, but the treatment for that condition was not provided during the admission because another condition that could have been detected and corrected on an outpatient basis prior to the admission made the treatment medically inappropriate.

In any of the situations noted above, the hospital cannot bill the Customer for any portion of the covered services not paid for by us.

**Diagnosis-related group (DRG) hospitals**

DRG is a statistical system of classifying an inpatient stay into groups of specific procedures or treatments. When a hospital contracts for a full DRG, we will reimburse the hospital a specific amount (determined by the contract) based on the billed DRG rather than paying a per diem or daily rate (DRG facility). A DRG is determined after the Customer has been discharged from the hospital.

When admission information is received through our website, we will consider this to be notification only; first day approval will not be granted to hospitals with a DRG contract. When we receive notification of an admission to a hospital with a DRG contract, our Case Manager will review the admission for appropriateness. If the Case Manager cannot make a determination based on the admitting diagnosis, the Case Manager will request an initial review to determine whether the admission is medically necessary. The hospital is required to provide admission notification and a daily inpatient census of all our Customers.

**Prepayment DRG validation program**

We may request a DRG hospital to send the inpatient medical record prior to claim payment so we may validate the submitted codes. After review of all available medical information, the claim will be paid based on the codes that have been substantiated following review of the medical record. See Payment Appeals section of this Supplement for Appeal Rights.

Hospital records may be requested to validate ICD-10-CM or its successor codes and/or revenue codes billed by participating facilities for inpatient hospital claims. If the billed ICD-10-CM codes (or successor codes) or revenue codes are not substantiated, the claim will be paid only with the codes that are validated.

**Disposition determination**

A disposition determination is a technical term describing a process of care determination that results in payment as agreed at specific contracted rates, and is designed to eliminate certain areas of contention among participating parties and allow processing of claims. Specific instances where a disposition determination may apply:

- Delay in hospital stay
- APPAD/AMPAD when so contracted
- ALC determinations when so contracted, unless there is a separate ALC rate
- Discharge delays that prolong the hospital stay under a case rate
Late and no notification
Late notification is defined as notification of a hospital admission after the contracted 48-hour notification period and prior to discharge. No notification is defined as failure to notify us of a Customer's admission to a hospital after discharge, up to and including at the time of submitting the claim.

Behavioral health care services
The Behavioral Health (BEH) department specializes in the management of mental health and substance abuse treatments. The department consists of a Medical Director who is licensed in psychiatry, facility care advocates (licensed RNs and licensed/certified social workers) and Behavioral Health intake staff who collectively handle certification, referrals and case management for our Customers.

We encourage coordination of care between our participating behavioral health physicians and primary care physicians as the best way to achieve effective and appropriate treatment. For this purpose, we developed a Release of Information (ROI) form that is designed to facilitate Customer consent and to share information with the PCP in the presence of his/her behavioral health physician. See the How to contact Oxford Commercial section for telephone numbers.

Clinical definitions and guidelines
The BEH department uses OptumHealth’s Level of Care guidelines when determining the medical necessity of inpatient psychiatric, partial hospitalization substance abuse treatment and rehabilitation, and outpatient mental health treatment. For a complete list of programs and detailed information on the level of care guidelines, please visit Optum’s website at providerexpress.com.

Inpatient mental health
A mental health condition is defined as justifying inpatient (or acute) care when it involves a sudden and quickly developing clinical situation characterized by a high level of distress and uncertainty of outcome without intervention.

Partial hospitalization - mental health
Partial hospitalization for mental health treatment is defined as day treatment of a psychiatric disorder at a hospital or ancillary facility with the following criteria:

- The primary diagnosis is psychiatric.
- The facility is licensed and accredited to provide such services.
- The duration of each treatment is 4 or more hours per day.

Residential treatment
Residential treatment services are provided in a facility or a freestanding residential treatment center that provides overnight mental health services for Customers who do not require acute inpatient care but who do require 24-hour structure. This benefit is subject to Prior Authorization and ongoing medical necessity reviews.

Outpatient mental health
A psychotherapeutic outpatient treatment is defined as a range of approaches for the treatment of mental and emotional disorders that include methods from different theoretical orientations (i.e., psychodynamic, behavioral, cognitive, and interpersonal) and may be administered to an individual, family or group.

Inpatient detoxification
Inpatient detoxification is defined as the treatment of substance dependence to prevent a life-threatening withdrawal syndrome, provided on an inpatient basis.

Outpatient substance abuse rehabilitation
Outpatient substance abuse rehabilitation is defined as the treatment of substance abuse or dependence at an accredited, licensed substance abuse facility.

Certification for mental health, substance abuse and detoxification treatment

Inpatient care
All inpatient behavioral health treatment requires Prior Authorization.
Partial hospitalization
Partial hospitalization always requires certification through the BEH department. If clinical criteria are met, the Case Manager will facilitate certification and management at a contracted facility with a partial hospitalization program; the Case Manager will continue to follow the Customer’s treatment while he or she is in the program.

Prior Authorization Outpatient mental health services (New York Only)
Covered services are those received on an outpatient basis from duly licensed psychiatrists or practicing psychologists, certified social workers, or a facility issued operating certificate by the commissioner of mental health, a facility operated by the office of mental health, a professional corporation or university faculty practice corporation including:

- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Crisis intervention

Coverage will be provided to the maximum number of visits shown on the Customer’s Summary of Benefits.

Inpatient mental health services (New York Only)
Covered services are received on an inpatient or partial hospitalization basis in a facility as defined by subdivision 10 of section 1.03 of the mental hygiene law, as well as by any other network physician or other health care professional we deem appropriate to provide the medically necessary level of care.

If an inpatient stay is required, it is covered on a semiprivate room basis. If partial hospitalization is authorized two partial hospitalization visits may be substituted for one inpatient day. Coverage will be provided for active treatment to the maximum number of days shown on the Customer’s Summary of Benefits.

Note: Visits for biologically based services will count toward this limit. Active treatment means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meet standards prescribed pursuant to the regulations of the commissioner of mental health.

Ancillary Services
Our network of laboratory service providers consists of an extensive selection of walk-in patient service centers, many regional and local laboratories and a national provider of laboratory services, Laboratory Corporation of America (LabCorp). Quest Diagnostics is a non-participating laboratory.

Outpatient laboratory policies and procedures
It is important that you refer your patients to participating service centers and laboratories to help them avoid unnecessary costs. Referrals are not required (only a physician’s prescription or lab order form is required).

We review laboratory ordering information periodically, if our data shows a pattern of out-of-network utilization for your practice, we will contact you to share this information and engage you to utilize the contracted network.

Participating Provider Laboratory & Pathology Protocol (New York Products Only)
Specific guidelines must be followed if you are recommending the use of, making a referral to, or involving a non-participating laboratory or pathologist in a Customer’s care. This includes the following:

- Specimens collected in your office for processing by a non-participating provider (on and off-site).
- Providing the Customer with a requisition form, prescription or other form to obtain laboratory or pathology services outside of your office.

Prior to making the recommendation, involving, or referring a Customer to a non-participating laboratory or pathologist, you are required to:

1. **Verbally discuss options and financial impact with the Customer.** The discussion must explain participating and non-participating alternatives and the reason for any referral to a non-participating laboratory or pathologist. The discussion must also include a conversation explaining the financial impact of using a non-participating provider.
2. Obtain a Completed Laboratory & Pathology Services Consent Form. The Customer will need to either agree or disagree to the use of an out of network laboratory or pathologist by signing and dating the Laboratory & Pathology Services Consent Form.

3. Coordinate the Customer’s Care as Directed by the Customer in the Laboratory & Pathology Services Consent Form.

You are required to keep a signed copy of the Laboratory & Pathology Services Consent Form on file in order to provide to us upon request. If you cannot provide the signed Laboratory & Pathology Services Consent Form within 15 days of the request, the Evaluation & Management (E&M) code from the office visit which generated the non-participating laboratory or pathology referral will be reversed and denied administratively for failure to comply with this protocol. Any payment previously made for the service will be subject to recovery. You are prohibited from balance billing the Customer for claims denied for administrative reasons.

For additional details and/or to obtain a copy of the Non-Participating Provider Consent Form, refer to the complete policy at OxfordHealth.com: Providers → Tools & Resources → Medical Information → Medical and Administrative Policies → Medical & Administrative Policy Index → New York Participating Provider Laboratory & Pathology Protocol.

In-office laboratory testing and procedures list
The in-office laboratory testing and procedure list outlines the laboratory procedural/testing codes that will be reimbursed to network physicians when performed in the office setting. For the most up-to-date list, refer to: OxfordHealth.com: Providers → Tools & Resources → Medical Information → Medical and Administrative Policies → In-Office Laboratory Testing List. Lab procedures/tests not appearing on this list must be performed by one of the participating laboratories in our network. See the How to contact Oxford Commercial section for contact information.

Specimen handling and venipuncture:
A physician’s prescription or lab order form is required when using participating laboratories to process specimen. If specimen handling and venipuncture codes are billed in conjunction with a lab code on the in-office Laboratory Testing and Procedures List, only the lab and venipuncture codes will be reimbursed.

If specimen handling and venipuncture codes are billed without a lab code on our In-Office Laboratory Testing and Procedures List or with other non-laboratory services, the specimen handling and venipuncture codes will be paid per our fee schedule.

Outpatient Radiology Procedures
The outpatient imaging self-referral policy is designed to promote appropriate use of diagnostic imaging by PCPs, specialty physicians and other health care professionals in the office and outpatient setting.

Oxford also requires a minimum accreditation and certification requirements for ultrasound, echocardiography and nuclear medicine studies. The outpatient imaging self-referral policy does not apply to radiology services performed during an inpatient stay, ambulatory surgery, urgent care, emergency room visit, or pre-operative/pre-admission testing. See the How to contact Oxford Commercial section for contact information.

The outpatient imaging self-referral list is applicable to Commercial plans (excluding Oxford USA Plans).

Imaging requiring Prior Authorization
The referring physician is responsible for contacting eviCore Healthcare to request Prior Authorization and to provide sufficient history to demonstrate the appropriateness of the requested services. Our policy does not permit Prior Authorization requests from persons or entities other than referring physicians.

Radiology Prior Authorization policy for urgent cases
It is the imaging facility’s responsibility to confirm that an Authorization number has been issued prior to providing a service. In the case of urgent examinations, or in cases in which, in the opinion of the attending physician or other health care professional, a change is required from the authorized examination, and the eviCore Healthcare offices are unavailable, the services may be performed, and you may request a new or modified Authorization number. Requests must be made within 2 business days of the date of service through the Imaging Care Management department for Radiology and 15 days for Cardiac Catheterization. If the eviCore Healthcare offices are available, the request should be
made immediately. Clinical justification for the request will be reviewed using the same criteria as a routine request. See the *How to contact Oxford Commercial* section for additional information.

**Prior Authorization online**

eviCore Healthcare provides a secure, interactive web-based program where Prior Authorization requests can be initiated and determined in real time. If medical necessity is demonstrated during this process an Authorization number will be issued immediately. If medical necessity is not demonstrated through the online process, physicians may submit additional information at the conclusion of the session and print a procedure request summary page. Requests for an Authorization that do not meet medical necessity criteria online are forwarded for clinical review and additional information may be requested by eviCore Healthcare for medical necessity review with a Medical Director.

In the event that criteria has not been met the physician’s office as well as the Customer will be notified in writing of the denial. Log into evicore.com and the automated system will guide you through a series of prompts to collect routine demographic and clinical data. This eliminates the need for a call to eviCore Healthcare and allows you to enter multiple clinical certification requests at your convenience.

**Radiology and Cardiology utilization review process**

The utilization review process involves matching the patient clinical history and diagnostic information with the approved criteria for each imaging procedure requested. Utilization review decisions are made by qualified health professionals including board certified radiologists and board certified cardiologists for cardiac based diagnostic procedures. Data collection for clinical certification of imaging services may be assigned to non-medical personnel working under the direction of qualified health professionals. You will receive communication of review determinations for non-urgent care by fax/telephone within 2 business days of receiving all the necessary information. Communication received for a determination involving an urgent request is given within 24 hours of the receipt of information necessary to make a medical necessity determination.

For Customers, requests for retrospective clinical certification review of medically urgent care are accepted up to 2 business days after the care has been given for Radiology and 15 days for Cardiac Catheterization, if the services are performed outside eviCore Healthcare’s hours of operation and rendered on an urgent basis. Retrospective review decisions are made within 30 business days of receiving all of the necessary information. If your request is not authorized, the review determination will be sent in writing to the Customer and the requesting physician within 5 business days of the decision. All authorization reference numbers are issued at the time of approval. eviCore Healthcare uses the reference CPT code as the last 5 digits of the authorization number. We require the submission of clinical office notes for specific procedures. Clinical notes include the patient’s medical record and/or letters received from Specialists.

**Cardiac Catheterization Procedures**

For Oxford products, there is a Prior Authorization and medical necessity review program for all outpatient Cardiac Catheterizations and Echocardiology studies. Prior Authorization is managed through eviCore Healthcare. Our policy does not permit Prior Authorization requests from persons or entities other than referring physicians.

Prior Authorization is required for Customers with an Oxford product for Echocardiogram and Stress Echocardiogram. CPT codes 93303, 93304, 93306, 93307, 93308, 93350 and 93351 are subject to this protocol. See *How to contact Oxford Commercial* section for phone and web contact information.

**Radiation Therapy Procedures**

**Radiation therapy and Radiation utilization review of Oxford products**

For Oxford products, there is a Prior Authorization and medical necessity review program for all outpatient radiation therapy services. Radiation therapy Prior Authorization is managed through eviCore Healthcare. Our policy does not permit Prior Authorization requests from persons or entities other than referring physicians and Radiation oncologists. See *How to contact Oxford Commercial* section for phone and web contact information.

The following radiation therapy treatments require Prior Authorization through eviCore Healthcare for Oxford products:

- Ionizing radiation
- Brachytherapy
- Conventional external beam radiation therapy (CRT)
• Three-dimensional conformal radiation therapy (3D CRT)
• Intensity modulated radiation therapy (IMRT)
• Image-guided radiation therapy (IGRT)
• Proton beam therapy (PBT)
• Stereotactic radiosurgery (SRS)
• Other emerging therapies that use ionizing radiation to treat cancer such as hyperthermia and neutron beam therapy

For Oxford products, the rendering radiation therapist’s office is required to request Prior Authorization and, guided by the Physician Worksheets, provide sufficient information to determine the medical necessity of the requested services. If a treating physician does not obtain an Authorization number from eviCore Healthcare for a radiation therapy course of treatment, corresponding claims may not be reimbursed.

Oxford has engaged eviCore Healthcare to perform initial reviews of requests for Prior Authorization and medical necessity reviews. Oxford continues to be responsible for decisions to limit or deny coverage and for appeals.

All Prior Authorization requests are handled by eviCore Healthcare. To obtain Prior Authorization for a course of radiation therapy, providers must contact eviCore Healthcare at (877) 773-2884 or visit evicore.com. eviCore Healthcare has established correct coding and evidence-based guidelines to determine the medical necessity and appropriate billing of radiation oncology services. These guidelines have been carefully researched and are continually updated in order to be consistent with the most current evidence-based guidelines and recommendations for the provision of radiation therapy from national and international medical societies and evidence-based medicine research centers.

In addition, the criteria are supplemented by information published in peer reviewed literature. Full details of this policy can be found at OxfordHealth.com → Providers or Facilities → Tools & Resources → Medical Information → Radiology and Radiation Therapy Information → Radiation Therapy Procedures Requiring Precertification for eviCore Healthcare Arrangement. Radiation therapy evidence-based guidelines and management criteria are available at eviCore.com → eviCore Solutions → Radiation Therapy → Radiation Therapy Tools and Criteria → Criteria.

Radiology, Cardiology and Radiation Therapy Medical Necessity Review process for New Jersey Small, Individual, Municipality, and School Board Customers

A review for medical necessity can be requested prior to rendering the service by contacting eviCore Healthcare at (877) 773-2884, or eviCore.com. eviCore Healthcare will review Oxford claim submissions to evaluate certain outpatient radiology and radiation therapy services for medical necessity. A list of Current Procedural Terminology (CPT®) codes requiring medical necessity review is available at: OxfordHealth.com → Providers or Facilities → Tools & Resources → Medical Information → Radiology and Radiation Therapy Information. The clinical criteria consistent with existing UnitedHealthcare and Oxford policy are available at eviCore.com.

We require the submission of clinical office notes for specific procedures if a Medical Necessity Review/Utilization Review is not conducted prior to rendering services. Clinical notes include the patient’s medical record and/or letters received from Specialists. Supporting clinical information provided by the ordering physician must contain the ordering/referring physician’s name and signature, address, phone and fax numbers, specialty, tax identification number and information such as:

• Reason for the procedure performed;
• Patient’s signs and symptoms;
• Treatment, including type and duration;
• Previous studies for the specific medical issue; and
• Any other pertinent clinical information to determine medical necessity.

Note: It is the ordering physician’s responsibility to provide medical documentation to demonstrate clinical necessity for the outpatient radiology, cardiology or radiation therapy procedure that is being requested, for pre- and post-service review.
Referrals
Certain Oxford products require referrals for cardiology or radiation therapy from the Customer’s primary care physician. If your patient is enrolled in one of these plans, he or she will be required to obtain a referral before seeing you for an initial visit.

Claims processing
We will continue to process claims from participating physicians and other health care professionals for radiation therapy services. You will receive payment directly from us.

If a claim is denied because medical necessity was not demonstrated, contract provisions that prohibit balance billing of Customers will apply. For any service that is not approved for payment, we will offer all appropriate rights of appeal.

Outpatient Cardiac Catheterization and Echocardiogram Utilization Review Process
Oxford has delegated eviCore Healthcare to perform medical necessity review for outpatient cardiac catheterizations and Echo cardiology studies. Prior Authorization will not be required for services rendered in the emergency room, observation unit, urgent care facility, or during an inpatient stay.

For a list of Codes that will require Prior Authorization, refer to OxfordHealth.com → Providers or Facilities → Tools & Resources → Medical and Administrative Policies → Medical & Administrative Policy Index → Cardiology Procedures Requiring Pre-certification for eviCore Healthcare Arrangement. Prior Authorization requirements can be verified through one of the following options:

1. Begin the Prior Authorization process online at eviCore.com or by calling eviCore Healthcare toll-free at (877) 773-2884. When prompted, please provide the Customer’s demographic information and the system will enable you to continue with the Prior Authorization process or respond automatically that pre-certification is not needed.

2. Call the number on the back of the Customer’s health care ID card and check for eligibility. To ensure physicians or physician representatives have the required information available to initiate the Prior Authorization process, please use the Diagnostic Heart Catheterization worksheets found online at eviCore.com.

For more information, including the clinical criteria, please visit eviCore.com → eviCore Solutions → Cardiology → Cardiology Tools and Criteria.

Infertility Utilization Review Process
Oxford has delegated OptumHealth, a UnitedHealth Group company, to perform medical necessity review for outpatient infertility services under their Managed Infertility Program (MIP)* for all Oxford Commercial Customers with an infertility benefit. OptumHealth’s MIP is intended to promote both quality of care and continuity of service by supporting patients through every aspect of the infertility process. The program is supported by OptumHealth infertility nurse case managers who will assist patients in making informed decisions about their infertility treatment and care through: treatment education, considerations in choosing where to obtain care, and assistance in navigating the health care system.

For Oxford products, the rendering physician is required to request Prior Authorization and/or notification of services. This is accomplished by using the Managed Infertility Program Treatment form* and providing sufficient information to determine the medical necessity of the requested services.

OptumHealth has been diligent in their research to help ensure that the clinical policies and guidelines they are using are consistent with best practices and state mandates.

Physical and Occupational therapy services
OptumHealth Care Solutions, a UnitedHealth Group company, administers the physical and occupational therapy benefit for Oxford products and most Commercial outpatient physical and occupational therapy services.

Utilization review process
All physical therapy and/or occupational therapy visits require utilization review and an authorization, including the initial evaluation. A Patient Summary Form must be submitted to OptumHealth by the treating physician or health care professional. Once the required form is completed, it should be submitted through the OptumHealth website myoptumhealthphysicalhealth.com. Patient Summary Forms should be sent within 3 days of initiating treatment and must

* The MIP Prior Authorization template can be found on the OptumHealth website at myoptumhealthcomplexmedical.com or by calling OptumHealth at (877) 512-9340 or email: MIP@optum.com.
be received within 10 days from the initial date of service indicated on the Patient Summary Form. Forms received outside of the 10-day submission requirement will reflect an adjustment to the initial payable date.

The submission of the Patient Summary Form must include the initial visit. If OptumHealth Care Solutions does not receive the required form(s) within this time frame, your claim will be denied. Once the forms are received, OptumHealth Care Solutions will review the services requested for medical necessity, and will make any denial determinations. If a patient’s care requires additional visits or more time than was approved, you must submit a new Patient Summary Form with updated clinical information after the initially approved visits have occurred.

**Note:** Prior Authorization is not required for certain groups.

**Musculoskeletal Services**
OrthoNet, a musculoskeletal disease management company is our network manager for most musculoskeletal services. OrthoNet's orthopedic division will perform utilization management to review requested services that should meet approved clinical guidelines for medical necessity. Review is conducted by determining medical necessity and medical appropriateness, and to initiate discharge planning as appropriate. The review will be based on the obtained clinical information and some or all of the following criteria/tools:

- Customer benefits
- Oxford medical and reimbursement policies
- MCG™ Care Guidelines, 19th edition, 2015 (Inpatient Care)

OrthoNet currently manages the following specialties (regardless of diagnosis):

- Orthopedic Surgery
- Pediatric Orthopedic Surgery
- Podiatry
- Neurosurgery
- Hand Surgery
- Physical Medicine Rehabilitation

OrthoNet also manages the following services if there is an orthopedic diagnosis:

- Acute Care Hospital
- Ambulatory Surgery
- DME
- Other Ancillary Facility
- Home Health
- Physical Rehab Hospital
- Physical Rehab Facility
- Skilled Nursing Facility

**Note:** For a comprehensive list of orthopedic diagnosis codes, refer to OxfordHealth.com → Providers or Facilities → Tools & Resources → Medical and Administrative Policies → Medical & Administrative Policy Index → Orthopedic Services.

For additional information on Oxford’s arrangement with OrthoNet, refer to OxfordHealth.com → Providers or Facilities → Tools & Resources → Medical and Administrative Policies → Medical & Administrative Policy Index → Orthopedic Services.

**Chiropractic guidelines**
OptumHealth Care Solutions currently manages our chiropractic benefit. To receive the standard chiropractic benefit coverage, Customers must obtain an electronic referral from their PCP. PCPs should perform the customary initial comprehensive differential diagnosis with the necessary and appropriate work-up.
A chiropractic referral can be generated for a maximum of one visit within 180 days (6 months). Once the referral is made (if applicable), all participating chiropractors must complete and submit Patient Summary Forms to OptumHealth Care Solutions for services performed.

Patient Summary Forms should be submitted through the OptumHealth Care Solutions website at myoptumhealthphysicalhealth.com, within 3 business days and no later than 10 business days following the Customer’s initial visit or recovery milestone. The submission of the Patient Summary Form must include the initial visit. If OptumHealth Care Solutions does not receive the required form(s) within this time frame, your claim will be denied. Once the forms are received, OptumHealth Care Solutions will review the services requested for medical necessity, and will make any denial determinations.

If a Customer’s care requires additional visits or more time than was approved, you must submit a new Patient Summary Form with updated clinical information after the initially approved visits have occurred.

**Note:** According to your contract with OptumHealth Care Solutions, the Customer may not be balance billed for any covered service not reimbursed due to the provider’s failure to submit the Patient Summary Form, or for those services which do not meet medical necessity or coverage criteria. However, you may file an appeal.

**Acupuncture guidelines**

Acupuncture is only covered for Customers who have the alternative medicine rider. If a Customer does not have the alternative medicine rider, all requests to cover acupuncture will be denied, even if a letter of medical necessity has been submitted. Acupuncture is covered on an in-network basis and must be performed by one of following provider types:

- Participating licensed acupuncturist (LAC)
- Participating licensed naturopaths
- Participating physician (MD or DO) who has been credentialed as physician acupuncturist

**Pharmacy**

**Pharmacy management programs**

The pharmacy benefit plan includes a dynamic medication list, referred to as the Prescription Drug List (PDL), and various clinical drug utilization management programs. These programs are based upon FDA-approved indications and medical literature or guidelines.

The PDL contains medications within three tiers; Tier 1 is the lowest cost option and Tier 3 is the highest cost option. To help make medications more affordable for your Customer, consider whether a Tier 1 or Tier 2 alternative is appropriate if the patient is taking a Tier 3 medication currently. Some of our groups have a 4-tier benefit design. The PDL is reviewed on an ongoing basis and updated at least twice per year. Medications that require notification or Prior Authorization are noted with an “N”, medications that require step therapy are noted with “ST” and supply limits with “SL.”

**PDL management and pharmacy and therapeutics committee**

The UnitedHealthcare PDL Management Committee, a group of senior physicians and business leaders, makes tier decisions and changes to the PDL based on a review of clinical, economic and pharmacoconomic evidence.

The UnitedHealth Group National Pharmacy and Therapeutics Committee (P&T) is responsible for evaluating and providing clinical evidence to the PDL Management Committee to assist them in assigning medications to tiers on the PDL. The information provided by the P&T Committee includes, but is not limited to, evaluation of a medication’s place in therapy, its relative safety and its relative efficacy.

The P&T Committee also reviews and approves clinical criteria for prior authorization and step therapy programs, and supply limits. In addition to medications covered under the pharmacy benefit, the P&T Committee is responsible for evaluating clinical evidence for medications, which require administration or supervision by a qualified, licensed health care professional.

The P&T Committee is comprised of medical directors, network physicians, consultant physicians, clinical pharmacists and pharmacy directors.
Quality management and patient safety programs Drug Utilization Review (DUR)
The majority of prescription claims are submitted electronically for payment. Within seconds, the Customer’s claim is recorded and the past prescription history is reviewed for potential medication-related problems. DUR helps review for potentially harmful medication interactions, inappropriate utilization and other adverse medication events in an effort to maximize therapy effectiveness within the appropriate medication usage parameters. There are two types of DUR programs: concurrent and retrospective.

Concurrent Drug Utilization Review (C-DUR)
The C-DUR program performs online, real-time DUR analysis at the point of prescription dispensing. This program screens every prescription prior to dispensing for a broad range of safety and utilization considerations. C-DUR uses a clinical database to compare the current prescription to the Customer’s inferred diagnosis, demographic data and past prescription history. Criteria are used to identify potential inappropriate medication consumption, medical conflicts or dangerous interactions that may result if the prescription is dispensed.

If a potential problem is identified, the system either notifies the dispensing pharmacist by sending a soft alert (warning message) or a hard alert (a warning message that also requires the pharmacist to enter an override). The dispensing pharmacist uses his/her professional judgment to determine appropriate interventions, such as contacting the prescribing physician or other health care professional, discussing concerns with the Customer and dispensing the medication.

Retrospective Drug Utilization Review (R-DUR)
The R-DUR program involves a quarterly review of prescription claims data to identify medication prescribing and/or medication utilization patterns that may indicate inappropriate or unnecessary medication use. The program uses a clinical database to review patient profiles for potential over- or under-dosing as well as duration of therapy, potential drug interactions, drug-age considerations and therapy duplications.

On a quarterly basis, physicians and other prescribers receive a patient-specific report that outlines the opportunities for intervention and asks them to respond to the issues and concerns raised.

Clinical programs

Prescription medications requiring Prior Authorization (subject to plan design)
Based on the Customer’s benefit plan design, select high-risk or high-cost medications may require advance notification (N) in order to be eligible for coverage. You may be asked to provide information explaining medical necessity and/or past therapeutic failures. A representative will collect all pertinent clinical data for the service requested. If the Prior Authorization cannot be approved, a pharmacist or medical director, in keeping with state regulations, will make the final coverage determination and you as well as the Customer will be notified of the decision.

Step Therapy (subject to plan design)
Certain medications may be subject to step therapy (ST), also referred to as First Start for New Jersey Customers. The step therapy program requires a trial of a lower-cost, Step 1 medication before a higher-cost, Step 2 medication is eligible for coverage. When a Customer presents a Step 2 medication at the pharmacy, the claims history may automatically be checked to see if there is a history of a Step 1 medication in claims history and the medication may automatically process. If not, you may request a coverage review. If the medication cannot be approved, a pharmacist or medical director, in keeping with state regulations, will make the final coverage determination and you as well as the Customer will be notified of the decision.

Supply limits (subject to plan design)
Certain medications may be subject to supply limits (SL). Supply limits are based on FDA-approved dosing guidelines as defined in the product package insert and the medical literature or guidelines and data that support the use of higher or lower dosages than the FDA-recommended dosage. This program focuses on select medications or categories of medications that are high cost and/or are frequently used outside of generally accepted clinical standards.

When a pharmacist submits an online prescription claim, the online claims processing system compares the quantity entered with the allowable limits.

If the prescription exceeds the established quantity limits, the claim is rejected and the pharmacist receives a message to that effect. In addition, the current supply limit for the medication is displayed in the message. A subset of medications...
has coverage criteria available to obtain quantities beyond the established limit. For these medications, the pharmacist receives a message that includes the toll-free number to call for the coverage review.

**Refill and Save Program**
The Refill and Save Program (also known as Adherence Incentive) encourages Customers to adhere to their treatment regimen by rewarding them with a discount on their copayment/coinsurance for refilling their prescription within the defined time period. Medications that are included in this program are noted in the PDL.

**Select Designated Pharmacy Program**
The Select Designated Pharmacy Program encourages Customers who are on select high cost Tier 3 (non-specialty) medications to save money with three easy options. To receive pharmacy benefit coverage on some medications, a Customer is required to fill their prescription through a designated Mail Order Pharmacy, stay at retail with a lower-tier alternative or both.

**Healthcare Effectiveness Data and Information Set (HEDIS) measures**
The annual Healthcare Effectiveness Data and Information Set (HEDIS) was developed by the National Committee for Quality Assurance (NCQA). NCQA is an independent group established to provide objective measurements of the performance of managed health care plans, including access to care, use of medical services, effectiveness of care, preventive services, and immunization rates, as well as each plan’s financial status.

HEDIS measures have become key criteria that employers, consultants, the CMS (Center for Medicare and Medicaid Services), state regulators (Commercial), and prospective Customers use to evaluate the demonstrated value and quality of different health plans.

Each year we collect data from a randomly selected sample of our Customers’ medical records for HEDIS. HEDIS is mandated by the New York Department of Health, New Jersey Department of Health and Senior Services, Connecticut Department of Health, and the CMS. The HEDIS medical record study measures our participating physicians’ adherence to nationally accepted clinical practice guidelines.

**Medical record review**
As a participating physician or other health care professional, you are required to provide us with copies of medical records for our Customers within a reasonable time period following our request for the records. We may request such records for various reasons, including an audit of your practice. Such an audit can be performed at our discretion and for several different purposes, as we deem appropriate for our business needs.

**Standards for medical records**
A comprehensive, detailed medical record is vital to promoting high quality medical care and improving patient safety. Our recommended medical record standards are published each November for Commercial plans in the Network Bulletin found here: OxfordHealth.com → Providers or Facilities → Tools & Resources → Network Information → Network Bulletin.

**Transferring Customer medical records**
If you receive a request from a Customer to transfer their medical records, please do so within 7 days to ensure continuity of care. In order to safeguard the privacy of the Customer’s records, please mark them as “Confidential” and be sure that no part of the record is visible during the transmission.

**Continuity of care**
Continuity and coordination of care ensures ongoing communication, monitoring and overview by the PCP across each Customer’s entire health care continuum. Documentation of services provided by Specialists such as podiatrists, ophthalmologists and behavioral health practitioners, as well as ancillary care physicians including home care and rehabilitation facilities, help the PCP maintain a medical record that comprises a complete picture of the health care delivered to each individual.

Elements of the chart indicating continuity and coordination of care among practitioners are required by NCQA and state departments of health in the tri-state area (New York, New Jersey and Connecticut). We monitor the continuity and coordination of care that Customers receive through the following mechanisms:
Medical record reviews

Adverse outcomes that may develop as the result of disruptions in continuity or coordination of care

Physician and other health care professional termination

Reassignment of Customers who are in an ongoing course of care or who are being treated for pregnancy

We adhere to the following guidelines when notifying Customers affected by the termination of a physician or other health care professional:

- All Customers who are patients of any terminated PCP’s panel - internal medicine, family practice, pediatrics, OB/GYN - are notified of our policy and what steps to follow should the Customer require transitional care; the same notification procedures hold true for patients being seen regularly by a Specialist who is terminated.*

- Customers of such a PCP’s panel are instructed to call the Customer Service department if they choose to select a new PCP, or to request transitional care from their current practitioner; they are also encouraged to request our Roster of Participating Physicians and Other Health Care Professionals, if needed, to make their new selection.

- Customers of a terminated Specialist are instructed to call the Customer Service department if they need to request transitional care from their current Specialist; they are also directed to call their current PCP for an alternate Specialist referral.

Claims, Reimbursement and Customer Billing

Time frame for claims submission

In order to be considered timely, physicians, other health care professionals and facilities are required to submit claims within the specified period from the date of service:

- Connecticut - 90 days from date of service.
- New Jersey - 90 days from date of service OR 180 days from date of service if submitted by a New Jersey participating physician for a New Jersey Line of Business Customer.
- New York - 120 days from date of service.

The claims filing deadline is based on the date of service on the claim; it is not based on the date the claim was sent or received. Claims submitted after the applicable filing deadline will not be reimbursed; the reason stated will be “filing deadline has passed” or “services submitted past the filing date” unless one of the following exceptions applies.

Exceptions:

- If an agreement currently exists between you and Oxford or UnitedHealthcare containing specific filing deadlines, the health plan’s agreement will govern.

- If coordination of benefits has caused a delay, you will have 90 days from the date of the primary carrier Explanation of Benefits to submit the claim to us.

If the Customer has a health benefits plan with a specific time frame regarding the submission of claims, the time frame in the Customer’s Certificate of Coverage will govern. For claims submitted after April 1, 2010, if a claim is submitted past the filing deadline due to an unusual occurrence (e.g., provider illness, provider’s computer breakdown, fire, or flood) and the provider has a historical pattern of timely submissions of claims, the provider may request reconsideration of the claim.

Clean and unclean claims/Required information for all claim submissions

For complete details and required fields for claims processing, please go to OxfordHealth.com → Providers or Facilities → Tools and Resources → Administrative Tools & Information → Claims → Claims Submission Information. Appropriate state and federal guidelines are applied to determine whether the claim is complete and can be processed.

* CT Customers - Transitional services may continue on an in-network basis for up to 120 days from the date of notice to the Customer.

NY Customers - Transitional services may continue on an in-network basis for up to 120 days from the date the Provider ceases to be in the Network.

NJ Customers - Transitional period varies depending on required services. Customers in this state must contact Customer Service for specific details.
Processing

Time frame for processing claims
The state-mandated time frames for processing claims for our fully insured Customers are listed below. The time frames are applied based upon the site state of the Customer’s product.

- Connecticut - 45 days (paper and electronic)
- New Jersey - 40 days (paper), 30 days (electronic)
- New York - 45 days (paper), 30 days (electronic)

We strive to process all complete claims within 30 days of receipt. If you have not received an explanation of benefits (EOB) / remittance advice within 45 days, and have not received a notice from us about your claim, please verify that we have received your claim.

Requirements for claim submission with coordination of benefits (COB)
Under COB, the primary plan pays its normal plan benefits without regard to the existence of any other coverage. The secondary plan pays the difference between the allowable expense and the amount paid by the primary plan, provided this difference does not exceed the normal plan benefits which would have been payable had no other coverage existed.

If Oxford is secondary to a Commercial payer, you should bill the primary insurance company first and when you receive the primary carrier’s explanation of benefits (EOB)/remittance advice, submit it to us along with the claim information. These claims must be submitted via paper claim with primary remittance advice attached. Oxford secondary claims cannot be sent electronically.

We participate in Medicare Crossover for all of our Customers who have Medicare primary. This means Medicare will automatically pass the remittance advice to us electronically after the claim has been processed. We can then process the claim as secondary without a claim form or remittance advice from your office. When you receive your remittance advice from Medicare, it should indicate that the claim has been forwarded. If it does not, please submit the claim.

Note: If Medicare is the secondary payer, you must continue to submit the claim to Medicare; we cannot crossover in reverse.

Reimbursement claim components
Modifiers: Modified procedures are subject to review for appropriateness in accordance with the guidelines outlined in our policies. For complete details regarding the reimbursement of recognized modifiers, refer to OxfordHealth.com → Providers or Facilities → Tools & Resources → Medical Information → Medical and Administrative Policies → Medical & Administrative Policy Index → Modifier Reference Policy.

Global surgical package (GSP): A global period for surgical procedures GSP may be found in the following for complete details on OxfordHealth.com → Providers or Facilities → Tools & Resources → Medical Information → Medical and Administrative Policies → Medical & Administrative Policy Index → Global Days Policy.

Fee schedules: Although our entire fee schedule is proprietary and cannot be distributed, we will, upon request, provide our current fees for the top codes you bill. Provider Services is available to provide this information and to answer questions regarding claims payment.

Release of information: Under the terms of HIPAA, we have the right to release to, or obtain information from, another organization in order to perform certain transaction sets.

Requests for additional information: To request additional information to process a claim, information must be submitted promptly within 45 days or an appeal must be submitted with the information.

Reimbursement Address, phone or TIN changes
An accurate billing address is necessary for all claims logging and payment as well as mailings that may go out. It is critical that you notify us of any changes. For instructions and forms on how to do so, refer to Oxfordhealth.com → Providers or Facilities → Tools & Resources → Network Information → Forms → Provider Demographic Updates & W-9 Form.
Additional Copies of EOBs/remittance advice
Should you misplace a remittance advice and need another copy, you can obtain one by performing a claims status inquiry on OxfordHealth.com → Providers or Facilities → Transactions → Check → Claims.

New York Health Care Reform Act of 1996 (HCRA)
The enactment of the HCRA, in part, created an indigent care (bad debt and charity care) pool to support uncompensated care for individuals with no insurance or who lack the ability to pay. As a result of this act, the New York Bad Debt and Charity (NYBDC) surcharge is applied on a claim-by-claim basis. The NYBDC surcharge applies to most services of general facilities and most services of diagnostic and treatment centers in New York. The physician's or other health care professional's obligation is to:

- Understand their eligibility as it relates to HCRA
- Know what services are surchargeable services, and bill such services accordingly

For additional information on HCRA, physicians and other health care professionals should reference the New York Department of Health’s website: health.ny.gov → Laws and Regulations (on the right under Site Contents) → Health Care Reform Act.

Customer billing
Balance billing policy
Facilities, physicians and other health care professionals in our network are contracted with Oxford to provide specific services to Customers. Providers who are participating with Oxford are subject to all Oxford referral, precertification and privileging policies and procedures and may not bill Customers for unpaid charges above their specific Customer cost share (i.e., copayment, deductible, and coinsurance). This includes balance billing a Customer for a covered service that was denied by Oxford because there was no referral or authorization on file with Oxford when one was required.

Exceptions: The instances in which you are authorized to balance bill a Customer are listed below. (You are still required to follow Oxford's privileging, referral and/or precertification requirements.) In these instances, you may balance bill the Customer billed charges. To the extent that the terms and conditions of your contract conflict with these guidelines the terms and conditions of your contract shall prevail. You may balance bill a Customer when:

- A service or item is not a covered benefit (i.e., the service is excluded in the “Exclusions and Limitations” section of the Customer’s Certificate of Coverage); or
- The benefit limit, if any limit is applicable, is exceeded/exhausted; or
- Oxford denied a request for precertification, prior to the service being rendered, and the Customer proceeded to receive the service anyway; or
- Oxford denied a concurrent certification request (i.e., the Customer is currently receiving the service) and you obtained the Customer’s signature to a clear, written statement that the service is not covered, and acknowledging s/he would be responsible for the cost of the service, prior to the service being rendered; or
- If you do not participate in a customer’s network, and a Customer self refers to you (i.e.; Liberty Customer self refers to you and you do not participate in Oxford Liberty Network).

Note: In this instance, if you participate in our W500 network, you may only bill up to your contracted rate for emergent services.

If you are uncertain whether a service is covered, you must make reasonable efforts to contact us and obtain coverage determination before seeking payment from a Customer.

Participating providers who repeatedly violate these restrictions on billing Oxford Customers will be subject to discipline up to and including termination of their provider participation agreement.

Customer out-of-pocket costs
Out-of-pocket amounts for outpatient and inpatient care vary by group, type of physician or other health care professional and type of plan. Please check the Customer’s health care ID for the out-of-pocket cost specific to their plan.

PCP/Specialist reimbursement - All PCPs and Specialists agree to accept our fee schedule and the payment and processing policies associated with the administration of these fee schedules.
**Hospital reimbursement** - We will reimburse hospitals for services provided to Customers at the rates established in the attachment of the hospital contract.

**Ancillary facility reimbursement** - Reimburse ancillary health care professionals for services provided to Customers at the rates established in the fee schedule or in attachment or schedule of the ancillary contract.

**Claim reconsideration**
See Claim reconsideration, appeals process and resolving disputes found in the main section of the guide under Our claims process for general reconsideration requirements and submission steps. Continue below for Oxford specific requirements.

**Timeframe:**
If you disagree with the way a claim was processed or need to submit corrected information, you generally have 12 months from the date of the original remittance advice to appeal the claim. The two step process described in the Claim Reconsideration and Appeal Process allows for a total of 12 months for timely filing – not 12 months for step 1 and 12 months for step 2.

**How to Request:**
See the How to contact Oxford Commercial section at the beginning of this Supplement for more details on Internal Appeals-Claims Payment Disputes and Claim Submission – Corrections/Resubmissions.

**Payment Appeals**
See Claim reconsideration, appeals process and resolving disputes found in the main section of the Guide under Our claims process for general appeal requirements.

**Participating physician and other health care professional claim reconsiderations and appeals**
Our administrative procedures for Customers with an Oxford product require facilities, physicians or other health care professionals participating in our network to file a claim reconsideration and/or appeal before proceeding to arbitration under their contract.

Refer to the How to contact Oxford Commercial section at the beginning of this Supplement for contact information on Internal Appeals-Claims Payment Disputes.

**Timeframe:**
You must file your reconsideration and/or appeal request of an administrative claim determination within 12 months (or as required by law or your participation agreement) from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). On appeal, you must include all relevant clinical documentation, along with a Participating Provider Review Request Form.

**Internal Utilization Management appeals process**

**Mandatory internal appeals process under your contract for medical necessity determinations**
If you would like to dispute our payment determination that a service requested for a Customer is not medically necessary, you may mail a written request, with relevant supporting clinical documentation that shows why the denial of services should be reversed, to:

Oxford Clinical Appeals Department
P.O. Box 29139
Hot Springs, AR 71903

The Clinical Appeals department will make a reasonable effort to render a decision within 60 calendar days of receiving the appeal and supporting documentation.

**Note:** There is a separate appeal process for Customer appeals.

**Mandatory internal appeals process-Claims payment disputes**
If you would like to dispute the payment of a claim that does not involve medical necessity, you should appeal the claim by submitting a Participating Provider Claims Review Request Form for Commercial Customers with the “Appeal” box
checked. This form is available on our website: OxfordHealth.com → Providers (or Facilities) → Tools & Resources → Network Information → Forms → Participating Provider Claims Review Request Form.

**Note:** There is a separate appeal process for Customer appeals.

**Post-appeal dispute resolution process**

If you have completed the internal appeals process and are not satisfied with the results of that internal appeal, you have a right to arbitrate your individual dispute with us as described in the *Resolving disputes - concern or complaint* section found in the main section of the Guide under Our claims process and in your participation agreement.

The American Arbitration Association (AAA) address and phone number for Connecticut, Pennsylvania, and Delaware products is as follows:

American Arbitration Association
Northeast Case Management Center
950 Warren Avenue, 4th Floor
East Providence, RI 02914
Phone: (866) 293-4053

Additional information, rules and forms for arbitration before the AAA may be found on the AAA’s website at adr.org.

**New Jersey state-regulated appeal process for claim payment appeals involving New Jersey Customers**

If you have a dispute relating to the payment of a claim for services that were rendered to a New Jersey Commercial plan Customer, your individual dispute may be eligible for, and you may elect to use, a two-step appeal process. This appeals process does not apply to the self-funded line of business. Process details, criteria for eligibility and exclusions can be found on the “Health Care Provider Application to Appeal a Claims Determination” form, as promulgated by the New Jersey Department of Banking and Insurance (DOBI) available on the DOBI website state.nj.us/dobi and on OxfordHealth.com.

**Internal appeal under this process:** You must submit an internal appeal to our Correspondence department or our collections vendor within 90 calendar days of receipt of an adverse claim determination. The NJ Internal Appeal Form is available on our website at OxfordHealth.com → Providers (or Facilities) → Tools & Resources → Network Information → Forms → New Jersey Provider Claim Appeal Form.

**Arbitration under this process:** In accordance with New Jersey law, disputes may be referred to arbitration when the internal appeal determination is in our favor or when we have not made a timely determination on an eligible claim appeal. To be eligible for the New Jersey arbitration process, the disputed claim amount must be at least $1,000.

The appeal must be submitted on the application form created by the DOBI, which is available online at njpicpa.maximus.com. Supporting documentation may be submitted online (if the information is in an electronic format) with your application, or by fax or mail using the case number generated through the online submission process to:

MAXIMUS, Inc.
Attn: New Jersey Provider Appeals
3750 Monroe Drive, Suite 705
Pittsford, New York 14534
Fax number: (585) 869-3388

(MAXIMUS has requested that faxes be limited to 25 pages.)

**New York state-regulated process for external review - For participating physicians and other health care professionals treating New York Customers**

This external appeals process applies only to services provided to Commercial Customers who have coverage by virtue of a HMO or insurance plan licensed in New York State.

This appeals process does not apply to the self-funded line of business. Providers cannot use this process unless there is written consent from the Customer or if it is a case involving retrospective review. If the provider’s agreement includes arbitration language or alternate dispute language, the provider must follow that process and the external review process is no longer an option for dispute resolution.
**External appeal process**

If the Clinical Appeals department upholds all or part of such an adverse determination, the Customer or Customer’s designee has the right to request an external appeal. All external appeal requests may be sent to the following:

New York State Insurance Department  
P.O. Box 7209  
Albany, NY 12224-0209  
Phone: (800) 400-8882  
Fax: (800) 332-2729

**Medical necessity appeals**

**Standard medical necessity appeals process**

If Customers or their designees would like to file an appeal, they must hand-deliver or mail a written request within 12 months of receiving the initial denial determination notice to:

Oxford Clinical Appeals Department  
P.O. Box 29139  
Hot Springs, AR 71903

**Expedited medical necessity appeals process for Customers:**

- Customers have the right to request an expedited appeal.
- In order to request an expedited appeal, the Customer or physician or other health care professional must state specifically that the request is for an expedited appeal.
- The Clinical Appeals department will determine whether or not to grant an expedited request.
- If the Clinical Appeals department determines that the request does not meet expedited criteria, then the Customer will be notified.

**Benefit appeals**

Appeals of benefit denials issued by the Clinical Services, Disease Management departments are handled by the Clinical Appeals department.

**Administrative appeals (Grievances)**

Administrative appeals without the Clinical Services department’s involvement are handled by the Customer appeals unit. If a Customer would like to file an appeal on a claim determination, they must mail all administrative appeals UnitedHealthcare Grievance Review Board. See *How to contact Oxford Commercial* section for address information.

**Second-level Customer appeals**

Customers have the right to take a second-level appeal* to our Grievance Review Board (GRB). If the Customer remains dissatisfied with the first-level appeal determination, the Customer may request a second-level appeal. Customers with a CT line of business do not have the option of submitting a second-level appeal request for a benefit or administrative issue. The request for appeal and any additional information must be submitted to the UnitedHealthcare Grievance Review Board. See *How to contact Oxford Commercial* section for address information.

**External appeal process for Customers**

New York, New Jersey and Connecticut Customers have the right to appeal a medical necessity determination to an external review agent. Customers can file a consumer complaint with one of the following applicable regulatory bodies. The applicable regulatory body is determined by the state in which the Customer’s certificate of coverage was issued, not where the Customer resides.

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* In New York, a second-level appeal is not required by us in order to be eligible for an external appeal.
### Participating physician and other health care professional responsibilities Primary Care Physicians (PCP)

As a PCP, it is your responsibility to deliver medically necessary primary care services, and you are the coordinator of your patients’ total health care needs. Your role is to provide all routine and preventive medical services and coordinate all other covered services, Specialist care and care at our participating facilities or at any other participating medical facility where your patients might seek care (e.g., emergency care). You are responsible for seeing all Customers on your panel who need assistance, even if the Customer has never been in for an office visit. You may not discriminate on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, place of residence, health status, or source of payment. Some PCPs are also qualified to perform services ordinarily handled by a Specialist. Such a PCP must also be listed as a participating Specialist in the particular specialty in order for us to pay claims submitted for Specialist services.

### HIV confidentiality

In accordance with New York regulations, all physicians should develop and implement policies and procedures to maintain the confidentiality of HIV-related information. The following procedures should be in place to comply with regulations specific to the confidentiality, maintenance and appropriate disclosure of HIV patient information.

Office staff shall:

- Receive initial and annual in-service education regarding the legal prohibition of unauthorized disclosure.
- Maintain a list containing job titles and specified functions for which employees are authorized to access such information.
- Maintain and secure records, including records which are stored electronically, and ensure records are used for the purpose intended.
- Maintain procedures for handling requests by other parties for confidential HIV-related information.
- Maintain protocols prohibiting employees, agents and contractors from discriminating against persons having or suspected of having HIV infection.

<table>
<thead>
<tr>
<th>State</th>
<th>Address</th>
<th>Phone Numbers</th>
</tr>
</thead>
</table>
| **Connecticut** | State of Connecticut Insurance Department  
153 Market Street  
P.O. Box 816  
Hartford, CT 06142-0816  
(860) 297-3862                                      |                                    |
| **New Jersey** | Division of Insurance Enforcement and Consumer Protection  
20 West State Street  
P.O. Box 329  
Trenton, NJ 08625-0329                                      | (800) 446-7467 (in NJ only)  
(609) 292-5316  
Fax (609) 292-5865                                      |
| **New York** | Consumer Protection Services Dept. of Banking and Insurance  
P.O. Box 329  
Trenton, NJ 08625-0329                                      | (800) 446-7467 (in NJ only)  
(609) 292-5316  
Fax (609) 292-5865                                      |
|          | Consumer Services Bureau  
State of New York Insurance Department  
25 Beaver Street  
New York, NY 10004-2349  
(212) 480-6400                                      |                                    |
|          | Office of Managed Care Certification and Surveillance  
New York Department of Health  
Corning Tower, Room 1911 Empire State Plaza  
Albany, NY 12237  
(518) 474-2121                                      |                                    |
Perform an annual review of the following policies and procedures:

- HIV testing must be performed on all newborns.
- Prenatal care physicians should counsel expectant mothers regarding the required testing of newborns and the importance of the mother getting tested.
- Expectant mothers should also be advised of the counseling and services offered when results are positive.

Only employees, contractors and medical, nursing or health-related students, who have received such education on HIV confidentiality, shall have access to confidential HIV-related information while performing the authorized functions.

**Specialists**

As a participating Specialist, you agree to the following, when applicable:

- Provide referral for specialty services
- Provide results of medical evaluations, tests and treatments to the Customer's PCP
- Pre-certify inpatient admission
- Receive compensation only from us and adhere to our balance billing policies
- Provide access to your records relating to services rendered to our Customers; if you believe consent is required from the specific Customer, you must obtain his/her consent
- Follow our authorization guidelines for those services requiring Prior Authorization

You will only be reimbursed for services if:

- We have a referral on file or the Customer has a non-gatekeeper plan and the service is covered and medically necessary.
- A referral is not on file and the Customer has an out-of-network benefit (i.e., a POS plan), and if the service is covered and medically necessary, you will be entitled to the contracted rate, but the Customer will be required to pay any deductible and/or coinsurance based on his/her out-of-network benefits.
- The Customer is enrolled in a plan without an out-of-network benefit (i.e., an HMO plan), we are not responsible for payment (except in cases of emergency), nor can the Customer be balance billed.

**Specialists as PCPs**

A Customer who has a life-threatening condition or a degenerative and disabling condition (i.e., complex medical condition) or disease, either of which requires specialized medical care over a prolonged period of time, is eligible to elect a network Specialist as his/her PCP. A standing referral is granted and that PCP then becomes responsible for providing and coordinating all of the Customer’s primary care and specialty care. The PCP, Specialist and health plan must all be in agreement with the established treatment plan.

A standing referral may be authorized when the physician or other health care professional is requesting more than 30 visits within a 6 month period or covered services beyond a 6 month period but within 12 months. Under a standing referral, a Customer may seek treatment with a designated Specialist or facility without having to seek a separate PCP referral for each service.

If such an election appears to be appropriate, our Clinical Services department will fax the Specialist a form to complete. Only after the form is completed and accepted by us will such services be covered without a referral, otherwise a referral would be required for Customers with a gatekeeper plan.

**Hospitals and ancillary facilities**

A Customer must be enrolled and effective with us on the date the hospital and ancillary service(s) are rendered. Once the facility verifies a Customer’s eligibility with us (we will maintain a system for verifying Customer status), that determination will be final and binding on us, except to the extent the Customer or group made a material misrepresentation to us or otherwise committed fraud in connection with the eligibility or enrollment.

If an employer or group retroactively dis-enrolls the Customer up to 90 days following the date of service, then we may deny or reverse the claim. If there is a retroactive disenrollment for these reasons, the facility may bill and collect payment
for those services from the Customer or another payer. Furthermore, a Customer must be referred by a participating physician to a participating facility within his/her applicable network; in-network services require an electronic referral or Prior Authorization, in accordance with the Customer’s benefits.

**Participating hospitals, ancillary and physicians agree to:**

- Verify a patient’s status, since no payment will be made for services rendered to persons who are not our Customers
- Obtain Prior Authorization/authorization from us or a delegated vendor for all hospital services that require Prior Authorization must be obtained prior to rendering services
- Generally, all hospital services require our Prior Authorization
- Notify us of all emergency/urgent admissions of Customers upon admission or on the day of admission*
- Notify of an ambulatory surgery that occurs as a result of an emergency room or urgent care visit within 24-48 hours
- Admit and treat Customers on the same basis as all other facility patients (i.e., according to the severity of the medical need and the availability of covered services).
- Render services to Customers in a timely manner; the services provided will be consistent with the treatment protocols and practices utilized for any other facility patient.
- Work with the responsible PCP to ensure continuity of care for our Customers
- Maintain appropriate standards for your facility
- Cooperate with our utilization review program and audit activities
- Receive compensation only from us and adhere to our balance billing policies
- Complete appeals process in a timely manner prior to proceeding to arbitration

**Basic administrative procedures**

**Standards of practice and Customer cost of services**

All services performed for Customers must be consistent with the proper practice of medicine and be performed in accordance with the customary rules of ethics and conduct of the American Medical Association and other bodies, formal or informal, governmental or otherwise, from which physicians and other health care professionals seek advice and guidance or to which they are subject to licensing and control.

**Office standards**

Your office must adhere to policies regarding the following:

- Confidentiality of Customer medical records and related patient information
- Patient-centered education
- Informed consent; including, advising a Customer prior to initiating services when a particular service is not covered and disclosing to the Customer the amount required to pay for the service.
- Maintenance of advance directives
- Handling of medical emergencies
- Compliance with all federal, state and local requirements
- Minimum standards for appointment and after-hours accessibility
- Safety of the office environment
- Use of physician extenders, such as physician assistants (PA), nurse practitioners (NP) and other allied health professionals, together with the relevant collaborative agreements.

**Americans with Disabilities Act (ADA) guidelines**

Participating physicians and other health care professionals must have practice policies that demonstrate that they accept for treatment any Customer in need of the health care they provide. The organization and its physicians and other health

* If the facility is unable to determine on the day of admission that the patient is our Customer, the facility will notify us as soon as possible after discovering that the patient has coverage with us.
care professionals must make public declarations (i.e., through posters or mission statements) of their commitment to nondiscriminatory behavior in conducting business with all Customers. These documents should explain that this expectation applies to all personnel, clinical and nonclinical, in their dealings with each Customer.

In this regard, new construction and renovations, as well as barrier reductions required to achieve program accessibility, must be undertaken in accordance with the established accessibility standards of the ADA guidelines. For complete details go to ADA.gov → Featured Topics → (scroll to) A Guide to Disability Rights Laws.

What we may request from a physician’s office
Any of the following ADA-related information may be requested from you:

- A description of accessibility to your office or facility.
- A description of the methods that you or your staff will use to communicate with Customers who have visual or hearing impairments.
- A description of the training your staff receives to learn and implement these guidelines.

Suggested accessibility standards
Note: Resources and technical assistance are available in New York State, through the New York State Office of Advocate for Persons with Disabilities - (800) 624-4143 V/TTY; and the Mayor’s Office for People with Disabilities - (212) 788-2830; in Connecticut, through the Connecticut Office of Protection and Advocacy - (800) 842-7303 (toll-free), (860) 297-4300, (860) 297-4380 (TTY); in New Jersey, through the New Jersey Office on Disabilities - (888) 285-3036 (toll-free), (609) 292-7800 (TTY).

Care for Customers who are hearing-impaired
Note: It is important for everyone to be able to communicate with his/her physicians and other health care professionals. Refusing to provide care, or the assistance of an interpreter while caring for a person with a qualifying disability, is a violation of the ADA. Customers who are hearing-impaired have the right to use sign-language interpreters to assist them at their doctor visits.

We will bear the reasonable cost of providing an interpreter; the Customer must not be billed for interpreter fees (28 CFR * Sect. 36.301(c) **. Interpreters are reimbursed by the physician/facility for their services. The physician/facility should bill us for these services by submitting a claim form with Current Procedural Terminology (CPT) code 99199 with a description of the interpreter service.

Case management and Disease Management Programs
We have created a number of programs designed to improve outcomes for our Customers and to allow us to better manage the use of medical services. Practitioners may refer Customers to these programs, or Customers may self-refer.

For more information, go to OxfordHealth.com → Providers (or Facilities) → Tools & Resources → Medical Information → Managing Disease or by utilizing phone numbers below.

The Case Management/Disease Management programs below are comprehensive case management programs supported by registered nurses.

Oxford Cancer Support ProgramSM (OCSP)
The OCSP is a clinical nurse case management program which may be available to Customers over the age of 18, with an Oxford Commercial ASO product, who are diagnosed with cancer (excluding acute leukemia), are in active treatment or end-stage management and are not in hospice. This program is managed by Optum.

Transplant Program
Optum is contracted to manage all aspects of every transplant including Prior Authorization and coordination of services.

Managed Infertility Program
Optum is contracted to manage infertility services for Oxford customers including Prior Authorization, coordination of services, and recommendations to Optum Infertility Centers of Excellence.

* 28 CFR Sect. 36...301(c)
** 28 CFR Sect. 36...303(b)(1)
Population Health Mailings (Oxford Customer Mailings)
Targeted, proactive mailings with educational content and additional resources aimed at helping Oxford Customers to better understand a medical condition and work with their health care providers to manage it appropriately.

Better Breathing® Asthma Intervention Program
The asthma mailing program is designed to help Customers diagnosed with asthma learn more about their condition, including treatment medications, monitoring devices and how to better control asthma through a healthy lifestyle in accordance with guidelines established by the National Institutes of Health.

Heart Health Mailings
The Heart related mailings are designed to help Customers diagnosed with hypertension and/or heart failure. Targeted mailings provide educational content and additional resources to help them better understand and manage their medical condition.

Preventive Health Exam Reminders
One mailing focuses on adolescent well care visits, including needed immunizations, with their primary care provider. Another mailing targets Customers 50 years of age. They receive an American Cancer Society brochure providing educational content and encouragement to get checked for colon cancer.

Influenza Vaccine Reminders
Customers aged 18 to 74 receive an automated telephone scripted call during the flu season to encourage them to get immunized—one call per household.

Healthy Mother, Healthy Baby
Extensive maternity educational information on prenatal care, postnatal care and childhood immunizations is mailed to parents when they notify Oxford of the pregnancy and of the delivery date. Included in the mailings is a form needed to add a new baby to their insurance plan.

Smoking Cessation
Customers identified from claims data as seeking counseling or medication to stop smoking receive a mailing of facts about the effects of smoking and e-cigarettes and counseling resources.

Utilization Management and Appropriate service and coverage
Utilization management (UM) is a process commonly used across a broad spectrum of industries, including health. Our UM represents a combination of different disciplines, including: utilization review with benefit and eligibility requirements, effective and appropriate delivery of medically necessary services, quality of care across the continuum, discharge planning, and case management. The goals of UM are to:

- Promote the delivery of appropriate care for all Customers
- Promote necessary care in the appropriate setting, at the appropriate time and using appropriate resources
- Assess and offer appropriate alternative services

Our Clinical Services department monitors services provided to Customers to identify potential areas of over and underutilization. UM decision making is based only on appropriateness of care and service and existence of coverage. We do not specifically reward or offer incentives to practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

Compliance with quality assurance and utilization review
Physicians and other health care professionals agree to fully comply with and abide by the rules, policies and procedures that we have or will establish, with written notice of any changes provided 30 days in advance, including, but not limited to, the following:

- Quality assurance, including, but not limited to, on-site case management of patients, intensivist programs and notification compliance measures
• Utilization management, including, but not limited to, Prior Authorization procedures, referral processes or protocols and reporting of clinical accounting data
• Customer and physician and other health care professional grievances
• Timely provision of medical records upon request by us or our contracted business associates
• Cooperation with quality of care investigations including timely response to queries and/or completion of improvement action plans
• Physician and other health care professional credentialing
• Any similar programs developed by us.

Utilization review of services provided to New York Customers
All adverse utilization review (UR) determinations (whether initial or on appeal) will be made by a clinical peer reviewer, while appeals of adverse UR determinations will be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the initial adverse determination.

Requirements for initial utilization review determinations
UR decisions will be made by the following methods and in the following time frames:

Prior Authorization - UR decisions will be made and notice will be provided to you and the Customer.
Concurrent review - UR decisions will be made and notice will be provided to the Customer or the Customer’s designee.
Retrospective - UR decisions will be made within 30 days of receipt of necessary information. A preauthorized treatment, service or procedure may be reversed on retrospective review.

In the event that an initial adverse UR determination is rendered without attempting to discuss such matter with the Customer’s physician or other health care professional who specifically recommended the health care service, procedure or treatment under review, such physicians and other health care professionals shall have the opportunity to request a reconsideration of the adverse determination.

Failure to make an initial UR determination within the time periods described above is deemed to be an adverse determination eligible for appeal.

Requirements for appeals of initial adverse utilization review determinations
Customer appeals must be submitted to us or our delegate within 180 days from the receipt of the initial adverse UR determination. While Customer appeals may be initiated verbally by calling our Customer Service department at the number on the Customer health care ID card or at (800) 444-6222, we strongly recommend that the appeal be filed in writing. Determinations concerning services that have already been provided are not eligible to be appealed on an expedited basis. Expedited UR appeals will be determined within 2 business days of receipt of necessary information to conduct such appeal. Standard (non-expedited) UR appeals may be filed by telephone or in writing by the Customer or Customer’s designee. Failure to make a determination within the applicable time periods shall be deemed to be a reversal of an initial adverse UR determination.

The law allows the Customer and the health plan to jointly agree to waive the internal UR appeal process. Typically, we will not agree to waive the internal UR appeal process. In those rare situations where we are willing to waive the internal UR appeal, we will inform the appeal requester and/or Customer verbally and/or in writing. If the Customer agrees to waive the internal UR appeal process, we will provide a written letter with information regarding filing an external appeal to the Customer within 24 hours of the agreement to waive the internal appeal process.

Components of a Final Adverse Determination Notice
Components of a final adverse determination vary based on the state in which the Customer's certificate of coverage was issued. Each notice of final adverse determination will be in writing, dated and include the following components:

Connecticut:
1. Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care professional and the claim amount, if known;
2. The specific reason(s) for the adverse determination, including, upon request, a listing of the relevant clinical review criteria including professional criteria and medical or scientific evidence used to reach the denial and a description of Oxford’s standard, internal rule, guideline, protocol or other criterion, if applicable, that were used in reaching the denial;

3. Reference to the specific health benefit plan provisions on which the determination is based;

4. A description of any additional material or information necessary for the covered person to perfect the benefit request or claim, including an explanation of why the material or information is necessary to perfect the request or claim;

5. A description of Oxford’s internal appeals process, which includes:
   a. Oxford’s expedited review procedures,
   b. Limits applicable to such process or procedures,
   c. Contact information for the organizational unit designated to coordinate the review on behalf of the health carrier, and
   d. A statement that the Customer or, if applicable, the Customer’s authorized representative is entitled, pursuant to the requirements of the Oxford’s internal grievance process, to receive from Oxford, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence regarding the Customer’s request.

6. If the adverse determination is based on:
   a. An internal rule, guideline, protocol or other similar criteria:
      i. The specific rule, guideline, protocol or other similar criteria; or
      ii. A statement that:
         · A specific rule, guideline, protocol or other similar criteria was relied upon to make the adverse determination and that a copy of such rule, guideline, protocol or other similar criteria will be provided to the covered person free of charge upon request;
         · Provides instructions for requesting a copy; and
         · The links to such rule, guideline, protocol or other similar criteria on Oxford’s Internet web site.
   b. Medical necessity or an experimental/investigational treatment:
      i. A written statement of the scientific or clinical rationale used to render the decision that applies the terms of the plan to the Customer’s medical circumstance;
      ii. Notification of the Customer’s right to receive, free of charge upon request, reasonable access to and copies of all documents, records, communications and other information and evidence not previously provided regarding the adverse determination under review;

7. A statement explaining the right of the Customer to contact the Office of the Healthcare Advocate at any time for assistance or, upon completion of the Oxford’s internal grievance process, to file a civil suit in a court of competent jurisdiction. Such statement shall include:
   a. The contact information for said offices; and
   b. A statement that if the Customer or the Customer’s authorized representative chooses to file a grievance that:
      › Appeals are sometimes successful;
      › The Customer may benefit from free assistance from the Office of the Healthcare Advocate, which can assist a Customer with the filing of a grievance pursuant to 42 USC 300gg–93, as amended from time to time;
      › The Customer is entitled and encouraged to submit supporting documentation for Oxford’s consideration during the review of an adverse determination, including narratives from the Customer or from the Customer’s authorized representative and letters and treatment notes from the Customer’s health care professional, and
      › The Customer has the right to ask the Customer’s health care professional for such letters or treatment notes.
8. A health carrier may offer a Customer’s health care professional the opportunity to confer with a clinical peer, as long as a grievance has not already been filed prior to the conference. This conference between the physician and the health care professional peer will not be considered a grievance of the initial adverse determination.

**New Jersey:**
1. Information sufficient to identify the claim involved, including date of service, health care provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning. Any request for such diagnosis and treatment information following an initial adverse benefit determination shall be responded to soon as practicable, and the request itself shall not be considered a request for a stage 1, stage 2 or stage 3 appeal;
2. The reason(s) for the adverse benefit determination, including denial code and corresponding meaning, as well as a description of the standard used by Oxford in the denial;
3. Any new or additional rationale, which was relied upon, considered or utilized, or generated by Oxford, in connection with the adverse benefit determination; and
4. Information regarding the availability and contact information for the consumer assistance program at the Department of Banking and Insurance, which assists covered persons with claims, internal appeals and external appeals, which shall include the address and telephone number at N.J.A.C. 11:24-8.7(b).

**New York:**
1. The specific reason for denial, reduction or termination of services.
2. Reference to the plan provision relied on in making the determination.
3. A description of any additional information needed to complete the claim.
4. A description of the appeal procedures including a description on the urgent appeal process if the claim involves urgent care.
5. If an internal rule, guideline or protocol was used in making the determination a copy of that information, or a statement that such information will be available to Customers free of charge. This includes copies of criteria used in medical necessity determinations or experimental treatments

If Oxford fails to adhere to the requirements for rendering decisions (above) the following rules apply to Customers enrolled on CT and NJ Products.

**Connecticut:** The Customer is deemed to have exhausted Oxford’s internal appeals process and may file an external review, regardless of whether Oxford could assert substantial compliance or de minimis error.

**New Jersey:** Customers are relieved of their obligation to complete the internal review process and may proceed directly to the External Review Process under the following circumstances:

- We fail to comply with any of the deadlines for completion of the internal appeals process without demonstrating good cause or because of matters beyond Our control while in the context of an ongoing, good faith exchange of information between parties and it is not a pattern or practice of noncompliance;
- We for any reason expressly waives Our rights to an internal review of any appeal; or
- The Customer and/or their Provider have applied for expedited external review at the same time as applying for an expedited internal review.

**Note:** In such a case where Oxford asserts good cause for not meeting the deadlines of the appeals process, Customers or their Designee and/or their Provider may request a written explanation of the violation. Oxford must provide the explanation within 10 days of the request and must include a specific description of the bases for which we determine the violation should not cause the internal appeals process to be exhausted. If an external reviewer or court agrees with Oxford and rejects the request for immediate review, the Customer will have the opportunity to resubmit their appeal.

**Criteria and Clinical guidelines**
We have adopted the MCG™ Care Guidelines and criteria for inpatient and ambulatory care where no specific Oxford policy exists. In addition to these guidelines, we develop specific policies related to covered services; each policy describes the service and its appropriate utilization.
We employ several means to review the consistency and quality of clinical decision making, as directed through policies and adopted guidelines. In addition to those required by regulatory agencies and NCQA are the following processes:

- Inter-rater reliability tests developed in conjunction with an external consultant
- Monthly Medical Director consistency meetings and case discussions
- Monthly blind reviews done by all Medical Directors on a common set of clinical factors

We employ a process for adopting and updating clinical practice guidelines for use by network physicians and other health care professionals. Clinical practice guidelines help practitioners and Customers make decisions about health care in specific clinical situations. Guidelines are developed for preventive screening, acute and chronic care, and appropriate drug usage, based on:

- Availability of accepted national guidelines
- Ability to monitor compliance
- Projected ability to make a significant impact upon important aspects of care

Clinical practice guidelines are available on our website. Simply go to OxfordHealth.com → Providers (or Facilities) → Tools & Resources → Medical Information → Clinical and Preventive Guidelines.

**Customers’ rights to external appeal**

The Customer has a right to an external appeal of a final adverse determination (FAD).

A FAD is a first-level appeal denial of an otherwise covered service where the basis for the decision is either a lack of medical necessity, appropriateness, healthcare setting, level of care or effectiveness or the experimental/investigational exclusion; The Customer’s condition or disease, and has certified that:

- Condition or disease is one for which standard health services are ineffective or medically inappropriate; or
- There does not exist a more beneficial standard health service or procedure covered by the health care plan; or
- There exists a clinical trial; and
- The Customer’s attending physician must have recommended either:
  - A health service or procedure including a pharmaceutical product within the meaning of PHL 4900(5) (b) (B) that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the Customer than any covered standard health service or procedure; or
  - A rare disease treatment for which the Customer’s attending physician certifies that there is no standard treatment.
  - A clinical trial for which the Customer is eligible; and
  - The specific health service or procedure recommended by the attending physician. An external appeal must be submitted within 4 months upon receipt of the FAD, regardless of whether or not a second level appeal is requested.
River Valley Entities Supplement

Important information regarding the use of this Supplement
This River Valley Entities Supplement applies to covered services rendered to River Valley Entities Customers other than Medicare Advantage, Medicaid and CHIP Customers by physicians, health care professionals, facilities and ancillary providers in either of the following categories:

- Their UnitedHealthcare participation agreement includes a reference to the River Valley or John Deere Health protocols or manuals, or they have directly contracted with one or more of the River Valley Entities to participate in networks maintained for River Valley Entities Customers; and

- They are located in AR, GA, IA, TN, VA, WI, or the following counties in Illinois: Jo Daviess, Stephenson, Carroll, Ogle, Whiteside, Lee, Mercer, Rock Island, Henry, Bureau, Putnam, Henderson, Warren, Knox, Stark, Marshall, Livingston, Hancock, McDonough, Fulton, Peoria, Tazewell, Woodford and McLean.

- River Valley Entities Customers are Customers whose benefit plans are sponsored, issued or administered by one of the following “River Valley Entities”:
  - UnitedHealthcare Services Company of the River Valley, Inc.
  - UnitedHealthcare Plan of the River Valley, Inc.
  - UnitedHealthcare Insurance Company of the River Valley

River Valley Entities Customers can be identified by a reference to uhcrivervalley.com on the back of their health care ID card.

Note: Physicians, health care professionals, facilities and ancillary providers whose participation agreements do not subject them to the River Valley Entities Supplement (including, but not limited to, providers in North Carolina, Ohio and South Carolina) can disregard the information in this Supplement and work with us when providing services to River Valley Entities Customers in the same way as you do when providing services to other UnitedHealthcare Customers. Information regarding a River Valley Entities Customer, including but not limited to eligibility information and claims status information, can be obtained by calling the telephone number on the back of the Customer’s health care ID card.

Note: This Supplement does not apply to Medicare Advantage, Medicaid or CHIP benefit plans. Refer to the UnitedHealthcare Community Plan administrative guides available on uhccommunityplan.com for Health Care Professionals for policies and procedures relating to the TennCare®, hawk-i®, and Secure Plus Complete Medicaid Plans®.

How to contact River Valley Entities
Physicians, health care professionals, facilities and ancillary providers that practice in Illinois, Iowa and Wisconsin should refer to the “Midwest” references in the following grid. Physicians, health care professionals, facilities and ancillary providers that practice in Arkansas, Georgia, Tennessee and Virginia should refer to the “Southeast” references in the following grid.

On or about April 1, 2016, we anticipate beginning to migrate members upon their employer renewal date from a legacy River Valley system to United’s platform. We will keep you informed via the Network Bulletin, letters and town hall meetings.
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<th>How to contact us</th>
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<th>What you can do there</th>
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<tr>
<td>Provider Web site</td>
<td>uhcrivervalley.com → Providers</td>
<td>• Find electronic claims submission guidelines</td>
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<td>• Review a Customer’s eligibility or benefits</td>
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<td>• Access provider e-Services</td>
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<td>• Find Clinical Practice Guidelines</td>
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<td>• Obtain demographic change forms</td>
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<td>• Obtain recoupment request forms to refund</td>
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<td>• overpayments</td>
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<td></td>
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<td>• Find the provider directory</td>
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<td>• Find newsletters</td>
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<td>• Find other forms</td>
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<tr>
<td></td>
<td></td>
<td>• View the monthly Medical Policy Update Bulletin</td>
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<td>• View the monthly Network Bulletin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Access Reimbursement Policies</td>
</tr>
<tr>
<td>Electronic claims submission</td>
<td>(866) 509-1593 or <a href="mailto:RVITEDISolutions@uhc.com">RVITEDISolutions@uhc.com</a></td>
<td>• Enroll in electronic data interchange (EDI) or ask questions regarding electronic claims submission requirements.</td>
</tr>
<tr>
<td>Claims submission on paper</td>
<td>UnitedHealthcare of the River Valley Commercial P.O. Box 5230 Kingston, NY 12402-5230</td>
<td>• Submit paper claims in hard copy (as outlined in the Claims section of this Supplement).</td>
</tr>
<tr>
<td>Tax ID numbers (TIN)/Provider ID numbers</td>
<td>(866) 509-1593 or <a href="mailto:RVITEDISolutions@uhc.com">RVITEDISolutions@uhc.com</a></td>
<td>• To update your NPI and related information online, go to uhcrivervalley.com → Providers → Forms</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contact our e-Business department for technical assistance about Tax or Provider ID numbers or for more information go to uhcrivervalley.com.</td>
</tr>
<tr>
<td>Claim reconsideration and appeal requests</td>
<td>Please refer to the Claim reconsideration, appeals process and resolving disputes section in the main part of this Guide under Our claims process.</td>
<td>• Obtain information regarding the process and timing for submitting claim reconsideration and appeal requests.</td>
</tr>
<tr>
<td>Enterprise Voice Portal</td>
<td>Phone: Illinois/Iowa/Wisconsin: (800) 747-1446 Tennessee/Virginia/Arkansas/Georgia: (800) 224-6602</td>
<td>• Determine Customer eligibility and benefits.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Check claim status</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Update facility/practice data.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Obtain information about the appeal submission process</td>
</tr>
<tr>
<td>Preauthorization for procedures and services, except for those otherwise referenced in this grid below, including preauthorization for certain Durable Medical Equipment (DME)</td>
<td>Fax: (888) 242-9058 Phone: (800) 747-1446 Ext: 65212 Mail: UnitedHealthcare Attn: Clinical Coverage Review 1300 River Drive, Suite 200 Moline, IL 61265</td>
<td>• Request preauthorization for procedures and services including DME, orthotics, prosthetics, and other supply items (may need to be obtained through a contracted vendor) by completing a Medical Necessity Form at: uhcrivervalley.com → Providers → Forms.</td>
</tr>
<tr>
<td>Mental health, substance abuse, vision, or transplant services</td>
<td>Illinois/Iowa/Wisconsin: (800) 747-1446 Tennessee/Virginia/Arkansas/Georgia: (800) 224-6602</td>
<td>• Inquire about a Customer’s behavioral health, vision, or transplant services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Most mental health and substance abuse services must be approved (preauthorized) through the contracted mental health or substance abuse vendor.</td>
</tr>
<tr>
<td>How to contact us</td>
<td>Where to go</td>
<td>What you can do there</td>
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<tr>
<td>-------------------------------------------------------</td>
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<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Skilled/extended Care</td>
<td>Phone: Midwest: (800) 747-1446</td>
<td>• Request preauthorization for skilled/extended care</td>
</tr>
<tr>
<td></td>
<td>Southeast: (800) 224-6602</td>
<td></td>
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<tr>
<td></td>
<td>Fax: Midwest: (888) 534-3258</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Southeast: (800) 880-5403</td>
<td></td>
</tr>
<tr>
<td>Pharmacy services/ prescription drugs requiring</td>
<td>OptumRx Phone: (800) 711-4555</td>
<td>• Request preauthorization for prescription drugs as outlined in this Supplement</td>
</tr>
<tr>
<td>preauthorization</td>
<td>uhcrivervalley.com - Pharmacy</td>
<td>• View the prescription drug list (PDL)</td>
</tr>
<tr>
<td>Preauthorization for end-of-life care and home care</td>
<td>Phone: (800) 747-1446 Ext: 65212</td>
<td>• Request preauthorization for home health care services by downloading a Home Health</td>
</tr>
<tr>
<td>and home health including infusion services</td>
<td>Fax: (800) 340-2184</td>
<td>Authorization Form:</td>
</tr>
<tr>
<td></td>
<td>Mail: UnitedHealthcare</td>
<td>uhcrivervalley.com → Providers → Forms → Home Health Authorization Form</td>
</tr>
<tr>
<td></td>
<td>Attn: Clinical Coverage Review</td>
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<tr>
<td></td>
<td>1300 River Drive, Suite 200</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Moline, IL 61265</td>
<td></td>
</tr>
<tr>
<td>Out-of-network referrals</td>
<td>Phone: (800) 747-1446 Ext: 65287</td>
<td>• Request an out-of-network (OON) referral by completing an OON Request Form, at:</td>
</tr>
<tr>
<td></td>
<td>Fax: (800) 299-3779</td>
<td>uhcrivervalley.com → Providers → Forms → Out-of-Network Referral Form</td>
</tr>
<tr>
<td></td>
<td>Mail: UnitedHealthcare</td>
<td></td>
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<tr>
<td></td>
<td>Attn: Clinical Coverage Review</td>
<td></td>
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<tr>
<td></td>
<td>1300 River Drive, Suite 200</td>
<td></td>
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<tr>
<td></td>
<td>Moline, IL 61265</td>
<td></td>
</tr>
<tr>
<td>Notification of inpatient admissions</td>
<td>Phone: Midwest: (800) 747-1446</td>
<td>• Notify us of inpatient admissions</td>
</tr>
<tr>
<td></td>
<td>Southeast: (800) 224-6602</td>
<td></td>
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<tr>
<td></td>
<td>Fax: Midwest: (888) 534-3258</td>
<td></td>
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<tr>
<td></td>
<td>Southeast: (800) 880-5403</td>
<td></td>
</tr>
<tr>
<td>Disease Management</td>
<td>Toll-Free Phone Number: (800) 369-2704, Option # 4</td>
<td>• Request Disease Management services for your patients</td>
</tr>
<tr>
<td></td>
<td>Hours: 8:00 a.m. – 4:30 p.m. Central Time</td>
<td>• Request Consumer and Provider Rights and Responsibilities</td>
</tr>
<tr>
<td></td>
<td>Toll-Free Fax Number: (866) 950-7759, Attn: CMT</td>
<td>• Provide information to the Care Management Tool (CMT) Coordinator</td>
</tr>
<tr>
<td></td>
<td>Coordinator</td>
<td></td>
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<td></td>
<td>Email: <a href="mailto:MailWebCDM@uhc.com">MailWebCDM@uhc.com</a></td>
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</tr>
<tr>
<td></td>
<td>uhcrivervalley.com → Providers → Health Programs</td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td>Phone: (800) 369-2704, Ext 2</td>
<td>• Request Case Management services for your patients</td>
</tr>
<tr>
<td>Cardiology:</td>
<td>Online: CareCoreNational.com</td>
<td></td>
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<tr>
<td>- Diagnostic Catheterization</td>
<td>Phone: (866) 889-8054</td>
<td></td>
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<tr>
<td>Electrophysiology Implants, Echocardiogram and Stress</td>
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<tr>
<td>Echocardiogram</td>
<td></td>
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</tr>
<tr>
<td>Radiology/Advanced Outpatient Imaging Procedures:</td>
<td>Online: CareCoreNational.com</td>
<td>• Request preauthorization for services as described in the Cardiology Notification/Pri</td>
</tr>
<tr>
<td>Certain CT scans, MRIs, MRAIs, PET scans and nuclear</td>
<td>Phone: (866) 889-8054</td>
<td>or Authorization Protocol for Commercial Customers section of this Guide.</td>
</tr>
<tr>
<td>medicine studies, including nuclear cardiology</td>
<td></td>
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</tr>
</tbody>
</table>
Claims

Claims format
All claims for medical or hospital services must be submitted using, as applicable, the CMS-1500 or UB-04, their successor forms for paper claims and HIPAA standard professional or institutional claim formats for electronic claims. The use of black ink is recommended when completing a CMS-1500 claim. Black ink on a red CMS-1500 claim will allow for optimal scanning into our claims processing system.

Electronic claims submission and billing
You should submit your claims electronically. Specific exceptions to this requirement are set forth below.

For electronic claims submission requirements, please see the River Valley Entities’ HIPAA Transaction Standard Companion Guide. The River Valley Entities’ HIPAA Transaction Standard Companion Guide is located at uhcrivervalley.com → Providers → HIPAA Information → Companion Documents.

This document should be shared with your software vendor. Please note that we update the Companion Guide from time to time and you should routinely review the Companion Guide to ensure you have the most current information about our requirements.

To obtain more information regarding electronic claims, please refer to the EDI section of this Supplement or the provider section of uhcrivervalley.com.

Exceptions to electronic claims submission guidelines
The following claims require attachments and, therefore, must be submitted on paper:

- Claims submitted for dental pre-treatments for crown lengthening, periodontics, implants and veneers.
- Claims submitted with unlisted procedure codes if sufficient information is not in the notes field.

Except as provided above, please do not send claims on paper or with claim attachments unless we request it.

- Note: No special rules apply to electronic claims that append Modifier 59 or for claims for dental pre-treatment; however, as noted above certain pre-treatment claims must be submitted on paper.

Claims with special rules for electronic submission

- Corrected Claims: must include the words “corrected claims” in the notes field. Your software vendor can instruct you on correct placement of all notes.
- Unlisted Procedure Code Claims: must include a sufficient description in the notes field. If you are not able to do so you must submit a paper claim.
- Claims That Require Dates of Service by Line Item: Claims for occupational therapy, speech therapy, physical therapy, dialysis, and mental health or substance abuse services require the date of service by line item. We do not accept span dates for these types of claims.
- Secondary Coordination Of Benefits (COB) Claims: must include the following fields:
  - Institutional: Payer Prior Payment, Medicare Total Paid Amount, Total Non-Covered Amount, Total Denied Amount.
  - Professional: Payer-Paid Amount, Line Level Allowed Amount, Patient Responsibility, Line Level Discount Amount (contractual discount amount of other payer), Patient-Paid Amount (Amount that the payer paid to the Customer not the provider).
  - Dental: Payer Paid Amount, Patient Responsibility Amount, Discount Amount (contractual discount amount of other payer), Patient Paid Amount (Amount that the payer paid to the Customer not the provider).
  - Span Dates: Exact dates of service are required when the claim spans a period of time. Please indicate the specific dates of service in Box 24 of the CMS-1 500, Box 45 of the UB-04, or the Remarks field. This will eliminate the need for an itemized bill and allow electronic submission.
Requirements for claims (paper or electronic) reporting revenue codes

- All claims reporting Revenue Codes require the exact dates of service if they are span dates.
- If Revenue Code 270 is submitted by itself on an institutional claim for outpatient services, we require a valid CPT or HCPCS code or description.
- If you report Revenue Code 274, you are required to provide a description of the services or a valid CPT or HCPCS code.
- Claims reported with Revenue Codes 250-259 require an itemized statement if the charges exceed $1,000.
- All claims reporting the Revenue Codes on the list below require that you report the appropriate CPT and HCPCS codes.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>260</td>
<td>IV Therapy (General Classification)</td>
</tr>
<tr>
<td>261</td>
<td>Infusion Pump</td>
</tr>
<tr>
<td>262</td>
<td>IV therapy/pharmacy services</td>
</tr>
<tr>
<td>263</td>
<td>IV therapy/drug/supply delivery</td>
</tr>
<tr>
<td>264</td>
<td>IV Therapy/Supplies</td>
</tr>
<tr>
<td>269</td>
<td>Other IV therapy</td>
</tr>
<tr>
<td>290</td>
<td>Durable Medical Equipment (other than renal) (General Classification)</td>
</tr>
<tr>
<td>291</td>
<td>Durable Medical Equipment/Rental</td>
</tr>
<tr>
<td>292</td>
<td>Purchase of new DME</td>
</tr>
<tr>
<td>293</td>
<td>Purchase of used DME</td>
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<tr>
<td>300</td>
<td>Laboratory (General Classification)</td>
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<tr>
<td>301</td>
<td>Chemistry</td>
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<td>302</td>
<td>Immunology</td>
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<td>303</td>
<td>Renal Patient (Home)</td>
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<td>304</td>
<td>Non-Routine Dialysis</td>
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<td>305</td>
<td>Hematology</td>
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<tr>
<td>306</td>
<td>Bacteriology &amp; Microbiology</td>
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<td>307</td>
<td>Urology</td>
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<td>309</td>
<td>Other laboratory</td>
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<tr>
<td>310</td>
<td>Laboratory -Pathology (General Classification)</td>
</tr>
<tr>
<td>311</td>
<td>Cytology Histology</td>
</tr>
<tr>
<td>312</td>
<td>Other Laboratory Pathological</td>
</tr>
<tr>
<td>319</td>
<td>Radiology –diagnostic (General Classification)</td>
</tr>
<tr>
<td>320</td>
<td>Angiocardiology</td>
</tr>
<tr>
<td>321</td>
<td>Arthrography</td>
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<td>322</td>
<td>Arteriography</td>
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<td>323</td>
<td>Chest X-Ray</td>
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<tr>
<td>324</td>
<td>Other Radiology-Diagnostic</td>
</tr>
<tr>
<td>329</td>
<td>Radiology –Therapeutic and/or Chemotherapy Administration (General Classification)</td>
</tr>
<tr>
<td>330</td>
<td>Chemotherapy Administration- Injected</td>
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<tr>
<td>331</td>
<td>Chemotherapy Administration- Injected Radiation Therapy</td>
</tr>
<tr>
<td>332</td>
<td>Chemotherapy Administration- Oral</td>
</tr>
<tr>
<td>333</td>
<td>Radiation Therapy</td>
</tr>
<tr>
<td>335</td>
<td>Chemotherapy Administration/IV</td>
</tr>
<tr>
<td>339</td>
<td>Other Radiology-Therapeutic</td>
</tr>
<tr>
<td>340</td>
<td>Nuclear Medicine (General Classification)</td>
</tr>
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<td>341</td>
<td>Diagnostic Procedures</td>
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<td>342</td>
<td>Therapeutic Procedures</td>
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<tr>
<td>350</td>
<td>CT Scan (General Classification)</td>
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<tr>
<td>351</td>
<td>CT-Head Scan</td>
</tr>
<tr>
<td>352</td>
<td>CT-Body Scan</td>
</tr>
<tr>
<td>359</td>
<td>Operating Room Services (General Classification)</td>
</tr>
<tr>
<td>360</td>
<td>Other Operating Room Services</td>
</tr>
<tr>
<td>361</td>
<td>Minor Surgery</td>
</tr>
<tr>
<td>362</td>
<td>Organ Transplant: Other Than Kidney Transplant</td>
</tr>
<tr>
<td>400</td>
<td>Diagnostic</td>
</tr>
<tr>
<td>401</td>
<td>Mammography</td>
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<tr>
<td>402</td>
<td>Ultrasound</td>
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<td>403</td>
<td>Screening Mammography</td>
</tr>
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<td>404</td>
<td>Positron Emission</td>
</tr>
<tr>
<td>409</td>
<td>Tomography Other Imaging Services</td>
</tr>
<tr>
<td>410</td>
<td>Respiratory Services (General)</td>
</tr>
<tr>
<td>412</td>
<td>Inhalation Services</td>
</tr>
<tr>
<td>419</td>
<td>Other Respiratory Services</td>
</tr>
<tr>
<td>460</td>
<td>Pulmonary Function (General Classification)</td>
</tr>
<tr>
<td>469</td>
<td>Other-Pulmonary Function</td>
</tr>
<tr>
<td>470</td>
<td>Audiology (General Classification)</td>
</tr>
<tr>
<td>471</td>
<td>Audiology/Diagnostic</td>
</tr>
<tr>
<td>472</td>
<td>Audiology/Treatment</td>
</tr>
<tr>
<td>480</td>
<td>Cardiology (General Classification)</td>
</tr>
<tr>
<td>481</td>
<td>Cardiac Cath Lab</td>
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<td>482</td>
<td>Stress Test</td>
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<td>483</td>
<td>Echocardiology</td>
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<tr>
<td>489</td>
<td>Other Cardiology</td>
</tr>
<tr>
<td>490</td>
<td>Ambulatory Surgical Care (General Classification)</td>
</tr>
<tr>
<td>499</td>
<td>Other Ambulatory Surgical Care</td>
</tr>
<tr>
<td>610</td>
<td>Magnetic Resonance Technology (General Classification)</td>
</tr>
<tr>
<td>611</td>
<td>MRI – Brain/Brain Stem</td>
</tr>
<tr>
<td>612</td>
<td>MRI - Spinal Cord/Spine</td>
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<tr>
<td>614</td>
<td>MRI - Other</td>
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<tr>
<td>615</td>
<td>MRA – Head and Neck</td>
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<tr>
<td>616</td>
<td>MRA – Lower Extremities</td>
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<tr>
<td>618</td>
<td>MRA Other</td>
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<tr>
<td>618</td>
<td>Other MRT</td>
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<tr>
<td>623</td>
<td>Surgical Dressing</td>
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<tr>
<td>624</td>
<td>FDA Investigational Devices</td>
</tr>
<tr>
<td>634</td>
<td>Erythropoietin (EPO) &lt; 10,000 units</td>
</tr>
<tr>
<td>635</td>
<td>Erythropoietin (EPO) &gt; 10,000 units</td>
</tr>
<tr>
<td>636</td>
<td>Drugs Requiring Detail Coding</td>
</tr>
<tr>
<td>730</td>
<td>EKG/ECG (Electrocardiogram) (General Classification)</td>
</tr>
<tr>
<td>731</td>
<td>Holter Monitor</td>
</tr>
<tr>
<td>732</td>
<td>Telemetry</td>
</tr>
<tr>
<td>739</td>
<td>Other EKG/ECG</td>
</tr>
<tr>
<td>740</td>
<td>EEG (Electroencephalogram) (General Classification)</td>
</tr>
<tr>
<td>750</td>
<td>Gastro-Intestinal (GI) Services (General Classification)</td>
</tr>
<tr>
<td>790</td>
<td>Extra-Corporeal Shock Wave Therapy (formerly Lithotripsy) (General Classification)</td>
</tr>
<tr>
<td>921</td>
<td>Peripheral Vascular Lab</td>
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<tr>
<td>922</td>
<td>Electromyogram</td>
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<td>923</td>
<td>Pap Smear</td>
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<td>924</td>
<td>Allergy Test</td>
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<td>925</td>
<td>Pregnancy Test</td>
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<tr>
<td>929</td>
<td>Additional Diagnostic Services</td>
</tr>
<tr>
<td>940</td>
<td>Other Therapeutic Services (General Classification)</td>
</tr>
<tr>
<td>941</td>
<td>Recreational Therapy</td>
</tr>
<tr>
<td>942</td>
<td>Education/Training (Diabetic Education)</td>
</tr>
<tr>
<td>949</td>
<td>Other Therapeutic Services (HRSA approved weight loss providers)</td>
</tr>
</tbody>
</table>
**Claim Reconsideration and Appeals Process and Resolving Disputes**

Please refer to *Claim reconsideration, appeals process and resolving disputes* section in the main part of this Guide under Our claims process for detailed information about the reconsideration and appeal process.

**Electronic Data Interchange (EDI)**

You may use EDI to submit claims and conduct other business with us electronically. To enroll, please call EDI Customer service at (866) 509-1593 or send an email to: RVIDISolutions@uhc.com.

**Claims transmission**

You should inform your office software vendor that you want to begin electronic transmission of claims to the River Valley Entities, Payer ID 87726 for medical claims and 95378 for dental.

All claims are received through our clearinghouse, OptumInsight. The clearinghouse sets up all claims as commercial. Your EDI software vendor is responsible for establishing your connectivity to the clearinghouse. Your vendor can advise you of the specific requirements that apply to claims transmissions to the River Valley Entities.*

**EDI acknowledgment/status reports**

Your software vendor will provide you with a report that shows only that an electronic claim left your office. It does not confirm that claims have been received or accepted at the clearinghouse or by us.

Clearinghouse acknowledgment reports do show the status of your claims. They are returned after each transmission so you are able to confirm immediately whether a claim reached us for payment or was rejected because of an error, because additional information is needed or for any other reason. This allows you to correct any errors and retransmit a claim the same day so there will be no delay in processing.

You will also receive various Status Reports from the River Valley Entities that provide additional information on the status of claims including copies of EOBs/remittance advice and denial letters that may request additional information.

It is very important that you carefully review all Vendor Reports, Clearinghouse Acknowledgment Reports and the River Valley Entities’ Status Reports as soon as you receive them. You will know the status of each claim you have submitted and you will be able to correct any errors promptly.

**Provider e-Services**

The River Valley Entities’ provider e-Services can be accessed at uhcrivervalley.com. You will find the following tools that will allow you to quickly and efficiently obtain important and up-to-date information you need when providing services to our Customers:

**Claim status review**

You may locate specific claims using either your provider ID or a specific Customer’s ID and obtain a claim summary or line-item detail about claims status including whether we have received the claims and whether they have been paid, pended or denied.

**Benefits and eligibility**

You may verify the eligibility of your patients before you see them and obtain information about their benefits including required co-payments and any deductibles, out-of-pocket maximums or co-insurance for which your patients are responsible.

**PCP roster**

You may find a list of all Customers who have designated you as their Primary Care Physician.

**Registration for provider e-Services**

Before you may use Provider e-Services, your office is required to designate a Security Administrator. The Security Administrator (1) will be the primary contact with the River Valley Entities and (2) is responsible for maintaining access for all users in your office. An officer of your organization who has authority for the TINs and is seeking access to Provider

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* For River Valley Customers, Providers are not able to submit claims via the “Connectivity Director” or UnitedHealthcareOnline.com All-Payer GatewayTM. The tools for preparing, submitting and managing claims found on UnitedHealthcareOnline.com, including the Claim Estimator are also not available with respect to River Valley Customers.
e-Services should complete the Security Administrator Form identifying the Security Administrator. You may submit the form online at: uhcrivervalley.com → Providers → Providers e-Services → Register -Today.
Within 7 to 10 days after submission, the Security Administrator will receive a User ID and Password in separate letters via US mail.
For additional information on the registration process, go to uhcrivervalley.com, and in the section entitled “e-Services” select “Register Now” or the link for providers under “Why use e-Services”.
For technical assistance or information, you may contact our e-Business department from 8:00 a.m. – 4:30 p.m. CST by telephone at (866) 509-1593.

Reimbursement policies
In accordance with your agreement with us, payment of claims is subject to reimbursement policies, among other things. You may find these policies at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Reimbursement Policies – Commercial. Changes to our reimbursement policies are generally announced in the Network Bulletin available at UnitedHealthcareOnline.com → Quick Links → Network Bulletin.
We also apply coding edits procedures, based primarily on the National Correct Coding Initiative (NCCI) edits developed by the Centers for Medicare and Medicaid Services (CMS) as well as the CMS’ Outpatient Code Editor (OCE). You may find the NCCI edits and the OCE at cms.gov → Medicare → Coding → National Correct Coding Initiative Edits.

Utilization Management Program
Program components
The River Valley Entities’ Utilization Management Program (UM) has several components. These include but are not limited to: (1) preauthorization for various procedures, medical services, treatments, prescription drugs and durable medical equipment; (2) review of the appropriateness of inpatient admissions and ongoing coverage of in-patient care; (3) prior approval for referrals to non-participating providers, if applicable under a Customer’s benefit plan; and (4) case management. Our goal is to encourage the highest quality of appropriate care, in the most appropriate setting from the most appropriate provider.

Providers must cooperate with our UM program. You will allow us access, in the form we request, to information on covered services provided to our Customers and you will allow us to collect data that will facilitate UM reviews and decisions.

Medical policies, drug policies and coverage determination guidelines
The River Valley Entities have adopted Medical Policies, Drug Policies and Coverage Determination Guidelines (previously referred to as “Coverage Policies”), to assist us in making coverage determinations which includes evaluating whether a particular treatment or service is medically necessary and appropriate in a particular case. The Medical Policies, Drug Policies and Coverage Determination Guidelines are developed and approved by a committee that includes physicians and other medical professionals representing multiple specialties and are based on current clinical practices, current peer-reviewed medical literature, evidence-based medicine and other relevant factors.
Coverage determinations are also based on other factors including but not limited to a Customer’s eligibility, the Customer’s benefit plan document (such as a summary plan description), applicable state or federal law benefit mandates, and evidence-based guidelines which may include MCG™ Care Guidelines, (formerly known as Milliman Care Guidelines®). The clinical coverage criteria reflected in our policies is based on current clinical principles and processes and evidence-based practices. Medical Policies, Drug Policies and Coverage Determination Guidelines are developed as needed and are regularly reviewed and modified as necessary to ensure that they reflect changes and advances in healthcare treatment.

Access to Policies
**Policy Updates**

**Preauthorization**

**Services that require preauthorization**
“Preauthorization” means a process of evaluating and authorizing coverage for services using clinical coverage review criteria. The River Valley Entities require preauthorization for certain procedures, items of durable medical equipment (DME), prescription drugs and other services. Many are indicated throughout this Supplement and are posted at uhcrivervalley.com → Providers → Coverage Policy Library → Services Requiring Preauthorization.

**Physician responsibility for submitting adequate clinical documentation**
It is your responsibility to request preauthorization when it is required. It is important that you provide complete clinical information and medical documentation to support the services you are requesting at the time you submit your request so that we may promptly determine whether the services are covered and medically necessary. We make these determinations based upon the information available to us at the time we are required to make a decision. We will consider additional information provided within the time period allowed for review, but delayed submissions increase administrative time and work for you and for us.

The preauthorization request also must include the documentation needed to evaluate each particular procedure, device, drug and service for which you seek authorization. You should refer to our Coverage Policies when determining what documentation and information you should provide.

**How to request preauthorization when required**
Please refer to the How to contact River Valley section at the beginning of this Supplement for information regarding how to submit a request for preauthorization when required.

Failure to obtain preauthorization when required may result in denial of a claim and you cannot bill the Customer for such denied services.

**Preauthorization review hours**
The River Valley Entities’ staff is available for review of preauthorization requests from Monday through Friday from 8:00 a.m. CT to 4:30 p.m. CT with the exception of national holidays and the day after Thanksgiving. Medical Directors are available to discuss clinical policies or decisions by calling the following numbers: Illinois/Iowa/ Wisconsin: (800) 747-1446; Tennessee/Virginia/Arkansas/Georgia: (800) 224-6602.

**Clinical review of a preauthorization request**
When we receive a preauthorization request, our Clinical Coverage Review Department evaluates the submitted clinical information to determine whether the procedures, devices, drugs or other services are medically necessary and appropriate in a particular case. River Valley Entities’ nursing staff may make decisions to approve care based on specific criteria. Care and/or services that do not fall within the criteria are referred to a Medical Director or other appropriate reviewer such as a Board-Certified Physician in the applicable specialty or a Registered Pharmacist, to evaluate circumstances or conditions that the criteria do not address. Only physicians and other appropriate providers may issue a medical necessity denial for coverage.

The River Valley Entities’ staff and their delegates who make these decisions are not rewarded for denying coverage. The River Valley Entities and its delegates do not offer incentives to physicians to encourage underutilization of care or services.
The treating physician has the ultimate authority for the medical care of the patient. The medical management process does not override this responsibility.

**Timing of utilization management decisions**

We make our utilization management decisions within the time periods required by state and federal law (including ERISA when applicable) for the nature of the request, and in accordance with National Committee for Quality Assurance (NCQA) standards.

We also provide notice of our decisions to providers and Customers in the form and manner required by applicable state and federal law and in accordance with NCQA standards and River Valley Entities’ policy. Among other things, all denial letters outline a Customer’s appeal rights, including, where applicable, the right to an expedited and/or external review, as well as the requirements for submitting an appeal and the requirements for our response. A Customer may designate a health care professional to appeal a decision on the Customer’s behalf. A copy of the Customer’s written consent is required and must be submitted with the appeal.

**Facility Utilization Review**

**Notification of inpatient admission required**

Facilities are required to notify us of an inpatient admission within 24 hours of the admission or on the next business day following a holiday or weekend admission. The notification should include the Customer’s name, identification number, admitting diagnosis, and the name of the attending physician.

**Failure to notify**

If the facility does not notify us of an inpatient admission as required, claims will be returned to the facility as not allowed (the facility is not allowed to bill the Customer for the services). The facility must contact our Utilization Management department with case information and a Medical Director will determine the appropriateness of the admission and length of stay. The facility will be responsible for all hospital charges deemed not allowed by our Medical Director. The facility will need to resubmit the claims.

**Inpatient review**

Inpatient review is a component of our utilization management activities. The Medical Director and other clinical staff review Customer hospitalizations to detect and better manage over- and under-utilization and to determine whether the admission and continued stay are medically appropriate and consistent with evidence-based guidelines.

Where appropriate, the River Valley Entities also use MCG™ Care Guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions, on a case by case basis, in many health care settings, including acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. Criteria other than MCG™ Care Guidelines may be used in special situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay.

Inpatient review also gives us the opportunity to contribute to decisions about discharge planning and case management. In addition, we may identify opportunities for quality improvement and cases that are appropriate for referral to one of our disease management programs.

We usually begin our review on the first business day following admission. If a nurse reviewer believes that an admission or continued stay does not meet criteria you will be asked for more information concerning the treatment and case management plan. The nurse will then refer the case to our Medical Director. If our Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified.

If you wish to speak with our Medical Director, you will be allowed that opportunity within 1 business day of the request. When complex decisions require expertise outside the scope of the usual physician advisor, we will have a board-certified physician of the relevant specialty (or similar specialty) review the case. External independent review will be obtained when we determine it is appropriate or by Customer request according to applicable law.
Admission to other facilities

Admission to Rehabilitation Units
All rehabilitation confinements require authorization for admission and are reviewed concurrently for continued services at this level of care. Please refer to the Skilled/Extended Care row in the How to contact River Valley section at the beginning of this Supplement for information on how to submit a request for preauthorization.

Admission to skilled nursing units
A Customer may require inpatient skilled nursing care due to acute illness, injury, surgery, or exacerbation of a disease process.

- Preauthorization is required for all admissions to a Skilled Nursing Facility (or skilled level of care within an acute facility). Please refer to the How to contact River Valley section at the beginning of this Supplement for information regarding how to submit a request for preauthorization.

- The facility must submit the documented plan of care including treatment goals, summary of services to be provided, expected length of stay (LOS), and initial discharge plan.

- Initial certification for admissions will be authorized consistent with the level of care required based upon the anticipated treatment plan.

Concurrent review is conducted at least weekly, or more often if indicated

- The skilled facility provider is responsible for providing appropriate/adequate documentation, including changes in the level of care.

- Approval for additional days of authorized coverage must be obtained prior to the expiration of the authorization.

- Determinations regarding levels of care must consider not only the level of service but also the medical stability of the Customer.

- Disagreements regarding the level of care required will be addressed by our Medical Director in consultation with you (as the physician managing the Customer in the skilled facility, not the transferring attending physician). The appeal procedure can be initiated as desired by the Customer and/or authorized representative when coverage is not authorized.

- We determine whether the admission and subsequent stay and care are covered and medically necessary based upon the following clinical guidelines among others:

  - Services must be ordered by a physician and be reasonable and necessary for the treatment of the Customer’s illness or injury, i.e., be consistent with the nature and severity of the individual’s illness or injury, particular medical needs, and accepted standards of medical practice.

  - The Customer must be clinically stable with clinical and lab findings improving/unchanged for the last 24 hours and diagnosis and initial treatment plan established prior to admission to the skilled nursing facility.

  - The services must also be reasonable in terms of duration and quantity. The Customer must require skilled services on a daily basis (i.e., available on a 24-hour basis, 7 days/week). If skilled rehabilitation services are not available on a 7 day-a-week basis, a Customer whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the daily basis requirement when he/she needs and receives those services at least 5 days a week. Skilled services, however, are required and provided at least 3 times per day. Note that the frequency with which a service must be performed does not, by itself, make it a skilled service.

  - The nature and complexity of a service and the skills required for safe and effective delivery of that service are considered in determining whether a service is skilled. Skilled care requires frequent patient assessment and review of the clinical course and treatment plan for a limited time period, until a condition is stabilized or a predetermined treatment course is completed. Skilled care is goal-oriented to progress the Customer toward functional independence, and requires the continuing attention of trained medical personnel.
Admission for observation
We may review observation services concurrently or post-discharge to determine whether the use of hospital services was appropriate and medically necessary. Inappropriate use of observation services may result in physician education, sanction, or payment denial or any other action permitted under your participation agreement.

Observation services are a means to evaluate and determine a Customer’s need for hospital admission. Observation may be appropriate when determining response to treatment, or monitoring/diagnosing a medical condition when such diagnostic testing or treatment exceeds usual outpatient care. Observation is generally used when 48 hours or less is needed for evaluation of a Customer’s condition. In rare and exceptional cases, observation services may span more than 48 hours. Transition to inpatient admission status from observation is generally indicated when:

- A condition is diagnosed requiring a long-term (usually greater than 48 hours) stay (e.g., acute MI).
- Long-term (usually greater than 48 hours) treatment or monitoring is needed for a condition (e.g., persistent severe asthma).

Notice of termination of inpatient benefits
We may determine that an admission and/or a continued stay in a Hospital, Rehabilitation Unit or Skilled Nursing Facility (SNF) are not covered benefits for a number of reasons including, but not limited to the following:

- A Medical Director determines that an admission or continued stay, which was not preapproved at an out-of-network facility, is not medically necessary at the level of care the facility provides;
- Preauthorization was not obtained for a procedure or service subject to that requirement and/or the procedure or service is not a covered benefit under the Customer’s benefit plan;
- A Medical Director determines that the Customer’s condition is custodial, and is a non-covered benefit;
- A Medical Director and the attending physician determine that continued acute inpatient/Acute Inpatient Rehabilitation/SNF level of care is no longer medically necessary but the patient refuses discharge;
- The Customer has exhausted all existing inpatient or skilled care benefits under his or her benefit plan. If a non-coverage determination is made, written notification will be provided to the physician, the Customer and facility on the day the determination is made.

Referrals
In-network referrals
An in-network referral allows a Customer enrolled in a primary care coordinator (PCC) plan to access care from a participating provider other than a PCP (for instance, a Specialist) at the in-network benefit level. Additional information regarding in-network referrals for PCC benefit plans is provided in the sections below.

Referrals are required when we are the primary or secondary payer. Please note that a referral does not guarantee payment of a claim.

In-network referral process for primary care coordinator (PCC) plans
An in-network referral allows a Customer to access care from a participating provider other than a PCP (for instance, a Specialist) at the in-network benefit level. Referral requests must originate from the Customer’s network PCP. The final decision concerning a referral will be the sole responsibility of the participating PCP. Specialist-to-Specialist referrals are not allowed. If the treating Specialist feels it is necessary for the Customer to see another Specialist, he/she must contact the Customer’s PCP, who will be responsible for making all new referrals.

Standard exceptions to the in-network referral process:
- Female Customers are allowed direct access to network OB/GYN providers without a referral.
- Customers are allowed direct access to network ophthalmologists or contracted vision providers for an annual diabetic dilated eye exam, without a referral.
- Customers with a split copayment (where the Customer has one copay amount for PCP visits and a higher copay amount for specialty visits) do not require a referral to see an network Specialist.
Process to facilitate in-network referrals for the Customer:

- The PCP determines the need for an in-network referral to a network Specialist, communicates this to the Customer, and sends a letter of referral or phones/faxes a referral to the consulting Specialist. The PCP indicates in the referral what services he/she is requesting that the Specialist provide.

- Service requests must be a covered benefit under the Customer’s plan and must be made to participating providers.

- To facilitate continuity and coordination of care, the referring PCP should provide timely communication of clinical information to the Specialist. Likewise, the Specialist should provide written communication to the Customer's PCP, providing a description of health services rendered to the Customer at the referrals visit(s).

- A Specialist submits claim(s) for services, providing PCP’s name and UPIN/NPI number in boxes 17 & 17a of the CMS-1500 form. The River Valley universal referral number 2009061 RV is placed in Box 23 of the HCIF 1500 form to serve as authorization for payment at the Customer's in-network benefit level.

Out-of-network (OON) referrals

An out-of-network (OON) referral means a written authorization provided by a participating physician and approved by the River Valley Entities for services from a non-participating provider. OON referrals must be requested by the Customer’s PCP. If an OON referral is obtained, services received from a non-participating provider are covered at an in-network level of benefits under the Customer’s benefit plan. An OON referral is needed when services are not available from a participating provider and may be needed for various services including, but not limited to, podiatry, chiropractic and mental health/substance abuse services. To determine whether an OON referral is necessary under a Customer’s benefit plan, contact Customer Care at the number on the back of the Customer’s health care ID card. Additional information regarding OON referrals is provided in a section below.

Referrals are required when we are the primary or secondary payer. Please note that a referral does not guarantee payment of a claim.

Out-of-network referral approval

When services are not available from a participating provider, an out-of-network referral to a non-participating provider must be approved by us prior to services being rendered by the non-participating provider. We must be advised of all requests for out-of-network referrals (except emergencies). A Medical Director will review requests not meeting approval criteria. In the case of emergencies, we must be notified the 1st business day following the referral. Prior approval for modified or expired out-of-network referrals must also occur as described herein. Prior approval for referral extensions must also occur as described above. Prior approval of an out-of-network referral is required for each follow up visit unless we indicate otherwise.

Requests for prior approval may be obtained by completing an out-of-network referral request form and faxing it with documentation for consideration. A copy of the out-of-network referral request form can be accessed at uhcrivervalley.com ➔ Providers ➔ Forms ➔ Out-of-Network Referral Form.

- Decisions will be made within the time periods required by state and federal law (including ERISA when applicable) for the nature of the request, and in accordance with National Committee for Quality Assurance (NCQA) standards.

- A letter confirming our approval or denial of a referral will be sent to the Customer and your office.

- If a Customer requests approval after the fact, please advise the Customer that this is contrary to policy and refer the Customer to call the following numbers if they have further questions: Illinois/Iowa/Wisconsin: (800) 747-1446; Tennessee/Virginia/Arkansas/Georgia: (800) 224-6602.

Participating physicians may not refer their own family Customers to non-participating physicians/facilities due to the inherent conflict of interest.

Note: If the physician denies a referral to the Customer, the physician must inform the Customer that he/she should refer to his/her benefit document for any appeal rights or call the following numbers:

- Illinois/Iowa/Wisconsin: (800) 747-1446;
- Tennessee/Virginia/Arkansas/Georgia: (800) 224-6602
Services obtained outside the River Valley Entities’ service area

- The River Valley Entities’ Clinical Services Department processes service requests for treatment authorizations as directed by you and the out-of-area (OOA) attending physician.

- The River Valley Entities’ Clinical Services Department in conjunction with you and the OOA attending physician coordinates a Customer’s transfer back to the Service Area when medically feasible and appropriate.

- We provide coverage for OOA services for urgent or emergent stabilization services in accordance with the Customer’s benefit plan. This will include the time he/she is stabilized in the emergency room, prior to admission as an inpatient or discharge from the facility.

- We also provide coverage for post-stabilization care services. Post-stabilization care services are those that are provided after a Customer is stabilized in order to maintain the stabilized condition.

- Coverage from OOA inpatient services continues only as long as the Customer’s condition prevents transfer to a participating hospital. Transfers should occur within 48 hours of the determination that a transfer is medically feasible and appropriate. Payment for preventive or non-emergent/urgent services performed outside of the network varies according to the benefit plan. Determinations on benefit coverage may include, but are not limited to: non-covered; covered at a reduced level of benefit; or covered at the in-network level of benefit with a referral. Please contact our Customer service department for specific questions.

Special requirements for certain referral requests

Durable Medical Equipment (DME)

- Preauthorization is required for some DME. Please refer to the How to contact River Valley section at the beginning of this Supplement for information on how to submit a request for preauthorization.

- Subject to the exceptions noted below, all DME, orthotics, prosthetics and supply items must be obtained from a contracted vendor. If an item is not available from a contracted vendor, whether or not preauthorization is required, you must obtain an out-of-network referral or payment for the item will be denied unless the Customer has an out of-network benefit for DME.

  Note: Even when medically necessary, certain items, (for example orthotic devices), may not be covered under a Customer’s benefit plan. Others, (for example prosthetic devices), may be subject to benefits limits.

Contact a Customer Service representative for information about a Customer’s benefit plan and about any additional requirements that may require preauthorization (for example DME, procedures, prescription drugs or other services).

Prescription drugs

- Preauthorization is required for some prescription drugs. Please refer to the How to contact River Valley section at the beginning of this Supplement for information on how to submit a request for preauthorization.

- Some drugs have special rules and require special management services. These include drugs with therapy prerequisites, quantity limitations and/or a multiple co-pay requirement. A list of some of the drugs that require preauthorization or have special rules may be found at uhcrivervalley.com → Providers → Preauthorization → Drugs. There are links for the list of drugs with special rules.

- If you order and/or administer any medication that requires preauthorization or special clinical management services, you may be required to acquire those medications from a participating specialty pharmacy, unless we authorize a non-specialty pharmacy in a particular situation.

- Certain drugs are available in quantities up to 90 or 100 day supplies, depending on plan benefit design. A list of many of the drugs on the three-month supply list is available at uhcrivervalley.com → Providers → Pharmacy - 90 and 100 day supply lists. This list is subject to change at any time without notice.

- The River Valley Entities’ Prescription Drug Lists (PDLs), which identify those drugs that currently have special rules are located at uhcrivervalley.com → Pharmacy, and can be found by clicking on the links for: “4 Tier PDL”, “Traditional PDL”, and “Advantage PDL”.

  Note: Not all drugs on a PDL are covered under a Customer’s pharmacy benefit. On uhcrivervalley.com → Providers → Pharmacy, you may determine whether a medication is covered by viewing the Online Pharmacy.
Sleep Studies (laboratory assisted, including polysomnography) to diagnose sleep apnea and other sleep disorders
Preauthorization is required for polysomnography treatment and for the site of service (sleep lab v. portable home monitoring).

Home health care including home infusion services
- Preauthorization is required for Home Health Care including but not limited to Home Infusion Services.
- You must complete a specific Home Health Authorization Form which you can be found at: uhcrivervalley.com Providers Forms. Please refer to the How to contact River Valley section at the beginning of this Supplement for information about how to submit this form.
- If requested services are required after business hours please notify us within 24 hours or the next business day following a holiday or weekend. The notification should include the Customer’s name, identification number, diagnosis, the name of the attending physician, and requested services.
- If you do not notify us, your claims will be denied and you may not bill the Customer for the service.

Assisted reproduction program
Most River Valley Entities’ benefit plans specifically exclude coverage for infertility evaluation or treatment. Some employer groups have a variation or rider to cover evaluation and/or treatment of infertility. Certain states, such as Illinois, have mandated treatment for infertility for some groups. For questions relating to assisted reproduction benefits or to obtain preauthorization for services, contact a Registered Nurse at (800) 747-1446, Ext. 65212.

Transplants
- Transplants require preauthorization. Please contact the OptumHealth transplant case manager at (888) 936-7246. The transplant case manager will request medical records necessary to review the Customer’s individual appropriateness for a potential transplant. All information is sent to a physician expert in that particular field of transplantation for review prior to authorization.
- If authorized, the case manager coordinates all referrals, assists in selecting a transplant center based upon the Customer’s needs, and provides information about the value of our transplant management program.
- If a transplant candidate is in need of home care or is actively involved with a participating center, services will be arranged by the transplant case manager.
- Any post-transplant lab or pathology that cannot be performed or interpreted by a network physician can be sent to the transplant center for interpretation. Please notify the transplant case manager if assistance is needed in making arrangements. Most of these services are covered under the transplant contract. It is cost effective to use the transplant center when appropriate. It is important that the transplant center be involved in the continuing care of the transplant patient.

Post-transplant care
- Preauthorization is required for all follow-up care. Requests should be made using the standard River Valley Entities’ preauthorization process.
- One year post transplant, Customers will be transferred back to their respective local physician for any additional care management services required.

End of life care
Some Customers have end of life care benefits which may include hospice services. Preauthorization is required for these services. Approved care is coordinated by the River Valley Entities’ care managers. Requests for end of life care may be faxed to the Home Health Department at (800) 340-2184.
UnitedHealthcare West Non-Capitated Supplement

**Important information regarding the use of this Supplement**

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

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

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<td>• AARP® MedicareComplete℠</td>
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<td>• UnitedHealthcare Group Medicare Advantage</td>
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<td>State</td>
<td>Legal Entities</td>
<td>Products Offered</td>
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<td>Texas</td>
<td>UnitedHealthcare Benefits of Texas, Inc.</td>
<td>Commercial and Medicare Advantage</td>
<td><strong>Commercial:</strong></td>
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<td>• UnitedHealthcare SignatureValue</td>
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<td>• UnitedHealthcare® Chronic Complete</td>
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<td>• UnitedHealthcare Dual Complete®</td>
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<td>• UnitedHealthcare Group Medicare Advantage</td>
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<tr>
<td>Washington</td>
<td>UnitedHealthcare of Washington, Inc. UnitedHealthcare of Oregon, Inc.</td>
<td>Commercial Medicare Advantage</td>
<td><strong>Commercial:</strong></td>
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<td>• UnitedHealthcare Group Medicare Advantage</td>
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Administrative services are provided by the following affiliated companies: United HealthCare Services, Inc. OptumRx or OptumHealth CareSolutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).

*This UHC West Capitated Supplement does not apply to this benefit plan.
### How to contact us

<table>
<thead>
<tr>
<th>Resource</th>
<th>Where to go</th>
<th>What you can do there</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare West Provider Website</td>
<td>Link and uhcwest.com</td>
<td>- <strong>Link</strong>&lt;br&gt;- <strong>Member Eligibility and Benefits</strong>&lt;br&gt;PCP assignment and history.&lt;br&gt;Review Customer benefits and copays.&lt;br&gt;Check claim(s) detail and status (by Customer ID or by TIN).&lt;br&gt;Inpatient and outpatient Notification/Prior Authorization submission update and check status.&lt;br&gt;Obtain a Notification/Prior Authorization reference number upon submission, which can be used to track the case.&lt;br&gt;Provide clinical notes upon submission and receive comments from the UnitedHealthcare West clinical team during the review process.&lt;br&gt;Print copies of Notification/Prior Authorization requests.&lt;br&gt;Request a Claim Reconsideration with or without attachments.</td>
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<tr>
<td></td>
<td></td>
<td>- <strong>Uhcwes.com</strong>&lt;br&gt;- Create/manage individual user accounts for your team.&lt;br&gt;- View the provider directory.&lt;br&gt;- Check Customer eligibility Status, up to 10 Customers at a time:&lt;br&gt;  - PCP assignment and history&lt;br&gt;  - Plan codes and coverage history.&lt;br&gt;- Review Customer benefits and copays.&lt;br&gt;- Access Medical Management Guidelines and Benefit Interpretation Policies.&lt;br&gt;- Access the monthly Medical Management Guideline and Benefit Interpretation Policy Update Bulletins.&lt;br&gt;- Check claim(s) detail and status (by Customer ID or by TIN).&lt;br&gt;- Access/download Capitation/Financial Reports by provider/by state if applicable.&lt;br&gt;- Access and submit Medicare Advantage Risk Adjustment data via CMS-HCC Risk Adjustment functionality.&lt;br&gt;- Inpatient and outpatient Notification/Prior Authorization submission update and check status.&lt;br&gt;  - Obtain a Notification/Prior Authorization reference number upon submission, which can be used to track the case.&lt;br&gt;  - Provide clinical notes upon submission and receive comments from the UnitedHealthcare West clinical team during the review process.&lt;br&gt;  - Print copies of Notification/Prior Authorization requests.&lt;br&gt;- Use the Library/Resource Center (without login) to access the following information:&lt;br&gt;  - Grievance forms&lt;br&gt;  - Guidelines &amp; interpretation manuals for Health Care Reform&lt;br&gt;  - Customer related Information (Customer Rights, Health Programs)&lt;br&gt;  - Pharmacy related information (Formulary/Pharmacy Directory)&lt;br&gt;  - Plan schedules and codes&lt;br&gt;  - Product information&lt;br&gt;  - Provider Disputes Resolution for California providers ONLY&lt;br&gt;  - Provider Policy and Procedures Manuals&lt;br&gt;  - Publications (California Language Assistance Program, Communication Highlights)&lt;br&gt;  - Quality Index Profiles&lt;br&gt;  - Continuing Medical Education&lt;br&gt;  - Electronic Data Interchange (EDI) and Clearinghouse information&lt;br&gt;  - Prior authorization information&lt;br&gt;  - IVR system information&lt;br&gt;  - Medicare Physician Fee Schedule Look Up National Provider Identifier (NPI)&lt;br&gt;  - Contact us via secure email by clicking on “Contact Us”</td>
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<tr>
<td>Resource</td>
<td>Where to go</td>
<td>What you can do there</td>
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</tbody>
</table>
| **UnitedHealthcare West Provider Website**    | Link and uhcwest.com                                                        | • Access monthly Medicare Advantage Patient Management Reports  
• Check claim(s) detail and status (by Customer ID or by TIN) in the Claims Management application.  
• Request a Claim Reconsideration with or without attachments.  
• Check patient eligibility and benefits.                                                                 |
| **Preauthorization (Non-delegated)**          | Arizona: Medicare Advantage Phone: (800) 746-7405  
California, Oregon and Washington: SignatureValue, Medicare Advantage, Direct contract network and medical group/IPA carve-out  
Phone: (800) 762-8456  
Colorado: Medicare Advantage  
Phone: (800) 746-7405  
Nevada: Medicare Advantage Phone: (888) 866-8297  
Texas and Oklahoma: Medicare Advantage, SignatureValue  
Inpatient Notification/Utilization Management  
Phone: (800) 668-8139 | • To view the most current and complete Advance Notification List, including procedure codes and associated services, go to: uhcwest.com ➔ Provider ➔ Prior Authorization List (non-delegated) |
| **Radiology-Advanced Outpatient Imaging Procedures:** | Online: UnitedHealthcareOnline.com ➔ Notifications/Prior Authorizations ➔ Radiology Notification & Authorization - Submission & Status  
Phone: (866) 889-8054 | • Request prior authorization of radiology services as described in the Outpatient Radiology Notification/Prior Authorization Protocol for Commercial Customers and the Outpatient Radiology Prior Authorization Protocol for Medicare Advantage Customers sections of this Guide |
| **Cardiology:**                               | Online: UnitedHealthcareOnline.com ➔ Notifications/Prior Authorizations ➔ Cardiology Notification & Authorization - Submission & Status  
Phone: (866) 889-8054 | • Request prior authorization of cardiology services as described in the Cardiology Notification/Prior Authorization Protocol for Commercial Customers and the Cardiology Prior Authorization Protocol for Covered Services to Medicare Advantage Customers sections of this Guide |
| **Hospital Inpatient Notification (Non-delegated)** | Inpatient & observation (800) 799-5252  
Mental health Medicare Advantage: (800) 508-0088  
Transplant (866) 300-7736  
Fax: (800) 274-0569  
Fax: (888) 361-0502 | • Notify us of any admission |

CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology (Non-delegated)
<table>
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<tr>
<th>Resource</th>
<th>Where to go</th>
<th>What you can do there</th>
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</thead>
<tbody>
<tr>
<td>EDI Support</td>
<td>uhcwest.com</td>
<td>• Obtain information on how to submit and receive transactions electronically and technical support</td>
</tr>
<tr>
<td></td>
<td>Password and User ID are not required to review and access EDI information on uhcwest.com or UnitedHealthcareOnline.com.</td>
<td>• Select Provider - Under &quot;Quick Link&quot; - Select &quot;Service and Tools&quot; to review services available for:</td>
</tr>
<tr>
<td></td>
<td>Online: UnitedHealthcareOnline.com → Contact Us → Electronic Data Interchange (EDI) Claims → EDI Transaction Support</td>
<td>› Eligibility</td>
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<td></td>
<td>Phone: (800) 842-1109 Email: <a href="mailto:supportedi@uhc.com">supportedi@uhc.com</a></td>
<td>› Claim Status</td>
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<td>› CMS-HHC Risk Adjustment ASM</td>
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<td>› Select Provider-Library-Resource Center-Electronic Data Interchange (EDI) to access EDI information.</td>
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<td>› HIPAA Resources</td>
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<td>› Companion Guide</td>
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<td>› Helpful Hints</td>
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<tr>
<td>Enterprise Voice Portal</td>
<td>Commercial &amp; Medicare Advantage HMO/MCO:</td>
<td>• Check eligibility</td>
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<td>California: (800) 542-8789 Arizona/Colorado/Nevada: (888) 866-8297 Oklahoma: (877) 847-2862 Oregon: (800) 920-9202 Texas: (877) 847-2862 Washington MCO: (800) 213-7356</td>
<td>• Access PCP assignment</td>
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<td>• Verify Plan Code</td>
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<td></td>
<td>• Verify Provider History</td>
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<td>• Access Coverage History</td>
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<td>• Check copay and benefits</td>
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<td>• Check claim status (TIN required)</td>
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<td></td>
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<td>• Quick FAX (eligibility and claims)</td>
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<td>• Pharmacy approval</td>
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<td>• Prior Authorization</td>
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<td>• Inpatient notification</td>
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<tr>
<td>Standard Customer Appeals</td>
<td>California, Oklahoma, Oregon, Texas, Washington</td>
<td>• Request a standard decision on an appeal.</td>
</tr>
<tr>
<td>(Applies only to Commercial UnitedHealthcare Signature Value HMO/MCO)</td>
<td>Mail: Mailstop CA124-0160 P.O. Box 6107 Cypress, CA 90630 Fax: (866) 704-3420 CA Phone: (800) 624-8822 OK/TX Phone: (800) 825-9355 OR/WA Phone: (800) 932-3004</td>
<td></td>
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<tr>
<td>Medicare Advantage Customer Appeals</td>
<td>Mailstop CA124-0157 P.O. Box 6106 Cypress, CA 90630 Fax: (888) 517 7113 AARPMedicareComplete.com</td>
<td>• Request a standard decision on an appeal.</td>
</tr>
<tr>
<td>(Applies only to Commercial UnitedHealthcare Signature Value HMO/MCO)</td>
<td>California Oklahoma, Oregon, Texas, Washington Phone: (888) 277-4232 Fax: (800) 346-0930</td>
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<td>Expedited Appeals</td>
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<td>• Request an expedited decision on an appeal.</td>
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<td>(Applies only to Commercial UnitedHealthcare Signature Value HMO/MCO)</td>
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<tr>
<td>Resource</td>
<td>Where to go</td>
<td>What you can do there</td>
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| Pharmacy Services | Commercial products: uhcwest.com Medicare products: UHCMedicareSolutions.com | • Access formularies, preauthorization guidelines and after-hours procedures, 24 hours a day, 7 days a week.  
• View the Medicare Advantage Part D (MAPD) Formulary or request a copy.  
• Request a Prior Authorization  
• For oral medications  
• For injectable medications  
• Request information on the Medicare Part D Medication Therapy Management Program. |
| Mental Health, Substance Abuse/ Substance Use, Vision or Transplant Services | See Customer’s health care ID card for carrier information and contact numbers Note: The health care ID card can be viewed on Link in the Eligibility and Benefits application. | • Inquire about a Customer’s behavioral health, substance abuse, substance use, vision or transplant benefits. |
| California Language Assistance Program (applies only to Commercial products in California) | uhcwest.com | • Access information regarding the California Language Assistance Program. |
| Health Management and Disease Management Programs | uhcwest.com Login Providers Library Click on the desired state Forms To enroll patients: Phone: (877) 840-4085 Fax completed referral form to: (877) 406-8212 | • Access referral forms for Disease Management and Health Management information. |

**Health care identification (ID) cards**

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

**Sample health care ID cards – Medicare Advantage products**

To help identify Customers associated with Medicare Advantage products offered through the AARP MedicareComplete and UnitedHealthcare brands, please go to the following provider website for health care ID card guides: UnitedHealthcareOnline.com Tools & Resources Medicare HMO, POS & PPO or Special Needs Plans (SNP) Scroll to “Benefit Plan Name Overviews” in the Reference Materials section.

For more detailed information on ID cards and to see a sample health care ID card, please refer to the *Health care identification (ID) cards* section of this guide.

**Our products**

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

**Commercial products - UnitedHealthcare SignatureValue Portfolio**

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

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

- Online via uhcwest.com or Link → Eligibility and Benefits Center
- Enterprise Voice Portal
- Electronic eligibility lists (upon request)

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

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

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

- Our Provider website at uhcwest.com or Link
- Enterprise Voice Portal

**Electronic Data Interchange (EDI) (Does not apply in Nevada)**
EDI is our preferred choice for conducting business transactions with contracted/participating physicians and health care industry partners. We accept EDI claims submission for all of our product lines.

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

**EDI claims/encounters**
EDI is the preferred method of claim submission for participating physicians and health care providers. You may submit all professional and institutional claims and/or encounter electronically for UnitedHealthcare West and Medicare Advantage HMO product lines as described more fully in this Supplement.

The HIPAA ANSI X1 25010 837 format is the only acceptable format for submitting claims/encounter data.

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

2. **Electronic eligibility inquiry/response**
   One of the primary reasons for claims rejection is incomplete or inaccurate eligibility information. This EDI transaction is a powerful productivity tool that allows providers to instantly obtain Customers’ eligibility and benefit
information in “real-time,” using a computer instead of the phone, prior to scheduling and confirming the patient’s appointment. The HIPAA ANSI X12 270/271 format is the only acceptable format for this EDI transaction.

3. Electronic claims status inquiry/response

This EDI transaction allows a provider to send and receive in “real-time” an electronic status of a previously submitted claim using a computer. Claims with missing or inaccurate information can be resubmitted, which greatly enhances the provider’s receivables and cash flow cycle. The HIPAA ANSI X12 276/277 format is the only acceptable format for this EDI transaction. To determine the status of your submitted electronic claims, log on to uhcwest.com. (You must register online before you can receive this information electronically.) Some software vendors and/or clearinghouses, may also offer Electronic Claims Status and Inquiry transaction services. Or, you may call us at the phone number on the back of the Customer’s health care ID card for more information.

Please refer to the UnitedHealthcare West’s published Companion Guides for the data elements required for these transactions. Companion guides are available for viewing or download at: UnitedHealthcareOnline.com → EDI Education for Electronic Transactions → Companion Guide Directory.

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

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

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

Begin submitting your claims and encounters using electronic data interchange (EDI)

• Before submitting your EDI claims to us, refer to the front of the Customer’s health care ID card to determine the appropriate UnitedHealthcare West product type.

• Then, refer to UnitedHealthcareOnline.com → EDI Educations for Electronic Transactions → Payer List for UnitedHealthcare, Affiliates, and Strategic Alliances for the correct Payer ID number.

Previously submitted claims that were either denied or pended for additional information should not be resubmitted via EDI or paper claim. Please use the Claim Management application on Link.

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

Benefit Interpretation Policies & Medical Management Guidelines

Access to Policies

A complete library of SignatureValue™ Benefit Interpretation Policies and Medical Management Guidelines is available at UHCWest.com → Provider Log In → Library → Resource Center → Guidelines & Interpretation Manuals.

Policy Updates

UnitedHealthcare West publishes monthly editions of the “Policy Update Bulletin”, a user-friendly online resource that provides notice to our network physicians and facilities of any changes to our SignatureValue™ Medical Management Guidelines and Benefit Interpretation Policies. The Policy Update Bulletins are posted on the first calendar day of every month and are accessible online at UHCWest.com → Provider Log In → Library → Resource Center → Guidelines & Interpretation Manuals. As a supplemental reminder to the detailed policy update summaries announced in the Policy Update Bulletins, a list of recently approved, revised and/or retired SignatureValue™ Medical Management Guidelines and Benefit Interpretation Policies is also provided in the monthly Network Bulletin available at UnitedHealthcareOnline.com → Quick Links → Network Bulletin.
Medical management
The purpose of the UnitedHealthcare Medical Management Program is to determine if medical services are:

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

In evaluating medical appropriateness of services, we also use MCG™ Care Guidelines, (formerly known as Milliman Care Guidelines). For Medicare Advantage Customers, we follow CMS guidelines, including National Coverage Determinations and Local Coverage Determinations. If MCG™ Care Guidelines or any other UnitedHealthcare Medical Policies or Coverage Determination Guidelines conflict with CMS guidelines, we will follow CMS guidelines.

Medical management may be delegated to a third party.

Compliance with the medical management program
Complying with the Medical Management Program includes, but is not limited to:

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

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

- Serious jeopardy to the health of the Customer or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part; or
- “Active labor” – a labor at a time when either of the following would occur:
  - Inadequate time to affect safe transfer to another hospital prior to delivery;
  - Transfer may pose a threat to the health and safety of the Customer and/or unborn child.

The Customer should be directed to call 911 or its local equivalent, or should be directed to the nearest emergency room. Prior Authorization/Advance Notification is not required for emergency services. However, notification of your emergency should be provided telephonically by calling us at (800) 799-5252 between 8:00 a.m. and 5:00 p.m. Monday through Friday.

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

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

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

<table>
<thead>
<tr>
<th>Product</th>
<th>State</th>
<th>Time frame</th>
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<tbody>
<tr>
<td>Medicare Advantage Urgent</td>
<td>All</td>
<td>72 Hours</td>
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<tr>
<td>Medicare Advantage Standard</td>
<td>All</td>
<td>14 Calendar Days</td>
</tr>
<tr>
<td>Commercial Urgent</td>
<td>OR, WA</td>
<td>2 Business Days</td>
</tr>
<tr>
<td></td>
<td>CA, OK</td>
<td>72 Hours</td>
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<td></td>
<td>TX</td>
<td>3 Calendar Days</td>
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<tr>
<td>Commercial Routine</td>
<td>OR, WA</td>
<td>2 Business Days Exception - a delay of decision (DOD) letter</td>
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<td>CA</td>
<td>5 Business Days Exception - a delay of decision (DOD) letter</td>
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<td>OK</td>
<td>15 Calendar Days</td>
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<td>TX</td>
<td>3 Calendar Days</td>
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</table>

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

Preauthorization
A list of services that require preauthorization is available at uhcwes.com → Providers → Login → Select State → Library → Resource Center.

Services that are rendered without the required preauthorization will be denied as provider liability. The Customer cannot be billed for such services.

- Most in-office PCP and specialty services do not require preauthorization.
- Participating Providers should refer Customers to network providers. Referrals to non-network providers require preauthorization from us.
- Once the PCP refers a Customer to a network Specialist, that Specialist may then see the Customer as needed for the referring diagnosis. The Specialist is not required to direct the Customer back to the PCP to order tests and/or treatment.
- If a Specialist feels that a Customer needs other services related to the treatment of the referral diagnosis, the Specialist may then refer the Customer, according to the online UnitedHealthcare West Preauthorization List, to a participating Provider.

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

Prior Authorization Referral process
If there are no network specialty or ancillary providers identified within the service area for a necessary service, the physician must submit a completed UnitedHealthcare West Prior Authorization Request Form to us or to the delegated Medical Group for approval, as appropriate. The Prior Authorization Request Form can be found at uhcwes.com → Providers → Login → Select State → Library → Resource Center.
Primary care services
Most PCP services do not require Prior Authorization. However, if prior authorization is required, the following guidelines apply:

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

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

Specialty care (including gynecology) in an office-based setting
The Specialist will receive via fax or an uhcwest.com notice (approved as requested, approved as modified, delayed or denied) of the status of the authorization request for services requiring prior authorization. For those services that do not require Prior Authorization, the Specialist office will receive a referral request directly from the PCP;
1. All Specialist authorizations will expire 90 calendar days from the date of issuance;
2. Plain film radiography rendered by a designated UnitedHealthcare West participating Provider, or in the Specialist’s office in support of an authorized visit, does not require Prior Authorization;
3. Routine lab services that are performed in the Specialist’s office, or are provided by a designated UnitedHealthcare West participating Provider in support of an authorized visit, do not require Prior Authorization;
4. Customers may self-refer to a gynecologist who is a participating Provider for their annual routine gynecological exams. Female Medicare Advantage Customers may self-refer to a women’s health Specialist who is a participating Provider for women’s routine and preventive health care services.
5. Female Medicare Advantage Customers over age 40 may self-refer to a UnitedHealthcare West radiology Provider who is a participating Provider for a screening mammogram.

Note: Mammograms may require Prior Authorization in California.

Obstetrics
1. A Customer may self-refer to a UnitedHealthcare West obstetrician who is a participating Provider for routine obstetrical (OB) care. If the Customer is referred to a non-participating Specialist, the Specialist must notify us through uhcwest.com or by fax at the number designated on the top of the Prior Authorization Form to make sure accurate claims payment for ante and postpartum care.
2. Routine OB care includes office visits and 2 ultrasounds.
3. Plain film radiography that is performed by a UnitedHealthcare West participating Provider or in the obstetrician’s office in support of an authorized visit, do not require Prior Authorization.
4. Routine labs that are performed in the obstetrician’s office, or are provided by a participating Provider in support of an authorized visit, do not require Prior Authorization.

5. Office procedures and diagnostic and/or therapeutic testing performed in the obstetrician’s office that do not require prior authorization may be performed.

**Specialty care in a hospital setting**

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

**Second opinions (California Commercial only)**

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

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

1. The Customer questions the reasonableness or necessity of a recommended surgical procedure;

2. The Customer questions a diagnosis or treatment plan for a condition that threatens loss of life, limb, or bodily function or threatens substantial impairment, including, but not limited to, a serious chronic condition;

3. The clinical indications are not clear or are complex and confusing;

4. A diagnosis is in doubt due to conflicting test results;

5. The treating provider is unable to diagnose the condition;

6. The Customer’s medical condition is not responding to the prescribed treatment plan within an appropriate period of time, and the Customer is requesting a second opinion regarding the diagnosis or continuance of the treatment; or

7. The Customer has attempted to follow the treatment plan or has consulted with the initial provider and has serious concerns about the diagnosis or treatment plan.

**Post-stabilization care**

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

1. The Customer is discharged;

2. A Participating Provider assumes responsibility for the Customer’s care (either at the hospital or through transfer); or

3. The treating physician and UnitedHealthcare West agree to another arrangement. We are responsible for the cost of post-stabilization services that are:
   
   › Pre-approved by us; and
   
   › Medically necessary.

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

**Extension of prior authorization services**

The Specialist must request an extension of authorization through uhocwest.com or by fax: If he/she desires to perform services that are:

1. Beyond the approved visits;

2. Beyond the allotted time frame of the approval (typically 90 calendar days);

3. In addition to the approved procedures, and/or diagnostic or therapeutic testing.
The extension must be authorized before care is rendered to the Customer. The request for extension of services must include the following information:

- Customer’s presenting complaint;
- Physician’s clinical findings on exam;
- All diagnostic and laboratory results relevant to the request;
- Conservative treatment that has been tried;
- Applicable CPT and ICD codes; and
- Requested services (e.g., additional visits, procedures).

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

**Inpatient authorization procedures**

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

- Certain urgent/emergent admissions require Prior Authorization; please verify benefits prior to requesting authorization. Prior Authorization for emergent/urgent services is not required for Medicare Advantage.
- Elective/scheduled medical admissions require prior authorization.
- For emergency admissions or transfers after-hours or on weekends, the Customer should be admitted to the appropriate facility at the appropriate level of care. Authorization can then be obtained on the next business day.
- Authorization is not required for a consultation with a participating network Provider during an inpatient stay.
- However, consultation with a non-participating, non-network provider requires Prior Authorization.
- Transfers/admissions to SNFs; although authorization is required, a Customer can be admitted directly from the emergency room or home to a SNF.
- After initial emergency treatment and/or post-stabilization, we may request that a Customer be transferred to a network hospital when medically appropriate. If a PCP directs a Customer to a non-network hospital for non-emergent care. Otherwise, the PCP may be held responsible.

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

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

**Hospital notification**

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

**Inpatient census reports**

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

- Census report for all our Customers;
- Discharge report;
- Face sheets to report outpatient surgeries and SNF admissions;
- Inpatient Admission Fax Sheet to report “no UnitedHealthcare West admissions” for that day;
The census report or face sheets must include the following information:

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

**Coordination of care**

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

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

**Concurrent review**

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

**Variance days**

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

**Medical observation status**

We (or our delegate) will authorize hospital observation status when medically appropriate. Hospital observation is generally designed to evaluate a Customer’s medical condition and determine the need for actual admission, or to
stabilize a Customer’s condition and typically lasts less than 48 hours. For Medicare Advantage Customers, we also follow any applicable CMS guidelines to determine whether observation services are medically appropriate. Typical cases, when observation status is used, include rule-out diagnoses and medical conditions that respond quickly to care. Customers under observation status may later convert to an inpatient admission if medically necessary.

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

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

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

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

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

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

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

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

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

To make sure timely review and payment determinations, the Provider must respond to requests for all appropriate medical records within 5-7 calendar days from receipt of the request, unless otherwise indicated in your agreement.

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

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

Minimum content of written or electronic notification

If we deny, delay delivery, or modify a request for authorization for health care services, our written or electronic notices will, at a minimum, include the following:

• The specific service(s) denied, delayed in delivery, modified or partially approved;
• The specific reference to the plan provisions to support the decision;
• The reason the service is being denied, delayed in delivery, modified, or partially approved, including:
  › Clear and concise explanation of the reasons for the decision in sufficient detail, using an easily understandable summary of the criteria, so that all parties can understand the rationale behind the decision;
  › Description of the criteria or guidelines used, and/or reference to the benefit provision, protocol or other similar criterion on which the decision was based;
  › Clinical reasons for decisions regarding medical necessity; and
  › Contractual rationale for benefit denials.
• Notification that the Customer can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request;
• Notification that the Customer’s physician can request a peer-to-peer review;
• Alternative treatment options offered, if applicable;
• Description of any additional material or information necessary from the Customer to complete the request, and why that information is necessary;
• Description of grievance rights and an explanation of the appeals and grievances processes, including:
  › Information regarding the Customer’s right to appoint a representative to file an appeal on the Customer’s behalf,
  › The Customer’s right to submit written comments, documents or other additional relevant information,
  › Information notifying the Customer and their treating provider of the right to an expedited appeal for time-sensitive situations (not applicable to retrospective review);
  › Information regarding the Customer’s right to file a grievance or appeal with the applicable state regulatory agency, including information regarding the independent medical review process, as applicable;
  › Information that the Customer may bring civil action, under Section 502(a) of the Employee Retirement Income Security Act (ERISA), if applicable (Commercial products only);
  › For the treating provider, the name and direct phone number of the health care professional responsible for the decision.

Pharmacy formulary

Customer benefit plans may or may not include pharmacy coverage. Our Commercial and Medicare formularies include most generic drugs and a broad selection of brand name drugs. Prescription drugs/medications listed on the formulary are considered a covered benefit. However, select formulary medications may require prior authorization in order to be covered.
In some instances, a Customer’s Commercial pharmacy plan may not include coverage for non-formulary prescriptions/medications. In these instances, the costs are the Customer’s financial responsibility, unless the prescribing physician requests prior authorization review for the non-formulary medications and the Customer meets our criteria for coverage.

To access the formulary and changes to the formulary, go to uhcwest.com → Provider → Library → Select State → Pharmacy → Click on the desired formulary. You will then be able to search by drug name or therapeutic class. Any restriction or limitation will also be noted along with formulary alternatives, when applicable. The Commercial formulary is updated twice a year, in January and July. The Medicare formulary is updated up to 9 times during a calendar year. Physician requests for formulary review of medications or preauthorization guidelines are welcome. Prior authorization guideline change request forms and formulary change request forms can be obtained by going to OptumRx.com → HealthCare Professionals → Healthcare Provider Tools → Forms and Documents.

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

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

You can request an authorization by:

- **Phone:** Toll-free: (800) 711-4555
- **Written request:** Fax: (800) 527-0531 for oral medications and (800) 853-3844 for injectable/specialty medications. You can obtain a Prior Authorization Medications Request Form at uhcwest.com after login or through OptumRx.com → Health Care Professionals Portal → Prior Authorizations.
- **Online:** OptumRx.com → Healthcare Professionals → Prior Authorizations. This new online service enables physicians and health care professionals to submit a real-time Prior Authorization request 24 hours per day, 7 days per week. After logging on at OptumRx.com with his or her unique National Provider Identifier (NPI) number and password, a physician or health care professional can submit patient details securely online, enter a diagnosis and medical justification for the requested medication, and, in many cases, receive authorization instantly.

- Physicians can submit information that previously had to be collected by phone or fax. Also, physicians and health care professionals can use this service to check on the status of a Prior Authorization request, even if it was not submitted online. This online service applies to oral drugs as well as specialty medications.

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

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

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

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

• Customer’s name
• Customer’s health care ID number
• Customer’s date of birth
• Customer’s gender
• Prescriber’s name
• Prescriber’s specialty
• Prescriber’s address
• Prescriber’s phone/fax number
• Name and dosage strength of the requested medication.
• Directions for use
• Diagnosis
• Date Customer was started on the non-formulary medication.
• Name of specific drugs tried and failed
• Documentation of patient chart notes in accordance with the specifications outlined in the NPTC Guidelines or, where appropriate, as the community standard of practice.
• Any other compelling medical information that would support the use of the non-formulary medication over a formulary alternative.

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

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

**Additional information (applies only to Medicare Advantage Part D Customers)**

For Medicare Advantage Customers, OptumRx Prior Authorization staff will follow the coverage determination timelines as established by CMS. Standard coverage determinations must be completed within 72 hours. Expedited coverage determinations must be completed within 24 hours.* OptumRx will communicate with the physician or his or her designee and the Customer for additional information regarding the request, as well as send notification of the resulting case decision.

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* Turnaround time varies by case type, and may be extended beyond the initial 24 or 72 hours based on incomplete service level agreements (SLAs) as agreed upon by the specific plan and Centers for Medicare & Medicaid Services (CMS).
Different types of requests include:
- Prior Authorization (PA)
- Medicare Part B vs Medicare Part D (BvsD)
- Non-Formulary (NF)
- Step Therapy (ST)
- Quantity Limit (QL)
- Tier Cost Sharing Exception (TCSE)

Criteria for copayment reduction (Tier Cost Sharing Exception) are:
- The Requested drug is FDA-approved for the condition being treated; or
- One of the following:
  - Diagnosis is supported as a use in AHFS under the Therapeutic Uses section; or
  - Diagnosis is supported as an “Accepted” indication in USPDI; or
  - Diagnosis is supported in the Therapeutic Uses section in DRUGDEX Evaluation with a Strength of Recommendation rating of IIb or better; or
- Both of the following:
  - Diagnosis is listed in the Therapeutic Uses section in DRUGDEX Evaluation and carries a Strength of Recommendation of III or Class Indeterminate; and
  - Efficacy is rated as “Effective” or “Evidence Favors Efficacy”;
- History of failure, contraindication, or intolerance to all formulary alternatives in the lower qualifying tiers.

Authorizing and dispensing injectable/infusion medications

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

The physician must submit the following information to request a covered injectable and/or self-injectable medication for a Customer:
- Complete Prior Authorization Medications Request Form (the requesting physician’s signature is required to allow the vendor to accept the document as a legal prescription);
- Recent history and physical.
- Copies of any pertinent laboratory results.
- Copies of any reports by consultant providers.

Submit requests to the OptumRx Specialty Pharmacy by calling (800) 711-4555, or fax requests directly to (800) 853-3844. OptumRx will verify the Customer’s eligibility, notify the physician of the determination, and if appropriate, contact the physician’s office to coordinate delivery of the medication(s). In the case of approved self-injectables, the vendor will contact the Customer to coordinate delivery of the medication(s).

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

California only: Prescribing providers in California must use the Prescription Drug Prior Authorization Request Form when submitting authorization requests to OptumRx. This applies to both Commercial HMO and PPO products.
- Article 1.2 Section 2218.30 to the California Code of Regulations (CCR) Title 10, Chapter 5, Subchapter 2.

* For Medicare Advantage Part D Customers, under certain circumstances and on an individual basis, customers or physicians may request a reduction in the copayment or coinsurance amount for a drug on the formulary (Tier Cost Sharing Exception).

** Tier Cost Sharing Exception rules vary by specific plan and available alternatives.
Also, the California utilization management delegates may have contractual responsibilities for payment of certain prescription medications. When the delegate requires prior authorization for use of those drugs prescribed by their providers, the delegate must also require the use of the Prescription Drug Prior Authorization Request Form. The delegate must have a policy and process in place and be able to demonstrate compliance.

**Claims processing**

**Claims adjudication**

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

**Complete claims requirements**

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

**National Provider Identification (NPI)**

UnitedHealthcare West is able to accept the NPI on all HIPAA transactions, including the HIPAA 837 professional and institutional (paper and electronic) claim submissions. A valid NPI is required on all covered claims (paper and electronic) in addition to the TIN. For institutional claims, please include the billing provider National Uniform Claim Committee (NUCC) taxonomy. UnitedHealthcare West will accept NPIs submitted through any of the following methods:

- **Online**: uhcwest.com → Provider → Electronic Data Interchange (EDI)/National Provider Identifier (NPI). Here you will find complete details regarding NPI.
- **Phone**: (877) 842-3210 through the Enterprise Voice Portal, select the “Health Care Professional Services” prompt. State “Demographic changes” and your call will be directed to the Service Center to collect your NPI, corresponding NUCC Taxonomy Codes, and other NPI-related information.

**Level of care documentation and claims payment**

Claims are processed according to the authorized level of care documented in the authorization record, reviewing all claims to determine if the billed level of care matches the authorized level of care.

If the billed level of care is at a higher level than the authorized level of care, UnitedHealthcare West will pay only the authorized level of care, and the Customer shall not be billed for any charges relating to the higher level of care. If the billed level of care is at a lower level than authorized, UnitedHealthcare West will pay the provider based on the lower level of care, which was determined by provider to be the appropriate level of care for the Customer.

**Customer financial responsibility**

Reference the applicable Commercial and Medicare Advantage Copayment Guideline Grids at uhcwest.com → Login → Library → Resource Center → Guidelines & Interpretation Manuals for more information about interpretation of copayments.

**Services provided to ineligible Customers**

In the event that UnitedHealthcare West provides eligibility confirmation indicating that a Customer is eligible at the time the health care services are provided and it is later determined that the patient was not in fact eligible, UnitedHealthcare West will not be responsible for payment of services provided to the Customer, except as otherwise required by state and/or federal law. In such event, you are entitled to collect the payment directly from the Customer (to the extent permitted by law) or from any other source of payment.

**Provider’s responsibility to monitor eligibility**

UnitedHealthcare West makes current Customer eligibility information available through the Enterprise Voice Portal, UnitedHealthcare West Provider website, and our Customer Service Center. The Provider is responsible for checking Customer eligibility within 2 business days prior to the date of service. Provider shall be eligible for reimbursement under the Authorization Guarantee program described herein for authorized services provided that Provider has checked and confirmed eligibility within 2 business days prior to the date of service.
**Authorization guarantee program (California Commercial only)**

The Authorization Guarantee program provides for reimbursement to the Participating Provider for covered services provided to a Customer for which (1) an authorization has been provided, (2) who is determined to have been ineligible with UnitedHealthcare West on the date the authorized services were rendered and, (3) where the Customer’s lack of eligibility is only determined after authorized services have been rendered. The Authorization Guarantee program does not apply to self-insured or Medicare Advantage benefit plans.

**Authorization guarantee and reimbursement program**

Our systems automatically deny claims for services provided to Customers who are not eligible regardless of prior authorization. We will review all fee-for-service claims denials that were based on lack of eligibility to determine whether services are eligible for reimbursement. UnitedHealthcare West will overturn denials that are payable under the California commercial Authorization Guarantee program without any action by provider. UnitedHealthcare West will reimburse provider in the amount that would have been due to Provider had the same services been provided to an eligible Customer.

**Note:** If, before or after UnitedHealthcare West makes a payment under the Authorization Guarantee program, the provider receives payment for the same services from another source, the provider shall refund the amount received from the other source to us, not to exceed the amount paid by us, within 45 business days.

Otherwise, for the Authorization and Guarantee and Reimbursement program the provider must submit the bulleted items below to the UnitedHealthcare West Provider Dispute Resolution Team for Authorization Guarantee reimbursement consideration at:

Provider Disputes  
P.O. Box 6098  
Cypress, CA 90630

- Copy of the itemized bill for services rendered;
- Proof of eligibility verification within 2 business days prior to the date of service;
- A copy of the authorization for the services rendered; and
- A record of any payment received from any other responsible payer, and amount due based on Provider’s contract with us, less any payment received from any other responsible payer.

**Claims status follow-up**

If, after submitting a claim within timely filing guidelines, you have not received an Explanation of Payment (EOP) within the time frames in accordance with state and federal law, the provider may follow-up on the status of a claim using one of the following methods:

- Online at uhcwester.com → Provider → Login → Check Eligibility. The website provides real-time data and is the quickest method for retrieving claim status information.
- You may also submit an Electronic Transaction (HIPAA 276/277). Please contact your EDI clearing house for additional information.
- Enterprise Voice Portal - See How to Contact Us sections for telephone numbers. This system provides a fax of the claim status detail information that is available.

**Claims submission requirements**

Claims shall be submitted to UnitedHealthcare West on CMS-1500s, or UB-04s and forwarded to the address listed on the Customer’s health care ID card. Refer to the Prompt claims processing section of this Guide for more information about electronic claims submission and other Electronic Data Interchange (EDI) transactions. If your claim is the financial responsibility of a UnitedHealthcare West delegated entity (e.g., PMG, MSO, Hospital), you should bill that entity directly for reimbursement.
Claims submission requirements for reinsurance claims for hospital providers

If contracted covered services fall under the reinsurance provisions set forth in your agreement with us, you shall abide by the terms of the agreement in making sure that:

- The stipulated threshold has been met;
- Only covered services are included in the computation of the reinsurance threshold;
- Only those inpatient services specifically identified under the terms of the reinsurance provision(s) may be used to calculate the stipulated threshold rate;
- Applicable eligible Customer copayments, coinsurance, and/or deductible amounts are deducted from the reinsurance threshold computation;
- The stipulated reinsurance conversion reimbursement rate is applied to all subsequent covered services and submitted claims;
- The reinsurance is applied to the specific, authorized acute care confinement;
- Claim submitted in accordance with the required time frame, if any, as set forth in the agreement. In addition, when submitting hospital claims that have reached the contracted reinsurance provisions and are being billed in accordance with the terms Agreement and/or this Supplement, you shall:
  - Indicate if a claim meets reinsurance criteria; and
  - Make medical records available upon request for all related services identified under the reinsurance provisions (e.g., ER face sheets).

If a submitted hospital claim does not identify the claim as having met the contracted reinsurance criteria, UnitedHealthcare West shall continue to process the claim at the appropriate rate in the agreement. In order to compute specific reinsurance calculations and to properly review reinsurance claims for covered services, an itemized bill is required.

Interim bills

We adjudicate interim bills at the per diem rate for each authorized bed day billed on the claim and reconcile the complete charges to the interim payments based on the final bill.

The process outlined below will increase efficiencies for both us and the Hospital/SNF business offices:

- 112 Interim – First Claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed or authorized level of care, unless the contract states otherwise).
- 113 Interim – Continuing Claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed or authorized level of care, unless the contract states otherwise).
- 114 Interim – Last Claim: Review admits to discharge and discharge and apply appropriate contract rates, including per diems, case rates, stop loss/outlier and/or exclusions. The previous payments will be adjusted against the final payable amount.

Reciprocity agreements

You shall cooperate with our participating Providers and other UnitedHealthcare West affiliates and agree to provide services to Customers enrolled in benefit plans and programs of UnitedHealthcare West affiliates and to assure reciprocity with providing health care services.

If any Customer who is enrolled in a benefit plan or program of any UnitedHealthcare West affiliate, receives services or treatment from you and/or your sub-contracted providers (if applicable), you and/or your subcontracted Providers (if applicable), agree to bill the UnitedHealthcare West affiliate at billed charges and to accept the compensation provided pursuant to your agreement, less any applicable copayments and/or deductibles, as payment in full for such services or treatment.

You shall comply with the procedures established by the UnitedHealthcare West affiliate and this agreement for reimbursement of such services or treatment.
Overpayments
If you identify a claim for which you were overpaid by us, or if we inform you of an overpaid claim that you do not dispute, you must send us the overpayment within 30 calendar days (or as required by law or your participation agreement), from the date of your identification of the overpayment or our request. If refund or dispute is not made within 45 calendar days of our request, we shall recoup the amount of overpayment through other means, which may include future claim payments, to the extent permitted by your agreement with us and applicable law.

All refunds of overpayments in response to overpayment refund requests received from us, or one of our contracted recovery vendors, should be sent to the name and address of the entity outlined on the refund request letter.

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

If we determine that a claim was paid incorrectly, we may make a claim adjustment without requesting additional information from you. In the case of an overpayment, we will request a refund at least 30 calendar days prior to implementing a claim adjustment, or as provided by applicable law. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). If additional or correct information is needed, we will ask you to provide it.

If you disagree with a claim adjustment, our request for an overpayment refund or a recovery made to recoup the overpayment, you must submit the dispute, in writing, to the recovery agent requesting the overpayment. The agent’s name and address is located on the recovery request letter.

If you dispute the refund request, the recovery of claims overpayment will not occur until after you have exhausted our appeals process. (See Provider appeals section of this Supplement.)

End-stage renal disease
If a Customer has or develops end stage renal disease (ESRD) while covered under an employer’s group plan, the Customer must use the benefits of the plan for the first 30 months after becoming eligible for Medicare, based on ESRD. After the 30 months elapse, Medicare will be the primary payer. However, if the employer group plan coverage were secondary to Medicare when the Customer developed ESRD, Medicare will be the primary Payer and there is no 30 month period.

Medicaid (applies only to Medicare Advantage)
Qualified Medicare Beneficiaries (QMB) are held harmless for Medicare cost-sharing under applicable CMS regulations. Medicare cost sharing includes the deductibles, coinsurance and copayments included under Medicare Advantage Plans.

Providers cannot bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Customer who is eligible for both Medicare and Medicaid, or the Customer’s representative, or the Medicare Advantage organization for Medicare Part A and B cost sharing (e.g., copays, deductibles, coinsurance) when Medicaid is responsible for paying such amounts. Providers will either: (a) accept payment made by or on behalf of the Medicare Advantage organization as payment in full; or (b) bill the appropriate Medicaid or other State source for this cost sharing amount.

Time limits for filing claims
All providers are required to submit to clean claims for reimbursement no later than 1) 90 days from the date of service, or 2) the time specified in the provider’s participation agreement, or 3) the time frame specified in the state guidelines, whichever is greater.

If a provider fails to submit clean claims within the foregoing time frames, UnitedHealthcare West reserves the right to deny payment for the claim(s). Claim(s) which are denied for untimely filing cannot be billed to a Customer.

UnitedHealthcare West has established internal claims processing procedures to make sure of timely claims payment to its providers. UnitedHealthcare West is committed to paying claims for which it is financially responsible within the time frames required by state and federal law.
The date of receipt shall be deemed to be the business day when a claim, by physical or electronic means, is first delivered to UnitedHealthcare West’s specified claims payment office, post office box, designated claims processor or to UnitedHealthcare West's capitated provider for that claim. The following date stamps may be used to determine date of receipt:

- UnitedHealthcare West Claims Department date stamp.
- Primary Payer claim payment/denial date as shown on the EOP.
- Delegated Provider date stamp.
- TPA date stamp.
- Confirmation received date stamp that prints at the top/bottom of the page with the name of the sender.

**Note:** Date stamps from other health plans or insurance companies are not valid received dates for timely filing determination.

### Provider appeals

**Claims research and resolution (applies only to Commercial in Oklahoma & Texas)**

The Claims Research & Resolution (CR&R) process applies:

- If you do not agree with the payment decision after the initial processing of the claim; and
- Regardless of whether the payer was UnitedHealthcare West, the delegated Medical Group/IPA or other delegated payer, or the capitated hospital/provider, you are responsible for submitting your claim(s) to the appropriate entity that holds financial responsibility to process each claim.

UnitedHealthcare West will research the issue to identify who holds financial risk of the services and will abide by federal and state legislation on appropriate timelines for resolution. We will work directly with the delegated payer when claims have been misdirected and financial responsibility is in question. If appropriate, provider-driven claim payment disputes will be directed to the delegated payer Provider Dispute Resolution process.

**Claim reconsideration requests (does not apply in California)**

You may request a reconsideration of a claim determination. These rework requests typically can be resolved with the appropriate documents to support claim payment or adjustments (e.g., sending a copy of the authorization for a claim denied for no authorization or proof of timely filing for a claim denied for untimely filing). All rework requests must be submitted within 365 calendar days following the date of the last action or inaction, unless your participation agreement contains other filing guidelines. The most efficient way to submit your requests is through the Claim Reconsideration application on Link. Learn more on UnitedHealthcareOnline.com → Quick Links → Link. You can submit your request to us in writing by using the Claims Rework Request form (available at uhcwest.com → Providers → Login → Select State → Library → Resource Center → Forms.

Please refer to the chart titled UnitedHealthcare West provider rework or dispute process reference table at the end of this section for the address to which your request should be sent.
Submission of bulk claim inquiries
The Claims Project Management (CPM) Team handles bulk claim inquiries. You should contact the CPM team at the address below to initiate a bulk claim inquiry:

UnitedHealthcare West bulk claims rework reference table

<table>
<thead>
<tr>
<th>Provider's state</th>
<th>Contact information</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>UnitedHealthcare Attn: WR Claims Project Management P.O. Box 52078 Phoenix, AZ 85072-2078</td>
<td>Submit requests for 20 or more claims.</td>
</tr>
<tr>
<td>California</td>
<td>Claims Research Projects CA120-0360 P.O. Box 30968 Salt Lake City, UT 84130-0968</td>
<td>Submit requests for 19 or more claims.</td>
</tr>
<tr>
<td>Colorado</td>
<td>Medicare Advantage Claims Department Attn: Colorado Resolution Team P.O. Box 30983 Salt Lake City, UT 84130-0983</td>
<td>Submit requests for 20 or more claims.</td>
</tr>
<tr>
<td>Nevada</td>
<td>For Medicare Advantage claims: UnitedHealthcare Attn: WR Claims Project Management Claims Research Projects P.O. Box 95638 Las Vegas, NV 89193-5638</td>
<td>The Nevada delegated payer handles bulk claim inquiries received from providers of service The provider of service should submit the bulk claims with a cover sheet indicating &quot;Appeal&quot; or &quot;Review&quot; to the Claims Research Department at the designated address to initiate a bulk claim inquiry. Submit requests for 10 or more claims.</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>Claims Research Projects P.O. Box 30967 Salt Lake City, UT 84130-0967</td>
<td>Submit requests for 20 or more claims.</td>
</tr>
<tr>
<td>Oregon</td>
<td>Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968</td>
<td>Submit requests for 10 or more claims.</td>
</tr>
<tr>
<td>Texas</td>
<td>Claims Research Projects P.O. Box 30975 Salt Lake City, UT 84130-0975</td>
<td>Submit requests for 20 or more claims.</td>
</tr>
<tr>
<td>Washington</td>
<td>Claims Research Projects P.O. Box 30968 Salt Lake City, UT 84130-0968</td>
<td>Submit requests for 10 or more claims.</td>
</tr>
</tbody>
</table>

UnitedHealthcare West’s response
We will respond to issues as quickly as possible.

- **Reworks/disputes requiring clinical determination**: Individuals with clinical training/background who were not previously involved in the initial decision will review all clinical rework/dispute requests. A letter will be sent to the Provider outlining the outcome of the determination and the basis for the decision.
- **Reworks/disputes requiring claim process determination**: Individuals not previously involved in the initial processing of the claim will review rework/dispute request.
- **Response details**: If claim requires an additional payment, the EOP will serve as notification of the outcome on the review. If the original claim status is upheld, the provider will be sent a letter outlining the details of the review.

**Applies to California only**: If a claim requires an additional payment, the EOP itself is insufficient to serve as notification of the outcome of the review. A letter will be sent to the Provider with the determination. In addition, payment must be sent within 5 calendar days of such determination based on the date on the determination letter. We will respond to the Provider within the applicable time limits set forth by Federal and State agencies. After the applicable time limit has passed, the Provider may contact Provider Relations at (877) 847-2862 to obtain a status.
**Provider Dispute Resolution (PDR) (applies to Commercial in CA, OR and WA)**

A provider dispute is a dispute of a claim for which a determination has previously been issued by us. You must submit a provider dispute in writing and accompanied by additional documentation for review. All disputes must be submitted within 365 calendar days following the date of the last action or inaction, unless other filing guidelines contained in your participation agreement or State law dictate otherwise. This time frame applies to all disputes regarding contractual issues, claims payment issues, overpayment recoveries and medical management disputes.

The PDR process is available to provide a fair, fast and cost-effective resolution of provider disputes, in accordance with state and federal regulations. We will not discriminate, retaliate against or charge you for submitting a provider dispute. The PDR process is not a substitution for arbitration and will not be deemed as an arbitration.

**What to submit**

As the provider of service, you should submit the dispute with the following information:

- Customer’s name;
- Customer’s health care ID number;
- Claim number;
- Specific item in dispute;
- Clear rationale/reason for contesting the determination and an explanation why the claim should be paid or approved;
- Submitting provider’s contract information.

**Note:** Physicians and health care professionals who do not submit the appropriate supporting documentation when requesting review of a previously processed claim will not have the dispute reviewed.

For California physicians and health care professionals: A Provider Dispute Resolution form can be obtained online at uhcw.com → Login → Select “California” → Library → Resource Center → Provider Disputes (California Only). The dispute resolution form is not required; however, the minimum requirements outlined in AB1455 must be met.

**Where to submit**

State-specific addresses and other pertinent information regarding the PDR process may be found in the UnitedHealthcare West Provider Rework or Dispute Process Reference Table at the end of this section.

**Accountability for review of a provider dispute**

The entity that initially processed/denied the claim or service in question is responsible for the initial review of a PDR request. These entities may include, but are not limited to, UnitedHealthcare West, the delegated medical group/IPA/payer or the capitated hospital/provider.

**Excluded from the PDR process**

The following are examples of issues that are excluded from the PDR process:

- Dates of service prior to January 1, 2004.
- Instances in which a Customer has filed an appeal and you have filed a dispute regarding the same issue. In these cases, the Customer’s appeal will take precedence. You can submit a provider dispute after the Customer appeal decision is made. If you are appealing on behalf of the Customer, the appeal will be processed as a Customer appeal.
- An Independent Medical Review initiated by a Customer through the Customer Appeal Process.
- Any dispute filed outside of the timely filing limit applicable to you, and for which you fail to supply “good cause” for the delay.
- Any delegated claim issue that has not been reviewed through the delegated payer’s claim resolution mechanism.
- Any request for a dispute which has been reviewed by the delegated medical group/IPA/payer or capitated hospital/provider and does not involve an issue of medical necessity or medical management.
### UnitedHealthcare West provider rework or dispute process reference table

<table>
<thead>
<tr>
<th>Provider’s state</th>
<th>Contact information</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>PacifiCare of Arizona Attn: Claims Resolution Team P.O. Box 52078 Phoenix, AZ 85072-2078</td>
<td>First Review: Request for reconsideration of a claim is considered a Grievance. Physicians and health care professionals are required to notify us of any request for reconsideration within 1 year from the date the claim was processed. Second Review: Request for reconsideration of a Grievance determination is also considered a Grievance. Physicians and health care professionals are required to notify us of any second level Grievance within 1 year from the date the first level Grievance was communicated to the provider.</td>
</tr>
<tr>
<td>California</td>
<td>UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764</td>
<td>UnitedHealthcare of California will acknowledge receipt of the dispute within 15 business days of receipt of the dispute for disputes submitted by paper, and within 2 business days of receipt of the disputes submitted electronically. We will issue a written determination to the provider within 45 business days. Also, we will return the provider dispute if additional information is required within 45 business days.</td>
</tr>
</tbody>
</table>
| Colorado         | Medicare Advantage Claims Department Attn: Colorado Resolution Team P.O. Box 30983 Salt Lake City, UT 84130-0983 | Upon receipt of a dispute, Colorado Resolution Team will:  
  - Acknowledge receipt of the dispute within 30 calendar days of the receipt of the dispute;  
  - Conduct a thorough review of the provider’s dispute and all supporting documentation;  
  - Acknowledge receipt, including the specific rationale for the decision, within 60 calendar days of receipt of the dispute;  
  - Process payment, if necessary, within 5 business days of the written determination;  
  - Reply to the provider of service within 30 calendar days if additional information is required.  
If additional information is required, we will hold the dispute request for 30 additional calendar days. |
| Nevada           | For Medicare Advantage claims: UnitedHealthcare P.O. Box 95638 Las Vegas, NV 89193-5638 | All Nevada Medicare Advantage HMO claims are processed by a delegated payer. Therefore, the provider appeals are reviewed primarily by the delegated payer. |
| Oklahoma         | UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764 | UnitedHealthcare of Oregon will allow at least 30 calendar days after the action giving rise to a dispute for physicians and health care professionals and facilities to complain and initiate the dispute resolution process. We will render a decision on provider or facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, we will render a decision within 60 calendar days of the complaint. |
| Oregon           | UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764 | UnitedHealthcare of Oregon will allow at least 30 calendar days after the action giving rise to a dispute for physicians and health care professionals and facilities to complain and initiate the dispute resolution process. We will render a decision on provider or facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, we will render a decision within 60 calendar days of the complaint. |
| Texas            | UnitedHealthcare West Claims Department P.O. Box 400046 San Antonio, TX 78229 | UnitedHealthcare of Washington will allow at least 30 calendar days after the action giving rise to a dispute for physicians and health care professionals and facilities to complain and initiate the dispute resolution process. We will render a decision on provider or facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, we will render a decision within 60 calendar days of the complaint. |
| Washington       | UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764 | UnitedHealthcare of Washington will allow at least 30 calendar days after the action giving rise to a dispute for physicians and health care professionals and facilities to complain and initiate the dispute resolution process. We will render a decision on provider or facility complaints within a reasonable time for the type of dispute. In the case of billing disputes, we will render a decision within 60 calendar days of the complaint. |
Access & availability: Exception standards for certain UnitedHealthcare West states

We monitor Customers’ access to medical and behavioral healthcare to make sure that we have an adequate provider network to meet the Customers’ healthcare needs. We use Customer satisfaction surveys and other feedback to assess performance against standards.

We have established access standards for appointments & after hours care as defined in the Access standards section of the UnitedHealthcare Guide. Exceptions or additions to those standards are shown in the table below for certain states.

<table>
<thead>
<tr>
<th>Type of Care</th>
<th>Guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular or routine</td>
<td>UnitedHealthcare Standard: 14 calendar days</td>
</tr>
<tr>
<td></td>
<td>California Commercial HMO: Customers are offered appointments for non-urgent PCP within 10 business days of request;</td>
</tr>
<tr>
<td></td>
<td>Texas: Within 3 weeks for medical conditions.</td>
</tr>
<tr>
<td>Preventive care</td>
<td>UnitedHealthcare Standard: 4 weeks</td>
</tr>
<tr>
<td></td>
<td>California: Preventive care services and periodic follow up care, including but not limited to, standing referrals to Specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.</td>
</tr>
<tr>
<td></td>
<td>Texas: Within 2 months for child, and within 3 months for adult, Medicare Advantage within 30 days.</td>
</tr>
<tr>
<td>Urgent exam (PCP or Specialist)</td>
<td>UnitedHealthcare Standard: Same day (24 hours)</td>
</tr>
<tr>
<td></td>
<td>California Commercial Customers: Are offered appointments within 48 hours when no prior authorization required, within 96 hours when prior authorization required.</td>
</tr>
<tr>
<td>In-office wait time</td>
<td>California Customers: In-office wait time is less than 30 minutes.</td>
</tr>
<tr>
<td>Referral process</td>
<td>Notification to the Customer should be completed in a timely manner, not to exceed 5 business days of a request for non-urgent care or 72 hours of a request for urgent care.</td>
</tr>
<tr>
<td>Non-urgent ancillary (diagnostic)</td>
<td>15 business days.</td>
</tr>
</tbody>
</table>

1. Customers must have access to all physicians and support staff that work for the physician and must not be limited to particular physicians. We recognize that some substitution between physicians who work out of the same office/building may occur due to urgent/emergent situations.

2. Customers must have access to appointments during all normal office hours and will not be limited to appointments on certain days or during certain hours.

3. Customers must have access to time slots that are the same as all other patients seen by the physician who are not UnitedHealthcare West Commercial Customers.

4. The physician must work cooperatively with our Medical Management department toward *:
   › Managing inpatient and outpatient utilization;
   › Customer Care and Customer satisfaction;

5. The physician will use best efforts to refer Customers to UnitedHealthcare West network providers. The physician must use only UnitedHealthcare West network laboratory and radiology providers, unless specifically authorized.

Timely access to non-emergency health care services (applies only to Commercial in California)

• The timeliness standards require licensed health care providers to offer Customers appointments that meet the California time frames. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care Provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Customer.

• Triage or screening services by phone must be provided by licensed staff 24 hours per day, 7 days per week. Unlicensed staff persons shall not use the answers to those questions in an attempt to assess, evaluate, advise or

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* As an “authorization representative” of the health plan, physicians are responsible to notify the Customer about the prior authorization determination, unless State regulation requires otherwise.
make any decision regarding the condition of a Customer or determine when a Customer needs to be seen by a licensed medical professional.

- UnitedHealthcare of California managed care Customers and covered persons of UnitedHealthcare Insurance Company benefit plans have access to free telephonic triage and screening services 24 hours a day, 7 days a week through OptumHealth’s Nurseline at (866) 747-4325.

**California Language Assistance Program (California Commercial only)**

UnitedHealthcare of California managed care Customers who have limited English proficiency, have accessibility to translated written materials and oral interpretation services, free of charge, to assist such Customers in obtaining covered services. For more information, call (800) 752-6096.

If the Provider knows the Customer’s language of choice is not English and has limited English proficiency, the Provider should arrange for oral interpretive services prior to the date of service, if feasible.

**Customer complaints & grievances**

We acknowledge that Customer disputes may arise with the health plan or its contracting/participating providers, especially related to coverage issues. UnitedHealthcare West respects the rights of its Customers to express dissatisfaction regarding quality of care/services and to appeal any denied claim/service. All Customers receive instructions on how to file a complaint/grievance with us in their Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable.
UnitedHealthOne Individual Plans Supplement (GRIC and UHCLIC)

Important information regarding the use of this Supplement

UnitedHealthOne is the brand name of the UnitedHealthcare family of companies that offers individual personal health products including Golden Rule Insurance Company (“GRIC”) and UnitedHealthcare Life Insurance Company, (“UHCLIC”).

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

How to contact us

<table>
<thead>
<tr>
<th>Resource</th>
<th>Where to go</th>
<th>What you can do there</th>
</tr>
</thead>
<tbody>
<tr>
<td>GRIC – Group Number 705214</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notification</td>
<td>Call the number on the back of the Insured’s health care ID card or go to UnitedHealthcareOnline.com.</td>
<td>Admission Notification is required for all inpatient services UnitedHealthcare standard Notification requirements for Facilities for Admission Notification apply.</td>
</tr>
<tr>
<td>Benefits and Eligibility</td>
<td>Call the number on the back of the Insured’s health care ID card or go to myuhone.com.</td>
<td>To inquire about an Insured’s plan benefits or eligibility.</td>
</tr>
<tr>
<td>Claims</td>
<td>Go to myuhone.com</td>
<td>To view claims pending and processed claims.</td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>Call the pharmacy number on the back of the Insured’s health care ID card.</td>
<td>For information on the Prescription Drug List (PDL).</td>
</tr>
</tbody>
</table>

| UHCLIC – Group Number 755870 | | |
| Notification | Call the number on the back of the Insured’s health care ID card or go to UnitedHealthcareOnline.com. | Prior Authorization is required for certain services Admission Notification is required for all inpatient admissions UnitedHealthcare Standard Advanced Notification and Admission Notification requirements apply. |
| Benefits and Eligibility | Call the number on the back of the Insured’s health care ID card or go to myuhone.com. | To inquire about an Insured’s plan benefits, eligibility or verify claims. |
| Pharmacy Services | Call the pharmacy number on the back of the Insured’s health care ID card. | For information on the Prescription Drug List (PDL). |
| Cardiology: Diagnostic Catheterization, Electrophysiology Implants, Echocardiogram and Stress Echocardiogram | Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Cardiology Notification & Authorization - Submission & Status Phone: (866) 889-8054 | Request prior authorization for services as described in the Cardiology Notification/Prior Authorization Protocol for Commercial Customers section of this Guide. |
| Radiology/Advanced Outpatient Imaging Procedures: CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology | Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization - Submission & Status Phone: (866) 889-8054 | Request prior authorization for services as described in the Outpatient Radiology Notification/Prior Authorization Protocol for Commercial Customers section of this Guide. |
| Referrals (Navigate, and Compass only) | Go to UnitedHealthcareOnline.com. | Submit referrals and verify referral status. |

| UHCLIC – All Other | | |
| Notification | Call the number on the back of the Insured’s health care ID card. | Notification is required for inpatient stays that exceed 3 days. |
| Benefits and Eligibility | Call the number on the back of the Insured’s health care ID card. | To inquire about an Insured’s plan benefits or eligibility. |
| Pharmacy Services | Call the pharmacy number on the back of the Insured’s health care ID card. | For information on the Prescription Drug List (PDL). |

| GRIC – Group Number 902667 | | |

100-6088  1/16  244
### Resource | Where to go | What you can do there
--- | --- | ---
**Notification** | Call the number on the back of the Insured’s health care ID card or go to UnitedHealthcareOnline.com. | Prior Authorization is required for certain services. Admission Notification is required for all inpatient admissions. UnitedHealthcare standard Advanced Notification and Admission Notification requirements apply.
**Benefits and Eligibility** | Call the number on the back of the Insured’s health care ID card or go to myuhone.com. | To inquire about an Insured’s plan benefits, eligibility or verify claims.
**Pharmacy Services** | Call the pharmacy number on the back of the Insured’s health care ID card. | For information on the Prescription Drug List (PDL).
**Cardiology: Diagnostic Catheterization, Electrophysiology Implants, Echocardiogram and Stress Echocardiogram** | Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Cardiology Notification & Authorization - Submission & Status Phone: (866) 889-8054 | Request prior authorization for services as described in the Cardiology Notification/Prior Authorization Protocol for Commercial Customers section of this Guide.
**Radiology/Advanced Outpatient Imaging Procedures: CT scans, MRIs, MRAs, PET scans and nuclear medicine studies, including nuclear cardiology** | Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization - Submission & Status Phone: (866) 889-8054 | Request prior authorization for services as described in the Outpatient Radiology Notification/Prior Authorization Protocol for Commercial Customers section of this Guide.

**Our claims process**

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

1. Notify GRIC and UHLCIC, in accordance with the notification requirements set forth in this Supplement.
2. For Navigate and Compass referrals, refer to the Referrals and Notification requirements - Navigate, Charter, Compass and Core section of the UnitedHealthcare Guide).
3. Prepare a complete and accurate claim form.
4. Submit electronic claims using the electronic payer ID on the health care ID card, or submit paper claims to the address listed on the Insured’s health care ID card.
5. For contracted providers who submit electronic claims for UHCLIC Customers who would like to receive electronic payments and statements, call Optum Financial Services Customer Service line at (877) 620-6194. Select option 1 followed by option 1 again to speak with a representative. You can also log onto OptumHealthFinancial.com.

**Note:** The Payer ID number on the insured’s health care ID card must be utilized. The electronic claims submission number does vary and is not forwarded on but instead rejected if the correct payer ID is not utilized.

**Claim adjustments**

If you believe your claim was processed incorrectly, please call the number on the back of the insured’s health care ID card and request an adjustment as soon as possible and in accordance with applicable statutes and regulations. If you or our staff identifies a claim where you were overpaid, we ask that you send us the overpayment within 30 calendar days from the date of your identification of the overpayment or of our request.

If you disagree with our determination regarding a claim adjustment, you can appeal the determination (see the UnitedHealthOne claims appeals section of this Supplement below).

**UnitedHealthOne claims appeals**

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

Grievance Administrator  
P.O. Box 31371  
Salt Lake City, UT 84131-0370  
Fax: (317) 715-7648  
Phone: (800) 657-8205
If you feel your situation is urgent, you may request an expedited (urgent) appeal orally, by fax or in writing at:

Grievance Administrator  
3100 AMS Blvd.  
Green Bay WI 54313  
Fax: (920) 661-9981  
Phone: (800) 657-8205

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

Please refer to Claim reconsideration, appeals process and resolving disputes section in this Guide under for detailed information about the reconsideration and appeal process.

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

Notice to Texas providers
• For Verification of Benefits for GRIC Insureds, please call (800) 395-0923.
• For Verification of Benefits for UHCLIC Insureds, please call (800) 657-8205.

GRIC and UHCLIC use tools developed by third parties, such as the MCG™ Care Guidelines, (formerly known as Milliman Care Guidelines®), to assist them in administering health benefits and to assist clinicians in making informed decisions in many health care settings, including acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities.

As affiliates of UnitedHealthcare, GRIC and UHCLIC may also use UnitedHealthcare’s medical policies as guidance. These policies are available online at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides.

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

To obtain a verification as required by 28 TAC §19.1719, please call (800) 842-1792.

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

The program for participating providers must emphasize best practice guidelines to help prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment. You can find the Standards of Medical Care in Diabetes and Clinical Practice Recommendations at care.diabetesjournals.org.

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

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

Be sure to check the Insured’s health care ID card at each visit and to copy both sides of the card for your files. When filing electronic claims, be sure to use the electronic Payer ID on the health care ID card.

For more detailed information on ID cards and to see a sample health care ID card, please refer to the Health care identification (ID) cards section of this guide.