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Important information regarding the use of this Guide

This 2014 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, 2014 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, 2014.

Terms used in this Guide include the following:

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

Except when indicated, the Guide applies to covered services you provide to UnitedHealthcare Medicare Advantage Customers, including Erickson Advantage Customers but excluding UnitedHealthcare MedicareDirect Customers. As used in this Guide, references to “Medicare Advantage Customers” only apply to those Medicare Advantage Customers enrolled in UnitedHealthcare Medicare Advantage plans offered under the AARP MedicareComplete, UnitedHealthcare Medicare Solutions, and Erickson Advantage brands.* If a particular section does not apply to 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/Website” of the Benefit plans table of this Guide. We do not own the other websites referred to in this Guide, but reference them because they may contain information that is useful or interesting to you. We do not endorse, and are not responsible for, the content and accuracy of websites operated by third parties or any of your dealings with such third parties. You are solely responsible for your dealings with such third parties, and so we encourage you to read the terms of use and privacy policies on such third-party websites.

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

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

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

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

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

<table>
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<th>Term used in this Guide</th>
<th>Definition</th>
<th>ID card reference</th>
<th>Location of most Customers subject to Additional Manuals</th>
<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>
</tr>
</thead>
</table>
| All Savers             | Benefit plan issued or administered by All Savers Insurance Company | “All Savers” | All markets | All Savers Supplement to this Guide Myallsaversprovider.com | 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:  
  • All Savers products offered on-Exchange |
| Empire Plan            | Self-insured benefit plans administered by UnitedHealthcare Insurance Company of New York, providing physician and certain ancillary provider benefits for employees of the State of New York and local governments in New York. | “The Empire Plan” and/or “NYSHIP” | NY | Empire Plan Physician & Provider Manual Empire Plan Home Care Provider Manual UnitedHealthcareOnline.com | The network for services rendered in New York to Empire Plan Customers is the Empire Plan network and not the UnitedHealthcare network, and such services are not subject to your UnitedHealthcare agreement or this Guide. If you are directly contracted to participate in the Empire Plan network, services you render in New York to Empire Plan Customers are subject to your Empire Plan agreement, and the applicable Additional Manual, and not to your UnitedHealthcare agreement or this Guide. The UnitedHealthcare network is the network for services rendered in AZ, CT, DC, FL, NJ, NC and SC to Empire Plan Customers. Services rendered in those states are subject to your UnitedHealthcare agreement and to this Guide, and not to the Additional Manuals described in this row. For services rendered to Empire Plan Customers in states other than NY, AZ, CT, DC, FL, NJ, NC and SC, the Empire Plan does not use the UnitedHealthcare network; services you render in these states to an Empire Plan Customers are not subject to your UnitedHealthcare agreement or this Guide. If you are directly contracted to participate in the Empire Plan network, services you render to Empire Plan Customers in states other than NY, AZ, CT, DC, FL, NJ, NC and SC are subject to your Empire Plan agreement, and the applicable Additional Manual. |

* 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.
<table>
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<th>Term used in this Guide</th>
<th>Definition</th>
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<th>When and how does the Additional Manual apply when you are providing services to the Customer of the benefit plan?*</th>
</tr>
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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>
</tr>
<tr>
<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>
</tr>
<tr>
<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.</td>
</tr>
<tr>
<td>OCI</td>
<td>Benefit plans issued or administered by Optimum Choice, Inc.</td>
<td>“OCI”</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>
</tr>
<tr>
<td>OneNet</td>
<td>Benefit plans accessing a network administered by OneNet PPO, LLC</td>
<td>PPO Network: “OneNet PPO” Workers Compensation Network: ID cards are normally not utilized</td>
<td>DC, DE, MD, NC, PA, VA, WV</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>
</tr>
<tr>
<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 Commercial benefit plans: Oxford Commercial Supplement to this Guide. NY Individual Off Exchange and NY SHOP UnitedHealthcareOnline.com</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.</td>
</tr>
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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.
| Term used in this Guide | Definition | ID card reference | Location of most Customers subject to Additional Manuals | Additional Manual/ website | When and how does the Additional Manual apply when you are providing services to the Customer of the benefit plan?*

---

**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 ID card  
Parts of AR, GA, IA, IL, TN, WI, VA.  
**Note:** River Valley also offers benefit plans in NC, OH & SC, but the River Valley Additional Manual does not apply to those benefit plans  
**River Valley Entities Supplement** to this Guide  
UnitedHealthcareOnline.com and uhcrivervalley.com  
The River Valley Additional Manual applies to you, and it supersedes this Guide if there is a conflict, if all of the following are true.  
Your United contract specifically references River Valley or John Deere Health protocols or manuals; 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 ID card references identify Sierra members who access the UnitedHealthcare network outside Nevada]  
NV  
Benefit plans for Sierra Health and Life Insurance Company, Inc.: sierrahealthandlife.com  
Benefit plans for Health Plan of Nevada, Inc.: healthplanofnevada.com  
The network for services in Nevada is the applicable Sierra network and not the UnitedHealthcare network; if you are in the applicable Sierra network, services you render in Nevada to Sierra Customers are subject to your Sierra agreement, and the applicable Additional Manual, and not to your UnitedHealthcare agreement or this Guide.  
Services rendered outside of Nevada to Sierra Customers with the ID card reference described in this row are subject to your UnitedHealthcare agreement and to this Guide, and not to the Additional Manuals described in this row (unless you are in Arizona or Utah and have a contract directly with Sierra).

**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 West Provider Handbook.

**UnitedHealthcare Community Plan Medicaid, CHIP and Uninsured**  
Benefit plans (including Medicaid, CHIP and other non-Commercial state government programs) offered through the UnitedHealthcare Community Plan business unit  
"UnitedHealthcare Community Plan*  
Multiple states  
UnitedHealthcare Community Plan Physician, Health Care Professional, Facility and Ancillary Administrative Guide for Medicaid, CHIP, or Uninsured  
uhcommunityplan.com and UnitedHealthcareOnline.com  
If your agreement specifically references UnitedHealthcare Community Plan or Medicaid, CHIP, Uninsured or Other Governmental benefit plans protocols or manuals (including references to "Arizona Physicians IPA", "APIPA", or older brand names such as "AmeriChoice", "Great Lakes Health Plan", "Unison" or "Evercare"), then the UnitedHealthcare Community Plan Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide.

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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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</tr>
</thead>
<tbody>
<tr>
<td><strong>UnitedHealthcare Community Plan Medicare Advantage</strong></td>
<td>Medicare Advantage benefit plans offered through the UnitedHealthcare Community Plan business unit.</td>
<td>“CP” on the back** of the card. **Note that UnitedHealthcare also offers Medicare Advantage benefit plans that are not subject to this Additional Manual. Those benefit plans have a reference to “UHC” (or in certain parts of the country, a reference to “OXH” or “WEST”) on the back of the ID card.</td>
<td>Multiple states</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 “AmerChoice”, “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>
</tr>
</tbody>
</table>
| **UnitedHealthcare West or UHC West (Benefit plans referenced in this row were formerly referenced in this Guide as (“PacifiCare”))** | Benefit plans issued or administered by any of the following entities:  
• 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 UnitedHealthcare WEST also provides benefit plans for “Commercial”. This statement should be modified to reflect this line of business. | “WEST” | AZ, CA, CO, NV, OK, OR, TX, WA | UnitedHealthcare West Non-Capitated Supplement to this Guide.  
UnitedHealthcareOnline.com and uhcwest.com | If your agreement specifically references PacifiCare or UnitedHealthcare West protocols or manuals, then the UnitedHealthcare West Additional Manual applies, and it supersedes conflicting provisions in the rest of this Guide. |
| **UnitedHealthOne** | Benefit plans issued or administered by any of the following entities:  
a. Golden Rule Insurance Company  
b. UnitedHealthcare Life Insurance Company  
c. PacifiCare Life and Health Insurance Company | a. “Golden Rule”  
b. “UnitedHealthcare Life Insurance Company”  
c. “PacifiCare” | All markets | UnitedHealthOne Individual Plans Supplement to this Guide  
UnitedHealthcareOnline.com and myUHOne.com | 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 |

* 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. To subscribe to our RSS feeds, copy and paste any or all of the following URLs into your RSS Reader:


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.

Are you interested in the impacts of Health Care Reform, and changes that may impact you? Please go to UHC.com → United for Reform Resource Center for more information.

Network Bulletin

UnitedHealthcare publishes 6 editions per year of the “Network Bulletin”, a user-friendly, online resource that includes notice to our network physicians and facilities of any protocol, policy, or program updates and changes as well as an array of other useful and interesting items. It includes information relevant across our lines of business, including Commercial, Medicaid and Medicare products. The Network Bulletin is posted and accessible online at UnitedHealthcareOnline.com → Quick Links → Network Bulletin. 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.

In 2014, the Network Bulletin will be available on UnitedHealthcareOnline.com and through email on the following dates:

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

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

General information about updates

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

<table>
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<th>Resource</th>
<th>Where to go</th>
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<tr>
<td>UnitedHealthcare provider website</td>
<td>UnitedHealthcareOnline.com</td>
<td>For more detailed information about available functionality, please go to UnitedHealthcareOnline.com → Help → Electronic Solutions → UnitedHealthcare Online.</td>
</tr>
</tbody>
</table>
|                                               | **Note:** the website is applicable to Commercial, Medicare Advantage and certain Medicaid plans (Community Plans) Claim Status, Eligibility and certain benefits can also be retrieved for River Valley (including Neighborhood Health Partnership) and UnitedHealthcare West. For more information, refer to: UnitedHealthcareOnline.com → Tools & Resources → UnitedHealthcare Community Plan Resources. | • Register for UnitedHealthcareOnline.com.  
• Review a Customer’s eligibility or benefits and current Health Reimbursement Account (HRA) balances.  
• View Patient Personal Health Records.  
• Submit check status and update Notifications/Prior Authorizations.  
• Submit referrals or check status of referrals.  
• View claim pre-determination and bundling logic using Claim Estimator (only for professional claims for Commercial Customers).  
• Submit professional claims (claims for Commercial Customers may be adjudicated in real time).  
• Check claims status.  
• Reprint an explanation of benefits (EOB) using the Single EOB Search.  
• Enroll in Electronic Payments and Statements (EPS) for direct deposit of payment for covered services and electronic EOBs.  
• Request a claims adjustment or a Claim Reconsideration when attachments are not needed.  
• Submit a Claim Research Project for 20 or more claims.  
• Update facility/practice data (except tax identification number (TIN)).  
• Review the physician directory.  
• Look up your fee schedule, 10 codes at a time.  
• Review/print a current copy of this Guide.  
• View UnitedHealthcare policies.  
• View current and past issues of our Network Bulletin.  
• View Advance Notification List.  
• Access and review clinical program information and patient safety resources.  
• View the Credentialing and Re-credentialing Plan.  
• View and register for webcast seminars.  |
|                                               | (866) UHC-FAST (842-3278), Option 2                                         | • Get help with UnitedHealthcareOnline.com.  
• View and register for webinars about using UnitedHealthcareOnline.com.  
• Access Quick Reference Guides and more.  |
| Advance Notification, Prior Authorization and Admission Notification (Notification requirements) apply to those Customers whose benefit plans require Prior Authorization and those whose benefit plans do not. | 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. | • Notify us about the procedures and services referenced in the Notification requirements section of this Guide.  
• Communicate with us regarding utilization management issues.  |
| Behavioral Health Services                      | See Customer’s health care ID card for carrier information and contact numbers. | • Inquire about a Customer’s behavioral health benefits.  |
| Cardiology Notification & Authorization – Submission & Status | UnitedHealthcareOnline.com  
Phone: (866) 889-8054 | • 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.  |
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| Chiropractic, Physical Therapy, Occupational Therapy, and Speech Therapy Providers contracted with OptumHealth Physical Health, a UnitedHealth Group company | myoptumhealthphysicalhealth.com Phone: (877) 842-3210 | • 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) | UnitedHealthcareOnline.com → Quick Links → Electronic Payments & Statements (information) or Claims & Payments → Electronic Payments & Statements (register or logon). (866) UHC-FAST (842-3278), Option 5. | • Learn about EPS.  
• Sign up for EPS.  
• Access online explanation of benefits (EOBs), 835 files and information about direct deposit payments.  
• Call for questions about EPS. |
| Electronic Submission (EDI Support Line) | Phone: (800) 842-1109 or Online: UnitedHealthcareOnline.com → Contact Us → Electronic Data Interchange (EDI) Claims → EDI Issue Submission. UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions. | • Learn about electronic transactions and submission options.  
• Obtain Payer IDs for UnitedHealthcare, Affiliates, and Strategic Alliances.  
• Claim submission tips. |
| Enterprise Voice Portal | Phone: (877) UHC-3210 (842-3210) For a Quick Reference Guide, go to UnitedHealthcareOnline.com → Contact Us → click on the quick reference link under Healthcare for Health Care Professionals (Enterprise Voice Portal). | • Inquire about a Customer’s eligibility or benefits (including copayments, deductibles, past/current coverage, coinsurance, and out-of-pocket information) and obtain a faxed confirmation.  
• Check claim status, reason code explanation and claims pending and mailing addresses.  
• Update facility/practice demographic data (except TIN).  
• Check credentialing/practice demographic data (except TIN).  
• Check appeal or claim project submission process information.  
• Check care notification process information.  
• Check privacy practice information. |
| Erickson Advantage* (A UnitedHealthcare Medicare Advantage product for residents of Erickson Retirement Communities). | See Customer’s health care ID card for Customer Care contact information. | • Inquire about benefits and services as indicated in this Guide, including Notification requirements. |
| Fraud, Waste and Abuse (Report Potential Non-Compliance or Suspected Issues) | Phone: Enterprise Voice Portal at (877) UHC-3210 (842-3210) Online: UnitedHealthcareOnline.com → Tools & Resources → Training & Education → Compliance, Fraud, Waste, and Abuse Training → Delegate Compliance Notice FAQ. | 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. |
| Optum Cloud Dashboard website | If you aren’t registered for Optum Cloud Dashboard, please go to: UnitedHealthcareOnline.com → Health Information Technology → Optum Cloud Dashboard.  
If you are registered on Optum Cloud Dashboard, please go to cloud.optum.com. | • Link to UnitedHealthcareOnline.com and affiliate websites.  
• Request a claim reconsideration when attachments are needed for a UnitedHealthcare Commercial, UnitedHealthcare Medicare Solutions, Oxford, UnitedHealthcare West or UnitedHealthcare Community Plan* claim. |
<table>
<thead>
<tr>
<th>Resource</th>
<th>Where to go</th>
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</tr>
</thead>
</table>
| Optum Cloud Dashboard website – continued | Phone: (855) 819-5909 or optumcloudsupport@optum.com | • Check the status of a claim reconsideration request that was submitted through Optum Cloud Dashboard.  
*The Claim Reconsideration with Attachments application is not yet available for:  
› TRICARE West  
› UnitedHealthcare Plan of the River Valley, Inc. (Commercial and Community Plan)  
› UnitedHealthcare Community Plan of the District of Columbia, Louisiana, Michigan and Nevada |
| Optum Cloud Dashboard | UnitedHealthcareOnline.com → Help → Optum Cloud Dashboard. | • Get help with registering or using Optum Cloud Dashboard. |
| Outpatient Radiology Notification & Authorization – Submission and Status | UnitedHealthcareOnline.com  
Phone: (866) 889-8054 | • 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. |
| Pharmacy Services (For services to Commercial Customers only) | UnitedHealthcareOnline.com → Tools & 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 | • View the Prescription Drug List (PDL) and a current list of participating specialty pharmacy provider(s) by drug.  
• Incentives that apply to the use of certain pharmaceuticals.  
• Learn about pharmaceutical management procedures for notification/Prior Authorization requirements, supply limits and step therapy protocols.  
• Call for medications requiring Notification/Prior Authorization.  
• Fax for medications requiring Notification/Prior Authorization. |
| Pharmacy Services (For services to Medicare Advantage Customers only) | Go to UHCMedicareSolutions.com → Search the drug list.  
Fax: (877) MDRXFAX (637-9329)  
Phone: (800) 711-4555  
Fax: (800) 527-0531  
Fax: (800) 853-3844  
Phone: (866) 798-8780, Option 2 | • View the 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. |
| Provider Relations | UnitedHealthcareOnline.com → Contact Us → Network Contacts. | • 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. |
| Specialty Drug Prior Authorization Submission & Status (Medicare Part B) | UnitedHealthcareOnline.com  
Phone: (866) 889-8054 | • Notify us of certain outpatient and office-based Part B Specialty Drug procedures as described in the Part B Specialty Drug Prior Authorization section of this Guide. |
| Transplant Services | See Customer’s health care ID card for carrier information and contact numbers. | • Inquire about a Customer’s transplant benefits. |
| Urgent Appeal Submission (Commercial Customers only) (Medicare Advantage – follow the directions in the Customer decision letter) | Fax: (801) 994-1083 | • An expedited appeal may be available to you if the Customer’s medical conditions are such that the time needed to complete a standard appeal could seriously jeopardize the patient’s life, health or ability to regain maximum function. |
| Vision Services | See Customer’s health care ID card for carrier information and contact numbers. | • Inquire about a Customer’s vision benefits. |
Healthcare identification (ID) cards

UnitedHealthcare Customers receive a health care ID card containing information needed for you to submit claims. Information may vary in appearance or location on the card due to payer or other unique requirements. However, cards display essentially the same information (such as claims address, copayment information, phone numbers such as those for Customer Care, Advance Notification and Prior Authorization) and are viewable on UnitedHealthcareOnline.com in the Patient Eligibility section (click on the “View Patient’s ID card” link located in the Patient Search results section of the Eligibility Detail page).

Please check the Customer's health care ID card at each visit and keeps a copy of both sides of the ID card for your records.

Commercial sample health care ID card

![Commercial sample health care ID card](image)

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

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

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

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

Medicare Advantage health care ID card

In order to help identify those Customers associated with our Medicare Advantage products, please go to UnitedHealthcareOnline.com → Tools & Resources → Products & Services → Medicare → UnitedHealthcare Medicare Solutions Physician & Provider Information → Scroll to the “Benefit Plan Name Overviews” section at the bottom of the page.
Our products

Commercial products

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

Beginning January 1, 2014, the products below may also be offered through the Individual Marketplace and/or Small Business Health Options Program (SHOP) Marketplace. The Health Insurance Marketplaces, also known as Exchanges, are intended to help individuals and small groups research, compare and enroll in quality health plans from health insurers. Commercial products offered through the Exchange will follow the same policies and protocols as outlined within the Administrative Guide, except as otherwise required by your agreement. Your agreement with us determines if you are participating in these products.

Visit UnitedHealthcareOnline.com → Tools & Resources → Products & Services for more information about Our Products in your area including Medicare Advantage and Medicaid products that are offered in select markets. If a Customer presents an ID card with a product name with which you are not familiar, please contact Customer Care at the number at (877) 842-3210. This product list is provided for your convenience and is subject to change from time to time.
<table>
<thead>
<tr>
<th>Product Name</th>
<th>How do Customers access physicians and health care professionals?</th>
<th>Is the treating physician and/or facility required to give notification when providing certain services?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UnitedHealthcare Choice and Choice Plus</strong></td>
<td>Customers can choose any network physician or health care professional without a referral and without designating a primary physician.*</td>
<td>Yes, on selected procedures, see guidelines in the <strong>Notification requirements</strong> section of this Guide.</td>
</tr>
<tr>
<td><strong>UnitedHealthcare CORE Choice and CORE Choice Plus</strong></td>
<td>Choice Plus and CORE Choice Plus provides out-of-network benefits.* Choice and CORE Choice do not (except for urgent care and emergency). <strong>Note:</strong> The UnitedHealthcare CORE Choice and UnitedHealthcare CORE Choice Plus Network may be different than UnitedHealthcare Choice and UnitedHealthcare Choice Plus in your local market. Please refer to your contract to determine whether you are part of that local network.</td>
<td>Yes, on selected procedures. See guidelines in the <strong>Notification requirements</strong> section of this Guide.</td>
</tr>
<tr>
<td><strong>UnitedHealthcare Select and Select Plus</strong></td>
<td>Customers choose, or are assigned, a primary care physician (PCP) for each family member from the network of participating physicians. Customer is encouraged to see their PCP to coordinate their care, but is not required to obtain PCP referrals 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 urgent care and emergency).</td>
<td>Yes, on selected procedures, see guidelines in the <strong>Notification requirements</strong> section of this Guide.</td>
</tr>
<tr>
<td><strong>UnitedHealthcare Options PPO</strong></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 benefits**</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 <strong>Notification requirements</strong> section of this Guide.</td>
</tr>
<tr>
<td><strong>UnitedHealthcare Indemnity</strong></td>
<td>Customers can choose any physician or health care professional.*</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><strong>UnitedHealthcare Navigate®, Navigate Balanced®, Navigate Plus</strong></td>
<td>For each covered family member, Customers choose a network primary care physician to manage the Customer’s care and generate referrals to network specialists when required. Navigate Plus provides out-of-network benefits**, Navigate and Navigate Balanced do not (except for emergency services). See referral requirements in the Navigate <strong>Specialist Referral Requirement</strong> section of this Guide.</td>
<td>Yes, on selected procedures, see guidelines in the <strong>Notification requirements</strong> section of this Guide.</td>
</tr>
<tr>
<td><strong>UnitedHealthcare Compass, Compass Balanced, Compass Plus</strong></td>
<td>For each covered family member, Customers choose a network primary care physician to manage the Customer’s care and generate referrals to network specialists when required. Compass Plus provides out-of-network benefits**, Compass and Compass Balanced do not (except for emergency services). See referral requirements in the Compass <strong>Specialist Referral Requirement</strong> section of this Guide.</td>
<td>Yes, on selected procedures, see guidelines in the <strong>Notification requirements</strong> section of this Guide.</td>
</tr>
</tbody>
</table>

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

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

UnitedHealthcare offers consumer-driven health plans which may be identified via the health care ID card or by looking up your patient’s eligibility information at UnitedHealthcareOnline.com. Each of these products includes 3 major components:

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

UnitedHealthcare Health Reimbursement Account (HRA) fast facts

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

UnitedHealthcare Health Savings Account (HSA) fast facts

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

Commercial UnitedHealthcare Navigate®, and UnitedHealthcare Compass Products (Specialist Referral Requirements)

• The UnitedHealthcare Navigate and Compass portfolio of products are gated products that meet Consumer needs around access and cost with an emphasis on primary care and referrals to specialists. Navigate and Compass products require Prior Authorization by UnitedHealthcare for selected services as referenced in the Advance Notification section in this Guide.
• Customers are required to select a network primary physician in order to receive the highest level of benefits. A Primary physician 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.
• The primary physician performs primary care services and generates electronic referrals to network specialists when required. The UnitedHealthcare logo, Navigate and Compass product name and Customer’s primary physician are indicated on the front of the Customer’s health care ID card. Reference to electronic referrals required is on the back of the ID card.
UnitedHealthcare Navigate & UnitedHealthcare Compass Sample ID cards:

Note: Sample health care ID cards (above) are for illustration only; information on ID cards may vary by payer, benefit plan design and/or other requirements. The 3 Navigate and Compass product models are:

- **Navigate and Compass**: A single-tier benefit, network-only product. Customers must have a referral from their primary physician to receive network benefits for services from any network physician who is not practicing under the same TIN as their primary physician. If Customers seek care from a network physician outside of their primary care physician's TIN without a referral, there is no benefit for that physician's services and related facility services, and the Customer is responsible for the billed amount (subject to the services that do not require a referral as listed below).

- **Navigate Balanced and Compass Balanced**: A 2-tier benefit, network-only product. Customers must have a referral from their primary physician in order to receive the highest level of network benefits for services from any network physician not practicing under the same TIN as their primary physician. If Customers seek care from a network physician outside of their primary physician's TIN without a referral, they receive a leaner level of network benefits (subject to the services that do not require a referral as listed below). If Customers seek care from a non-network provider, there is no benefit for the service(s) and the Customer is responsible for the billed amount (subject to the services that do not require a referral as listed below).

- **Navigate Plus and Compass Plus**: A 3-tier benefit, network and non-network product. Customers must have a referral from their primary physician in order to receive the highest level of network benefit for services from any network physician not practicing under the same TIN as their primary physician. If Customers seek care from a network physician outside of their primary physician's TIN without a referral, they receive a leaner level of network benefits (subject to the services that do not require a referral as listed below). Non-network benefits are available for services from non-network providers at a lower level of benefit.

**Changing Primary Physicians – Navigate and Compass**

Customers may elect to change their primary physician on a monthly basis. Changes submitted to UnitedHealthcare on or before the 15th of the month will be effective on the 1st day of the following month. Changes submitted on or after the 16th of the month will be effective on the 1st day of the second following month.
**Covering Physician – Navigate and Compass**

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

**Specialist Referrals – Navigate and Compass**

The Customer’s primary physician coordinates the Customer’s care and generates electronic referrals to network specialists through the Referral Submission function on UnitedHealthcareOnline.com prior to the Customer seeking care with any network physician not practicing under the same TIN as the primary physician. Referrals are valid for any physician within the same TIN as the specialist included on the referral. Referrals match on TIN only, there is no referral matching on diagnosis, level, or type of service. Referrals to a specialist are for any eligible service provided in any setting including inpatient or outpatient. Referrals are made to the specialist rendering the service, not to the facility where the services are performed. Retroactive referrals and referrals to non-network physicians are not accepted.

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

**Services Not Requiring a Referral – Navigate and Compass**

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

- Referrals are not required for any non-physician type of network services which include but are not limited to:
  - Outpatient lab, x-ray, or diagnostics.
  - Physical therapy, DME, home health, prosthetic devices, hearing aids.
  - Rehab services with the exception of manipulative treatment and vision therapy (i.e., physician services).

**Referral Submission Requirements – Navigate and Compass**

- Referrals must be submitted by the Customer’s primary physician on our secure website at UnitedHealthcareOnline.com → Notification/Prior Authorizations → Referral Submission. Referrals cannot be accepted via phone, fax or paper. Retroactive referrals are not accepted.

- UnitedHealthcareOnline.com requires first time user registration to submit online referrals. If you are not a registered user, simply click the ‘New User’ link in the upper right hand corner on the UnitedHealthcareOnline.com home page and follow the prompts. If you have questions about the website registration, call (866) UHC-FAST (866) 842-3278, and select Option 2.

* Referrals should be submitted if the specialist TIN is not known.
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 → Help → Quick Reference → User ID & Password Management → Roles Function Quick Reference.

**Maximum Referral Visits – Navigate and Compass**

Each referral may include up to 6 visits and any unused visits expire after 6 months. At any time after the 6 visits have been used or if any unused visits expire after 6 months, an additional referral to that network specialist with up to 6 visits may be entered. For Customers with chronic conditions, the online referral screen will allow Standing Referrals for 99 visits to be entered if the Customer’s diagnosis code is included in the Navigate and Compass Referrals for Chronic Conditions policy.

If any of the 99 visits are unused after 6 months, a new referral can be issued. Conditions eligible for Standing Referrals of up to 99 visits are:

<table>
<thead>
<tr>
<th>ICD-9 Code</th>
<th>Diagnosis</th>
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<tbody>
<tr>
<td>042X</td>
<td>AIDS/HIV</td>
</tr>
<tr>
<td>28X, 773.0, 773.1 &amp; 776.5</td>
<td>Anemia</td>
</tr>
<tr>
<td>140X-208x &amp; 230 - 234.9</td>
<td>Cancer</td>
</tr>
<tr>
<td>27200; 2720; 27201</td>
<td>Cystic Fibrosis</td>
</tr>
<tr>
<td>295X</td>
<td>Schizoaffective disorders/schizophrenia</td>
</tr>
<tr>
<td>332.0; 332.1</td>
<td>Parkinson’s Disease</td>
</tr>
<tr>
<td>335.20</td>
<td>Amyotrophic Lateral Sclerosis</td>
</tr>
<tr>
<td>340</td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td>345.0 - 345.9</td>
<td>Epileptic Seizure</td>
</tr>
<tr>
<td>358.0</td>
<td>Myasthenia Gravis</td>
</tr>
<tr>
<td>365 - 365.9X</td>
<td>Glaucoma</td>
</tr>
<tr>
<td>446.6</td>
<td>Thrombotic Microangiopathy</td>
</tr>
<tr>
<td>477X</td>
<td>Allergies</td>
</tr>
<tr>
<td>584.X</td>
<td>Renal Failure (acute)</td>
</tr>
<tr>
<td>780.39</td>
<td>Seizure</td>
</tr>
<tr>
<td>8XX.XX - 829.XX, 733.8X</td>
<td>Fracture Care</td>
</tr>
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</table>

**Note:** It is not necessary to have the procedure performed indicated on the referral “Fracture Care” is adequate.

**Referral Status – Navigate and Compass**

Specialists are expected to confirm the existence of a referral (specific to the referring specialist’s tax ID) when Customers are scheduling appointments (with the exception of services not requiring a referral (see above section Services Not Requiring a Referral.) Facilities are also encouraged to confirm the existence of a referral for planned services given that Navigate and Compass Customers have no, or significantly reduced, benefits for care provided without a referral. A list of existing referrals can be viewed on UnitedHealthcareOnline.com on the Referral Status Detail screen, including information on the network specialist to whom the referral is made, number of visits authorized and number of visits remaining.

The physician performing a service that requires Advance Notification, (as referenced in the Advance Notification section in this Guide) is the person who has the responsibility to follow the Advance Notification or Prior Authorization procedures. 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. Refer to the above Product Model description to determine financial responsibility for each of the product models when referrals are not on file. All other protocols and guidelines outlined in this manual for Commercial managed care products apply to the Navigate and Compass products.
## Medicare Advantage products

This table provides information about some of the most common UnitedHealthcare Medicare Advantage products for individuals and employer group retirees. Visit: UnitedHealthcareOnline.com; AARPMedicarePlans.com, UHCMedicareSolutions.com, uhwest.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. This product does not use a contracted provider network. For information about UnitedHealthcare MedicareDirect, go to: UnitedHealthcareOnline.com → Tools & Resources → Products & Services → Medicare → Private Fee-For-Service (PFFS).

### Medicare Advantage – Products for Individuals

<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 notification when providing certain services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO and HMO-POS plans under the UnitedHealthcare or AARP brands:</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. MedicareComplete Plus HMO-POS plans provide out-of-network coverage for some covered benefits.* MedicareComplete HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.</td>
<td>A referral may or may not be required to see a specialist, depending on the plan. ** For further information, call (877) 842-3210. Please have the health care ID and your Tax ID available. Primary care physicians should coordinate care with the appropriate network specialists.</td>
<td>Yes, see guidelines in the Notification requirements section of this Guide. ***</td>
</tr>
<tr>
<td>MedicareComplete</td>
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<tr>
<td>MedicareComplete Essential</td>
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<tr>
<td>MedicareComplete Plus</td>
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</tr>
<tr>
<td>Local PPO and Regional PPO (RPPO) plans under the UnitedHealthcare or AARP brands:</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. MedicareComplete Choice PPO plans provide out-of-network coverage for all benefits also covered in-network.*</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>
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<td></td>
</tr>
<tr>
<td>MedicareComplete Choice</td>
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<td></td>
<td></td>
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<tr>
<td>Essential</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Institutional Special Needs Plans (HMO, HMO-POS, PPO)</td>
<td>Customers who are Medicare eligible and reside in a contracted institutional setting.</td>
<td>Customers choose a primary physician from the network of physicians to coordinate their care. PPO and HMO-POS plans provide out-of-network coverage.* HMO plans do not cover out-of-network services, except for emergency services, urgently needed services and out-of-area renal dialysis.</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>
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<td></td>
</tr>
</tbody>
</table>

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

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

<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 notification when providing certain services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual Special Needs Plans (HMO, PPO and Regional PPO) Plans under the UnitedHealthcare brand</td>
<td>Customers who are Medicare and Medicaid eligible.</td>
<td>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.</td>
<td>A referral may or may not be required to see a specialist, depending on the plan. For further information, (877) 842-3210. Please have the health care ID card and your Tax ID available. Primary care physicians should coordinate care with the appropriate network specialists.</td>
<td>Yes, see guidelines in the Notification requirements section of this Guide.</td>
</tr>
<tr>
<td>Erickson Advantage Plans</td>
<td>Customers who are Medicare eligible and who reside in an Erickson Retirement Community.</td>
<td>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.*</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>

**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 notification when providing certain services?</th>
</tr>
</thead>
<tbody>
<tr>
<td>UnitedHealthcare Group Medicare Advantage (HMO/MCO and HMO-POS).</td>
<td>Customers who are Medicare eligible and 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 service area** For further information, call the number on the back of the health care ID card. Please have the health care ID and your tax ID available. Primary care physicians should coordinate care with the appropriate network specialists.</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 who are Medicare eligible and 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 and National PPO).</td>
<td>Customers who are Medicare eligible and meet employer’s requirements.</td>
<td>Customers are not required to choose a primary physician from the network of physicians.</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 members enrolled in gatekeeper plans in the South Florida (Broward, Miami-Dade and Palm Beach counties) and St Louis, MO markets require referrals and/or authorizations from the primary care physician, Physician Hospital Organization, or contracted entity such as a Managed Service Organization (MSO), dependent upon contractual arrangement.

Medicare Select (AARP Health)

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

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

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

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

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

Note: Medicare Part B claims billed to a Medicare carrier are, in most cases, received electronically from the Medicare carrier. To promote timely processing on all claim submissions, follow standardized Medicare billing practices. Be sure to include the 11-digit insured AARP membership number on the standard CMS billing form.

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

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

What advantages does Medicare Select give to participating hospitals?
• Participating in Medicare Select will likely increase the hospital’s access to insured members of AARP because to get the most out of their coverage, Medicare Select Customers must go to a participating hospital. Only participating hospitals will be included in AARP Medicare Select Plan marketing materials within their service area.
• By participating in Medicare Select, the hospital will be limiting its financial exposure to non-payment of the Medicare deductible and coinsurance amounts for inpatient and outpatient hospital services. Under the AARP Medicare Select Plans C and F, neither inpatient hospital stays nor outpatient hospital services will be covered unless they are received at a participating hospital. The participating hospital agrees to a reduced reimbursement of Medicare's Part A deductible. UnitedHealthcare reimburses all other Medicare Part A eligible expenses up to the 365-day limit, which are not paid for by Medicare, as well as all Medicare Part B eligible expenses not paid for by Medicare. If a non-participating hospital provides inpatient or outpatient services to a Medicare Select insured member the services will not be covered.

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

• This product meets “Safe Harbor” requirements under Federal Anti-Kickback legislation.

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

Sample AARP Medicare Select Plan ID card

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 & Admission Notification Requirements.

• Physicians, health care professionals and ancillary providers are responsible for providing Advance Notification for services referenced in the Advance Notification List on UnitedHealthcareOnline.com → Clinician Resources → Advance & Admission Notification Requirements.

• 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 disease 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 subject to this Advance Notification protocol.

What is the difference between Advance Notification and Prior Authorization?
Certain services require Prior Authorization which will lead to a clinical coverage review. You do not need to know if a service requires Prior Authorization (PA). In these cases, when you submit Advance Notification, we will request clinical information, perform a clinical coverage review based on medical necessity, and make a coverage determination. Regardless of whether Prior Authorization is required, the list of services and the process for submitting Advance Notification is the same.

What happens after the provider gives Advance Notification?
• In certain cases, services are subject to a pre-service clinical coverage review that will result in a either a coverage approval or coverage denial.
• You do not need to determine whether a coverage review is required in a given case or for a given Customer because the process for you to initiate Advance Notification is the same.
• Once you inform us of a planned service on the Advance Notification List, we will inform you if a clinical coverage review is required. We will advise you of the required information necessary to complete the review and you will be notified of the decision.
• It is important that you and the Customer are fully aware of coverage decisions before services are rendered.
• If you provide the service before a coverage decision is rendered, and we ultimately determine that the service was not covered, we may deny the claim and you must not bill the Customer. 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 and Medicare Advantage policies, receipt of an Advance Notification or a Prior Authorization approval does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual Customer’s benefit plan, the provider being eligible for payment, any claim processing requirements, and the Provider participation agreement with UnitedHealthcare.

Who is responsible for Advance Notification?
• Physicians, health care professionals and ancillary providers are responsible for Advance Notification for those planned services on the Advance Notification List.

What services require Advance Notification?
• Advance Notification is required only for those services on the Advance Notification List. In some cases, clinical coverage review is required to determine whether the services will be covered.
• Certain services may not be covered by an individual Customer's benefit plan, regardless of whether Advance Notification is required by this Guide.

• The Advance Notification protocols outlined in this section do not apply to the following, each of which are addressed in separate sections later in this Guide:
  † The required Outpatient Radiology Notification/Prior Authorization Protocol for specified Commercial plans.
  † The required Cardiology Notification/Prior Authorization Protocol for specified Commercial plans.
  † The required Cardiology Prior Authorization Protocol for specified Medicare Advantage plans.
  † The required Part B Specialty Drug Prior Authorization Program for specified Medicare Advantage plans.

**When is Advance Notification Required?**

• Advance Notification should be submitted as far in advance of the planned service as possible to allow enough time for coverage review.

• Advance Notification is required to be submitted at least 5 business days prior to the planned service date (unless otherwise specified within the Advance Notification List).

• Prioritization of case review is based on the specifics of the case and relevant state requirements, so review may take longer than 5 business days. Notifying as early as possible is best.

• Advance Notification for home health services and durable medical equipment is required within 48 hours after the physician's order.

• If, after submitting the original Advance Notification request (and prior to a decision being rendered), the planned service date changes or the requested procedure changes, you must call us to update our records with the new planned service date or procedure to facilitate accurate claim processing.

• For services requiring urgent care, please call the telephone number on the Customer’s health care ID card (unless specified differently below). You must state that the case is clinically urgent and explain the clinical urgency. Urgent requests for benefits are those that require Advance Notification or a benefit determination prior to receiving medical care, where a delay in treatment could seriously jeopardize the Customer’s life or health, or the ability to regain maximum function, or in the opinion of a Physician with knowledge of the Customer's medical condition, could cause severe pain.

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

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

**When can I update an Advance Notification or Prior Authorization?**

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

**May I change the Advance Notification or Prior Authorization after the service has been delivered?**

• No updates can be made to an existing Advance Notification AFTER the service has been delivered. If during the service, an additional or different service was performed than was 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 must contain the following information about the planned service:

- Customer name and Customer health care ID number.
- Ordering physician, health care professional, or ancillary provider name and TIN or National Provider Identification (NPI).
- Rendering physician or health care professional name and TIN or NPI.
- ICD-9-CM (or its successor) diagnosis code for the diagnosis for which the service is requested.
- Anticipated date(s) of service.
- Type of service (primary and secondary) procedure code(s) and volume of service (when applicable).
- Service setting (outpatient, inpatient, physician office, home or other).
- Facility name and TIN or NPI where service will be performed (when applicable).
- Original start date of dialysis (End Stage Renal Disease (ESRD) only).

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

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

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

Clinical coverage review: Clinical information

- You must cooperate with all UnitedHealthcare requests for information, documents or discussions for purposes of a clinical coverage review including, but not limited to, primary and secondary diagnosis codes providing pertinent medical records, imaging studies/reports and appropriate assessments for determining degree of pain or functional impairment. Please refer to the individual services listed in the Advance Notification List for specific, additional required information.

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

- UnitedHealthcare also may use tools developed by third parties, such as the 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 from your Case Reviewer or by calling the Enterprise Voice Portal at (877) 842-3210.

- In some cases for Medicare Advantage Customers, if clinical review is not performed, use of National Coverage Determination and Local Coverage Determination Guidelines may be leveraged to perform a clinical review when the claim is received.

- You can obtain copies of the Coverage Determination Guidelines (CDG) and Medical Policies we use for Commercial products and the UnitedHealthcare Medicare Coverage Summaries Manual used for Medicare Advantage products online at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols, and Guides.
• For Medicare Advantage Customers, we use CMS coverage documents to determine coverage, and if MCG™ Care Guidelines, other guidelines, or any other Medical Policies or CDGs contradict CMS guidance, including National Coverage Determinations and Local Coverage Determinations, then UnitedHealthcare will follow CMS guidance. You may request a copy of the clinical criteria from your Case Reviewer or by calling the Enterprise Voice Portal at (877) 842-3210.

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

Multiple submission options are available to submit 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 at UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Notification/Prior Authorization Submission. We will accept daily composite census logs for inpatient admissions with complete and relevant information via fax (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.

<table>
<thead>
<tr>
<th>Method</th>
<th>EDI 278 Transactions</th>
<th>UnitedHealthcare Online .com</th>
<th>Live Call</th>
<th>VoiCert</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Notification and Prior Authorization (278A) and Admission Notification (278N)</td>
<td>Advance Notification directly to UnitedHealthcare or through a clearinghouse.</td>
<td>Portal submission directly to UnitedHealthcare through UnitedHealthcareOnline.com.</td>
<td>Phone submission through assigned 800 number specific to facility.</td>
<td>Phone submission through assigned 800 number specific to facility.</td>
<td>Commercial Customers: (866) 756-9733; Medicare Advantage Customers: (800) 676-4798; Medicare Special Needs Plan Customers: (800) 538-1339.</td>
</tr>
</tbody>
</table>

**Business Hours (all times Eastern)**

<table>
<thead>
<tr>
<th>Method</th>
<th>Description</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday – Friday: 7 a.m. to 2 a.m.</td>
<td>Generally available 24 hours per day, 7 days a week. Maintenance is scheduled outside of the following hours: Monday – Friday: 6 a.m. to 12 a.m. Saturday: 6 a.m. to 7 a.m. Sunday: 7 a.m. to 5 p.m. Holidays: Same as above</td>
<td>Monday – Friday: 7 a.m. to 8 p.m. Saturday: 9 a.m. to 6 p.m. Sunday: 9 a.m. to 6 p.m. Holidays: 9 a.m. to 6 p.m.</td>
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</tbody>
</table>

VoCert can be used 24/7, but submissions are processed the following business day: Monday – Friday: 7 a.m. to 8 p.m. Saturday: 9 a.m. to 6 p.m. Sunday: 9 a.m. to 6 p.m. Holidays: 9 a.m. to 6 p.m.

Faxes can be sent 24/7, but are processed during the following business hours: Monday – Friday: 7 a.m. to 8 p.m. Saturday: 9 a.m. to 6 p.m. Sunday: 9 a.m. to 6 p.m. Holidays: 9 a.m. to 6 p.m.
**Advance Notification List**

To view the most current and complete *Advance Notification List*, including procedure codes and associated services, go to:

UnitedHealthcareOnline.com → Clinician Resources → Advance & 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.

- Certain services require Prior Authorization which will lead to a clinical coverage review. You do not need to know if a service requires Prior Authorization (PA). In these cases, when you submit Advance Notification, we will request needed clinical information, perform a coverage review based on medical necessity, and make a coverage determination. Regardless of whether Prior Authorization is required, the list of services and the process for submitting Advance Notification is the same.

- 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.

- Upon your request, UnitedHealthcare will provide a paper copy of the Advance Notification List. Please contact your Network Management representative, Physician Advocate, or Hospital & Facility Advocate to request a paper copy of the Advance Notification List.

| Excluded Plans (benefit plans not subject to the requirements set forth in the protocol)* |
|----------------------------------|----------------------------------|
| • Benefit plans for which the Customer (rather than the physician) is required to provide Advance Notification, such as UnitedHealthcare Options PPO (for states other than Colorado,) and UnitedHealthcare Indemnity. | • UnitedHealthcare West or UHC West |
| • UnitedHealthOne - Golden Rule Insurance Company (“GRIC” only) | • Sierra |
| • All Savers products offered off-Exchange | • UnitedHealthcare Community Plan Medicare Advantage benefit plans subject to an Additional Manual (see the Benefit Plan 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. |
| • MDIPA, OCI, OCI HSA or OneNet | • Other benefit plans such as Medicaid, CHIP and Uninsured that are neither Commercial nor Medicare Advantage. |
| • NHP | |
| • Oxford Commercial | |
| • Benefit plans subject to the *River Valley Entities Supplement.* | |

* The Advance Notification Requirements will not apply to the listed benefit plans However, these benefit plans may have separate Advance Notification and 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 to this guide for the plans listed above.

Standard Notification requirements for facilities (for most states*)

Confirming Coverage Approvals:

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

- If the facility fails to confirm that the coverage approval is on file and instead performs the service before a coverage decision is rendered:
  - If the service is ultimately determined not to have been covered under the Customer’s benefit plan, then UnitedHealthcare may deny the facility’s claim for the non-covered service and, as provided under the facility’s agreement with us, the facility must not bill the Customer or accept payment from the Customer, in light of the facility’s non-compliance with UnitedHealthcare’s notification protocols.
  - If a coverage review is in process on the date of service as a result of the Advance Notification or Prior Authorization request AND that coverage review ultimately determines the service to have been a covered service under the Customer’s benefit plan, UnitedHealthcare will not deny the facility’s claim despite the facility’s failure to take specific action to confirm the coverage approval.

Admission Notification:

<table>
<thead>
<tr>
<th>Excluded Plans (benefit plans not subject to the requirements set forth in the protocol)*</th>
<th>Erickson Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Benefit plans for which the Customer (rather than the physician) is required to provide notification, such as UnitedHealthcare Options PPO and UnitedHealthcare Indemnity</td>
<td>• UnitedHealthcare Community Plan Medicare Advantage benefit plans subject to an Additional Manual (please refer to the benefit plans table) Some UnitedHealthcare Community Plan Medicare Advantage benefit plans are not subject to an Additional Manual and, therefore, are subject to this Guide including these Admission Notification requirements.</td>
</tr>
<tr>
<td>• All Savers products offered off-Exchange</td>
<td>• Other benefit plans, such as Medicaid, CHIP and Uninsured that are neither Commercial nor Medicare Advantage.</td>
</tr>
<tr>
<td>• MDIPA, OCI, OCI HSA or OneNet</td>
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<tr>
<td>• NHP</td>
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<tr>
<td>• Oxford Commercial</td>
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<tr>
<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>
</table>

* 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.

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)

* For state specific variations, please refer to UnitedHealthcareOnline.com → Tools and Resources → Policies, Protocols, and Guides → Advance and Admission Notification
• Unless otherwise indicated, Admission Notification must be received within 24 hours after actual weekday admission (or by 5:00 p.m. local time on the next business day if 24 hour notification would require notification on a weekend or federal holiday). For weekend and federal holiday admissions, notification must be received by 5:00 p.m. local time on the next business day.

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

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

• Admission Notifications must contain the following details regarding the admission:
  ‣ Customer name and Customer health care ID number
  ‣ Facility name and TIN or NPI
  ‣ Admitting/attending physician name and TIN or NPI
  ‣ Description for admitting diagnosis or ICD-9-CM (or its successor) diagnosis code
  ‣ Actual admission date

• For emergency admissions when a Customer is unstable and not capable of providing coverage information, the facility should notify UnitedHealthcare via phone or fax within 24 hours (or the next business day, for weekend or federal 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 (members receiving Part A skilled services) for UnitedHealthcare Nursing Home Plan Customers must be authorized by an Optum Care Plus 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 timely provide 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 rate for the days preceding notification.¹</td>
</tr>
<tr>
<td>Admission Notification received after it was due, and more than 72 hours after admission, 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 imposed for maternity admissions.

Concurrent Review: Clinical Information
• You must cooperate with all UnitedHealthcare requests for information, documents or discussions for purposes of concurrent review and discharge planning including, but not limited to: primary and secondary diagnosis, clinical information, treatment plan, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information via access to Electronic Medical Records (EMR).

• You must cooperate with all UnitedHealthcare requests from the inpatient care management team and/or medical director to engage our Customers directly face-to-face or telephonically.

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

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

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

1. The information submitted to UnitedHealthcare regarding the service to be delivered to the Customer was fraudulent or intentionally misrepresentative;
2. Critical information requested by UnitedHealthcare regarding the service to be delivered to the Customer was omitted such that UnitedHealthcare's determination would have been different had it known the critical information;
3. A planned course of treatment for the patient that was approved by UnitedHealthcare was not substantially followed by the provider; or
4. On the date the service was authorized or approved service issued through Advance Notification was delivered the Customer was not covered by UnitedHealthcare and the provider could have verified the Customer eligibility status by utilizing UnitedHealthcare's 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 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.

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<th>Excluded Plans (benefit plans not subject to the requirements set forth in the protocol)</th>
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<td>• UnitedHealthcare Options PPO (for states other than Colorado).</td>
</tr>
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<td>• UnitedHealthcare Indemnity</td>
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</table>

**The following benefit plans:**
- UnitedHealthOne
- All Savers products offered off-Exchange
- MDIPA, OCI, or OneNet
- NHP
- Oxford
- Benefit plans subject to the River Valley Entities Supplement (in the benefit plans section of this Guide)
- Sierra
- UnitedHealthcare West or UHC West

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<th>Other Excluded Plans</th>
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<td>The UnitedHealthcare Cardiology Notification/Prior Authorization protocol does not apply to non-Commercial benefit plans such as Medicare Advantage Medicaid, CHIP and Uninsured.</td>
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</table>
The Cardiology Notification/Prior Authorization protocol requirements apply to all participating physicians ("Providers") who perform diagnostic catheterizations, electrophysiology implant procedures, echocardiograms, and stress echocardiograms (herein referred to as “Cardiac Procedures”) on UnitedHealthcare Customers.

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, urgent care center or inpatient setting (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.

Compliance with this protocol is required.

- 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.

To see the states in which this protocol applies, or for the most current listing of CPT codes for Cardiac Procedures, please refer to UnitedHealthcareOnline.com → Clinician Resources → Cardiology → Cardiology Notification/Prior Authorization. If the protocol applies to additional states or we make any other changes to the protocol, we will communicate that information to impacted Providers.

**Process for Provider**

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

- By 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 primary diagnosis or “rule out” with the ICD-9-CM (or its successor) code(s)

**Provider information**

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

• The Customer’s clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.

• Dates of prior imaging studies performed.

• Any other information the ordering Provider believes would be useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports.

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

• 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 authorize payment. Payment for 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’s participation agreement with UnitedHealthcare.

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

Urgent requests during regular business hours

The ordering Provider may request a 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.
Urgent requests outside of regular business hours

If the ordering Provider determines that care 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, a notification number or Prior Authorization number must be requested retrospectively following the Retrospective Review Process described below. You may also call (866) 889-8054 and follow the phone prompts provided.

Retrospective Review Process

• Retrospective notification number and Prior Authorization number requests must be made within 15 calendar days for diagnostic catheterizations and electrophysiology implants, and 2 business days for echocardiograms and stress echocardiograms after the cardiac procedure is rendered.

• 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.

• The ordering Provider should follow the same process outlined above for a standard notification or Prior Authorization number request. 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. Urgent services rendered without a required Prior Authorization number will be subject to retrospective review for medical necessity, and payment may be withheld if the services are determined not to have been medically necessary.

  Note: The member cannot be balance billed for any denied charges under these circumstances.

• 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 (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 or, (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:

• Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Cardiology Notification & Authorization- Submission & Status.

• By phone: (866) 889-8054 (select prompt 2 to check status of a notification request).

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

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

- Florida: AARP MedicareComplete Plan 1, HMO and AARP MedicareComplete Plus, HMO-POS Gatekeeper benefit plans Group 26019 and Group 26020
  

- 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.

- UnitedHealthcare Community Plan Medicare Advantage benefit plans subject to an Additional Manual (as further described in the benefit plans section of this Guide). As explained 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 Cardiology Prior Authorization protocol.

- Erickson Advantage® Plans
- UnitedHealthcare® Nursing Home Plan (HMO SNP), (HMO-POS SNP), (PPO SNP)
- UnitedHealthcare® Senior Care Options (HMO SNP)
- UnitedHealthcare MedicareDirect™ (PFFS)
- UnitedHealthcare West or UHC West Capitated
- Sierra

- Senior Dimensions Medicare Advantage plans

- Additionally, this Medicare Advantage Cardiology Prior Authorization protocol does not apply to Commercial benefit plans or to other benefit plans, such as Medicaid, CHIP and Uninsured that are not Medicare Advantage.
Prior Authorization for diagnostic catheterizations, echocardiograms and stress echoes is required for outpatient and office-based services only. Prior Authorization for electrophysiology implants is required for outpatient, office-based and inpatient services. Cardiac procedures rendered in and appropriately billed with any of the following places of service do not require Prior Authorization: emergency room, urgent care center or inpatient setting (except for electrophysiology implants).

Compliance with this protocol is required.

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

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

**Process for Provider:**

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

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

**Information required for a 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 primary diagnosis or “rule out” with the ICD-9-CM (or its successor) code(s)

**Provider information**

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

**Clinical information**

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

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.

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

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

**Urgent requests during regular business hours**

The ordering Provider may request a Prior Authorization number on an “urgent” basis if the Provider determines 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. 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 described below.

**Urgent requests outside of regular business hours**

If the ordering Provider determines that care is medically required on an urgent basis and Prior Authorization cannot be requested because it is outside of UnitedHealthcare’s normal business hours, the Prior Authorization must be requested retrospectively following the Retrospective Review Process described below. You may also call (866) 889-8054 and follow the phone prompts provided.

**Retrospective Review Process**

- Retrospective Prior Authorization requests must be made within 15 calendar days for diagnostic catheterizations and electrophysiology implants, and 2 business days for echocardiograms and stress echocardiograms after the cardiac procedure is rendered.
- Documentation must include an explanation as to why the procedure was required on an urgent basis and why Prior Authorization could not be requested during UnitedHealthcare’s normal business hours.
- The ordering Provider should follow the same process outlined above for a standard Prior Authorization request. 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. Urgent services rendered without a required Prior Authorization number will be subject to retrospective review for medical necessity, and payment may be withheld if the services are determined not to have been medically necessary. Please note the member cannot be balance billed for any denied charges under these circumstances.
- 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 - and 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 participating ordering Provider obtain Prior Authorization prior to the rendering of services.

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

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

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.

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The following benefit plans:

• UnitedHealthOne
• All Savers products offered off- Exchange
• MDIPA, OneNet or OCI
• NHP
• Oxford
• Benefit plans subject to the River Valley Entities Supplement
• Sierra
• UnitedHealthcare West or UHC West
• Benefit plans sponsored or issued by certain self-funded employer groups

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

To see the states in which this protocol applies, or 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. If the protocol applies to additional states or we make any other changes to the protocol, we will communicate that information to impacted Providers.

**Ordering Provider**
- The Provider ordering the imaging service is responsible for providing notification prior to scheduling any Advanced Outpatient Imaging Procedures. The process required by this protocol for ordering Providers is as follows:
  - Provide notification by contacting us:
    - Online: UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Radiology Notification & Authorization - Submission & Status
    - By phone: (866) 889-8054 (follow the phone prompts provided)

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 primary diagnosis or “rule out” with the ICD-9-CM (or its successor) code(s)

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

**Clinical information**
- The Customer’s clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.
- Dates of prior imaging studies performed.
- Any other information the ordering Provider believes would be useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports.
- Once notification of a planned Advanced Outpatient Imaging 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. 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. A Prior Authorization number will be issued to the ordering Provider if 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.

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 notification of a planned Advanced Outpatient Imaging 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 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, then 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 coverage within an individual Customer’s benefit plan, the Provider being eligible for payment, any claim processing requirements, and the Provider’s participation agreement 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 should be requested via the phone by calling (866) 889-8054. The ordering Provider must state that the case is clinically urgent and explain the clinical urgency. We will respond to urgent requests within 3 hours of our receipt of all required information.

Urgent requests outside of regular business hours
If the ordering Provider determines that an Advanced Outpatient Imaging Procedure is medically required on an urgent basis and 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 following the Retrospective Review Process described below. You may also call (866) 889-8054 and follow the phone prompts provided.
Retrospective Review Process
If an Advanced Outpatient Imaging Procedure is required on an urgent basis and a Notification or Prior Authorization number cannot be requested because it is outside of UnitedHealthcare’s normal business hours, the Notification or Prior Authorization number must be requested retrospectively.

- Retrospective Notification number and Prior Authorization number requests must be made within 2 business days after the Advanced Outpatient Imaging Procedure is rendered.
- Documentation must include an explanation as to why the procedure was required on an urgent basis and why a Notification number or Prior Authorization number could not have been requested during UnitedHealthcare’s normal business hours.
- Once notification of an Advanced Outpatient Imaging Procedure is received on a retrospective basis, 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. 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 of an Advanced Outpatient Imaging Procedure is received on a retrospective basis, 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 ordering Provider will confirm the procedure ordered and a Notification number will be issued.
- Ordering Providers must follow the same Notification process outlined above for a standard Notification or Prior Authorization number request.

Rendering Provider
To be eligible to receive payment for covered services rendered, (a) the rendering Provider must validate with us prior to performing an Advanced Outpatient Imaging Procedure that a Notification number is on file, or (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 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:

- By 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 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, 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 additional Advanced Outpatient Imaging Procedures**

If the Customer's benefit plan does not require that services be medically necessary in order to be covered:

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

If the Customer's benefit plan requires that services be medically necessary in order to be covered:

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

**Provision of a modified Advanced Outpatient Imaging Procedure**

If the Customer's benefit plan does not require that services be medically necessary in order to be covered:

If, during the delivery of an Advanced Outpatient Imaging Procedure, the rendering Provider determines that the procedure for which a Notification number has already been obtained must be modified, the Notification number request must be modified in accordance with the process described below:

• **Modifications within the CPT Code Crosswalk Table:**

  For certain specified CPT code combinations, as set forth in the CPT Code Crosswalk Table, Providers will not be required to contact UnitedHealthcare to modify the existing Notification number request. The CPT Code Crosswalk Table is available at UnitedHealthcareOnline.com → Clinician Resources → Radiology → Radiology Notification & Prior Authorization → Resources: Reference Materials.
• **Modifications outside of the CPT Code Crosswalk Table:**

In instances where the CPT code for the procedure for which a Notification number has been obtained differs from the CPT code for the rendered procedure, and the code combination is not listed on the CPT Code Crosswalk Table, a modification to the original Notification number request must occur as follows:

› If the procedure being performed is for a contiguous body part, either the ordering or rendering Provider must modify the original Notification number request by calling (866) 889-8054 or online at UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization - Submission & Status. The request must be modified within 2 business days after the procedure is rendered.

› If the procedure being performed is not for a contiguous body part, the ordering Provider must obtain a new Notification number prior to rendering the service. A test for a different, noncontiguous body part will be considered a new request for a Notification number.

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

If, during the delivery of an Advanced Outpatient Imaging Procedure, the rendering Provider determines that the procedure for which a Prior Authorization number has already been obtained must be modified, the Prior Authorization number request must be modified in accordance with the process described below:

• **Modifications within the CPT Code Crosswalk Table:**

For certain specified CPT code combinations, as set forth in the CPT Code Crosswalk Table, Providers will not be required to contact UnitedHealthcare to modify the existing Prior Authorization number request. The CPT Code Crosswalk Table is available at UnitedHealthcareOnline.com → Clinician Resources → Radiology → Radiology Notification & Prior Authorization → Resources: Reference Materials.

• **Modifications outside of the CPT Code Crosswalk Table:**

In instances where the CPT code for the procedure for which a Prior Authorization number has already been obtained differs from the CPT code for the rendered procedure, and the code combination is not listed on the CPT Code Crosswalk Table, a modification to the original Prior Authorization number request must occur as follows:

› If the procedure being performed is for a contiguous body part, either the ordering or rendering Provider must modify the original Prior Authorization number request by calling (866) 889-8054 or online at UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization - Submission & Status. The request must be modified within 2 business days after the procedure is rendered.

› If the procedure being performed is not for a contiguous body part, the ordering Provider must request a new Prior Authorization number and a coverage decision must be issued prior to rendering the service. A test for a different, noncontiguous body part will be considered a new request for a Prior Authorization number.
Outpatient Radiology Prior Authorization Protocol for Medicare Advantage Customers

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

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

- Florida: AARP MedicareComplete Plan 1, HMO and AARP MedicareComplete Plus, HMO-POS Gatekeeper benefit plans Group 26019 and Group 26020
- 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.
- UnitedHealthcare Community Plan Medicare Advantage benefit plans subject to an Additional Manual (as further described in the benefit plans section of this Guide). As explained 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 Radiology Prior Authorization protocol.
- Erickson Advantage Plans
- UnitedHealthcare Nursing Home Plan (HMO SNP), (HMO-POS SNP), (PPO SNP)
- UnitedHealthcare Senior Care Options (HMO SNP)
- UnitedHealthcare MedicareDirect (PFFS)

The following benefit plans:
- UnitedHealthcare West or UHC West
- Sierra
- Senior Dimensions Medicare Advantage plans

Additionally, this Medicare Advantage Radiology Prior Authorization protocol does not apply to Commercial benefit plans or to other benefit plans, such as Medicaid, CHIP and Uninsured that are not Medicare Advantage.

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

Please note Prior Authorization is required for only certain of these advanced imaging procedures. The advanced imaging procedures for which Prior Authorization is required are referred to herein as “Advanced Outpatient Imaging Procedures.”

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.

Compliance with this protocol is required.

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 protocol.

Ordering Provider:

The Provider ordering the imaging service is responsible for obtaining a Prior Authorization number prior to scheduling any Advanced Outpatient Imaging Procedures. 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 (follow the phone prompts provided).

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 primary diagnosis or “rule out” with the ICD-9-CM (or its successor) code(s)

**Provider information**

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

**Clinical information**

• The Customer’s clinical condition, which may include any symptoms, treatments, dosage and duration of drugs, and dates for other therapies.
• Dates of prior imaging studies performed.

Any other information the ordering Provider believes would be useful in evaluating whether the service ordered meets current evidence-based clinical guidelines, such as prior diagnostic tests and consultation reports. 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. The 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, 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.
**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.

**Urgent requests outside of regular business hours**

If the ordering Provider determines that an Advanced Outpatient Imaging Procedure is medically required on an urgent basis, and Prior Authorization cannot be requested because it is outside of UnitedHealthcare’s normal business hours, a Prior Authorization number must be requested retrospectively following the Retrospective Review process described below. You may also call (866) 889-8054 and follow the phone prompts provided.

**Retrospective Review Process**

If an Advanced Outpatient Imaging Procedure is required on an urgent basis and a Prior Authorization number cannot be requested because it is outside of our normal business hours, Prior Authorization number must be requested retrospectively:

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

**Rendering Provider**

To be eligible to receive payment for covered services rendered, the rendering Provider must validate with us prior to performing an Advanced Outpatient Imaging Procedure that 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 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 additional Advanced Outpatient Imaging Procedures
If, during the delivery of an Advanced Outpatient Imaging Procedure, the rendering Provider determines that an additional Advanced Outpatient Imaging Procedure should be performed above and beyond the service(s) for which a Prior Authorization number has already been obtained, a new Prior Authorization number must be obtained in accordance with the protocol above prior to rendering the additional procedure.

Provision of a modified Advanced Outpatient Imaging Procedure
If, during the delivery of an Advanced Outpatient Imaging Procedure, the rendering Provider determines that the procedure for which a Prior Authorization number has already been obtained must be modified, the Prior Authorization number request must be modified in accordance with the process described below:

• Modifications within the CPT Code Crosswalk Table:
  For certain specified CPT code combinations, as set forth in the CPT Code Crosswalk Table, Provider will not be required to contact UnitedHealthcare to modify the existing Prior Authorization number request. This CPT Code Crosswalk Table is available at UnitedHealthcareOnline.com → Clinician Resources → Radiology → Medicare Advantage Radiology Prior Authorization Program → Authorization Resources: Reference Materials.

• Modifications outside of the CPT Code Crosswalk Table:
  In instances where the CPT code for the procedure for which a Prior Authorization number has been obtained differs from the CPT code for the rendered procedure, and the code combination is not listed on the CPT Code Crosswalk Table, a modification to the original Prior Authorization number request must occur as follows:

  › If the procedure being performed is for a contiguous body part, either the ordering or rendering Provider must modify the original Prior Authorization number request by calling (866) 889-8054 or online at UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Radiology Notification & Authorization-Submission & Status. The request must be modified within 2 business days after the procedure is rendered.

  › If the procedure being performed is not for a contiguous body part, the ordering Provider must obtain a new Prior Authorization number and a coverage decision must be issued prior to rendering the service. A test for a different, noncontiguous body part will be considered a new request for a Prior Authorization number.
Part B Specialty Drug Prior Authorization Program for Covered Services to Medicare Advantage Customers

The UnitedHealthcare Medicare Advantage Part B Specialty Drug Prior Authorization Program will not apply to the following benefit plans. However, these benefit plans may have separate specialty drug Notification/Prior Authorization requirements. Please refer to the applicable benefit plans table of this Guide for additional details.

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

- Florida: AARP MedicareComplete Plan 1, HMO and AARP MedicareComplete Plus, HMO-POS Gatekeeper benefit plans Group 26019 and Group 26020
- 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.
- UnitedHealthcare Community Plan Medicare Advantage benefit plans subject to an Additional Manual (as further described in the benefit plans section of this Guide). As explained 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 Part B Specialty Drug Prior Authorization Program.
- Erickson Advantage Plans
- UnitedHealthcare Nursing Home Plan (HMO SNP), (HMO-POS SNP), (PPO SNP)
- UnitedHealthcare Senior Care Options (HMO SNP)

The following benefit plans:
- UnitedHealthcare West or UHC West
- Sierra
- Senior Dimensions Medicare Advantage plans

Additionally, this Medicare Advantage Specialty Drug Prior Authorization Program does not apply to Commercial benefit plans or to other benefit plans, such as Medicaid, CHIP and Uninsured, that are not Medicare Advantage.

The Part B Specialty Drug Prior Authorization requirements in this Program apply to all participating physicians, healthcare professionals, facilities and ancillary providers (“Providers”) that order or render certain specialty drugs.

For a complete list of specialty drugs that require Prior Authorization, please visit UnitedHealthcareOnline.com → Clinical Resources → Specialty Drugs → Medicare Advantage Part B Specialty Drug Prior Authorization Program.

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

Compliance with this Program is required.

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

To see the states in which this Program applies, please refer to UnitedHealthcareOnline.com → Clinician Resources → Specialty Drugs → Medicare Advantage Part B Specialty Drug Prior Authorization Program. If additional states are added to the program, we will communicate that information to impacted Providers.

Ordering Provider:
The Provider ordering the specialty drug is responsible for obtaining a Prior Authorization number prior to any rendering of the specialty drug. A Provider may obtain the required Prior Authorization number by contacting us via:
Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Specialty Drug Prior Authorization - Submission & Status (Medicare Part B);

Phone: (866) 889-8054.

Information required for a Prior Authorization request:

Customer/procedure information
- Customer’s health care ID number
- Customer’s group number
- Customer’s name
- Customer’s date of birth
- Customer’s phone number and address (optional)

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

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

Rendering Provider information (if different)
- Rendering Provider’s last name, first name
- Rendering Provider’s address
- Rendering Provider’s phone number
- Rendering Provider’s fax number

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

Note: Receipt of an authorization for Medicare Advantage services means that the service was medically necessary. It does not guarantee or authorize payment. Payment of covered services is contingent upon the Customer being eligible for services on the date of service, the Provider being eligible for payment, any claim processing requirements, and the Provider participation agreement with UnitedHealthcare.
The length of time for which a Prior Authorization will be valid will vary by request.

- For all specialty drugs used in the palliative setting, the Prior Authorization will be valid for 90 days from the date the Prior Authorization is approved.

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

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

**Urgent requests during regular business hours**
The ordering Provider may request a Prior Authorization number on an “urgent” basis if the Provider determines it to be medically required. Urgent requests should be requested via phone by calling (866) 889-8054 and selecting the option for Medicare Advantage Customers and then selecting the option for Specialty Drug Program. The Provider must state that the case is clinically urgent and explain the clinical urgency. The Prior Authorization number will be issued for urgent requests within 3 hours after our receipt of all required information.

**Urgent requests outside of regular business hours**
If the Provider determines that care is medically required on an urgent basis and Prior Authorization cannot be requested because it is outside of UnitedHealthcare’s normal business hours, Prior Authorization must be requested retrospectively following the Retrospective Prior Authorization process described below.

**Retrospective Prior Authorization process**
If a specialty drug is required on an urgent basis or Prior Authorization cannot be requested because it is outside of our normal business hours, authorization must be requested retrospectively.

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

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

- Phone: (866) 889-8054 - select the appropriate option for Medicare Advantage Customers and then select the option for the Specialty Drug Program.

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

If the rendering Provider determines there is no Prior Authorization number on file, and the ordering Provider does not participate in UnitedHealthcare’s network and is unwilling to complete the Prior Authorization process, the rendering Provider is required to complete the Prior Authorization process. If the rendering Provider does not obtain a Prior Authorization number for a specialty drug ordered by a non-participating Provider, the rendering Provider’s claim will be administratively denied, in part or in whole, for failure to obtain Prior Authorization and the Customer cannot be billed for the service.
Note: Non-participating Providers can submit Prior Authorization requests either through UnitedHealthcareOnline.com, if they are registered, or by calling (866) 889-8054 and selecting the option for Medicare Advantage Customers, and the selecting the option for the Specialty Drug Program.

Specialty Drug Crosswalk Table
Under the CPT Code Crosswalk Table, for certain specified CPT code combinations, Providers are not required to contact the Part B Specialty Drug Prior Authorization Program to modify the existing Prior Authorization record.


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

Specialty Drug Prior Authorization for Medical Benefit (for Commercial Customers only)
The UnitedHealthcare Commercial Specialty Drug Prior Authorization Program will not apply to the following benefit plans. However, these benefit plans may have separate specialty drug Notification/Prior Authorization requirements. Please refer to the applicable benefit plans table of this Guide for additional details.

<table>
<thead>
<tr>
<th>Excluded Plans (benefit plans not subject to the requirements set forth in the protocol)*</th>
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<tbody>
<tr>
<td>• Benefit plans for which the Customer (rather than the physician) is required to provide Advance Notification, such as UnitedHealthcare Options PPO (for states other than Colorado) and UnitedHealthcare Indemnity.</td>
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<tr>
<td>• UnitedHealthOne- Golden Rule Insurance Company (“GRIC” only)</td>
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<td>• All Savers products offered off- Exchange</td>
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<tr>
<td>• MDIPA, OCI, OCI HSA or OneNet</td>
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<tr>
<td>• NHP</td>
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<td>• Oxford Commercial</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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<td>• Sierra</td>
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<tr>
<td>• UnitedHealthcare Community Plan Medicare Advantage benefit plans subject to an Additional Manual (as further described in the benefit plans section of this Guide) As explained 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.</td>
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<tr>
<td>• Other benefit plans such as Medicaid, CHIP and Uninsured that are neither Commercial nor Medicare Advantage.</td>
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* The Advance Notification Requirements below will not apply to the listed benefit plans. However, these benefit plans may have separate Advance Notification and Prior Authorization Requirements.

Please refer to the applicable Additional Manual in the benefit plans table of this Guide for additional details. Please see the supplements to this guide for the plans listed above.

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

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

- Failure to follow the Specialty Drug Prior Authorization process may result in administrative denial. Claims denied for failure to request Prior Authorization may not be billed to the Customer.
- Failure to meet clinical criteria will result in a denial for lack of medical necessity or on drug policy criteria for proven indicators in accordance with the Customer’s benefit document. Upon issuance of the denial, the Customer and Provider will receive a denial notice with the appeal process outlined.

To see the drugs in which this Program applies, please refer to UnitedHealthcareOnline.com ➔ Clinician Resources ➔ Specialty Drug ➔ Commercial Specialty Drug Prior Authorization Program
Ordering Provider:
The Provider ordering the specialty drug is responsible for obtaining a Prior Authorization number prior to any rendering of the specialty drug. A Provider may request a Prior Authorization in 1 of 3 ways:

1. Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Notification/Prior Authorizations Submission
2. Fax: Toll-free (866) 756-9733
3. Phone: Toll-free (877) 842-3210

Information required for a Prior Authorization request:

Customer/procedure information
• Customer’s health care ID number
• Customer’s group number
• Customer’s name
• Customer’s date of birth
• Customer’s phone number and address (optional)

Ordering Provider information
• Ordering Provider’s TIN
• Ordering Provider’s last name
• Ordering Provider’s phone number
• Ordering Provider’s fax number
• Contact person at the ordering Provider’s office and their contact number

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

Rendering Provider information (if different)
• Rendering Provider’s last name, first name
• Rendering Provider’s TIN
• Rendering Provider’s address
• Rendering Provider’s phone number
• Rendering Provider’s fax number

A Prior Authorization number will be issued to the ordering Provider when the Prior Authorization process is completed and a determination has been reached. The Prior Authorization will be communicated by phone and/or online, consistent with how the request was initiated. The review process may take up to 15 days to complete. The determination will be communicated in writing or by phone once the final determination has been made. If the rendering Provider is different
from the ordering Provider, to help ensure proper payment, the Prior Authorization number should be obtained and communicated by the ordering Provider to the rendering Provider scheduled to render the specialty drug.

Please note that receipt of a coverage authorization means that the service met our criteria for medical necessity and/or met coverage and drug policy criteria. It does not guarantee or authorize payment.

Payment of covered services is contingent upon the Customer being eligible for services on the date of service, the Provider being eligible for payment, any claim processing requirements, and the Provider participation agreement with UnitedHealthcare. The length of time for which a Prior Authorization will be valid will vary by request.

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

**Retrospective Prior Authorization process**

If a specialty drug is required on an urgent basis and Prior Authorization cannot be obtained because it is outside of our normal business hours an authorization must be requested retrospectively.

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

**Rendering Provider (if different)**

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

- Online: UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Notification/Prior Authorizations Submission
- Fax: Toll-free (866) 756-9733
- Phone: Toll-free (877) 842-3210

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

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

If the rendering Provider does not obtain a Prior Authorization number for a specialty drug ordered by a non-participating Provider, the rendering Provider’s claim will be administratively denied, in part or in whole, for failure to obtain Prior Authorization and the Customer cannot be billed for the service.

**Note:** Non-participating Providers can still submit Prior Authorization requests either through UnitedHealthcareOnline.com, (if they are registered), or by calling (877) 842-3210 and selecting the option for Commercial Customers.
Providing Advance Notice to Commercial Customers for Non-Participating Providers

<table>
<thead>
<tr>
<th>Excluded Plans (benefit plans not subject to the following requirements)</th>
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<tr>
<td>The following benefit plans:</td>
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<td>• Medicare Advantage</td>
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<tr>
<td>• UnitedHealthcare Community Plan Medicaid, CHIP and Uninsured</td>
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</table>

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

Therefore you must:

1. **Discuss the Option to Use Participating Providers with Customers:** In non-emergent situations, and prior to services being rendered, a participating physician or other healthcare professional must discuss with the Customer the option to use a participating provider in situations where the participating provider has decided to use the following types of non-participating providers in the Customer’s care.

   - 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 Healthcare Providers
   - Laboratory Service Providers – for specimens collected in the physician's office and sent out to a nonparticipating laboratory for processing.
   - Outpatient Dialysis Providers
   - Specialty Drug Vendors

2. **Complete the Member Advance Notice Form:** If, after a discussion with the Customer regarding his or her option to use a participating provider, the Customer elects to use a non-participating provider, the participating physician or other healthcare professional must complete the Advance Notice Form of Non Coverage (ANN) for Medicare Advantage Members, and obtain the Customer’s signature on the form. The form and instructions can be found at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols.

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

As previously noted, this protocol does not apply in emergent situations. Also, this protocol does not apply when the participating provider or Customer has obtained an in-network exception from us to use a non-participating physician, facility or other healthcare provider.
Lastly, this protocol does not apply when the participating provider involves nonparticipating provider types that are not listed above in a Customer’s care. Please note that this protocol is not intended to deter Customers from using their out-of-network benefits, if available. Customers who have out-of-network benefits can exercise their right to use those benefits at any time.

**Administrative Actions for Non-Compliance**

We will monitor the involvement of the non-participating provider types, and services outlined above in our Customer’s care and may request a copy of the completed Member Advance Notice Form at any time. Compliance with this protocol will be reviewed by UnitedHealthcare and failure to comply with the protocol, including failure to completely respond to our requests for copies of the signed Member Advance Notice Form, may result in appropriate action under your agreement with us, which may include, but is not limited to, ineligibility for performance based compensation or termination of your agreement.

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

### Laboratory services protocol

**Requirement to use participating laboratories**

This protocol applies to all participating physicians and health care professionals, and it applies to all laboratory services, clinical and anatomic, ordered by physicians and health care professionals except as indicated in the following 2 bullets:

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

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

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

In the unusual circumstance that you require a specific laboratory test for which you believe no participating laboratory is available, please contact UnitedHealthcare in advance to confirm that the specific laboratory test is covered. We will work with you to assure that those covered tests are performed, even if that means the use of a non-participating laboratory.

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

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

If we identify an ongoing and material practice of referrals to out-of-network laboratory service providers, we will inform the responsible participating physicians of the issue and remind them that physicians in the UnitedHealthcare network are generally required by contract to refer their patients to other network providers. While it is our expectation that these actions will rarely be necessary, please note that continued referrals to non-participating laboratories may, after appropriate notice, subject the referring physician to one or more of the following administrative actions for failure to comply with this protocol:
• Loss of eligibility for the Practice Rewards programs;
• A decreased fee schedule; or
• Termination of network participation, as provided in your agreement with us.

**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™**

UnitedHealthcare will implement a Laboratory Benefit Management Program for its Customers in Florida. This Program will provide physicians and laboratories with point of order support for test selection and laboratory selection. Certain Laboratory Services will be subject to additional Protocols, including but not limited to, Advance Notification and Laboratory Point of Performance Requirements. Claims for Laboratory Services will be 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 administered by Beacon LBS™.

**Protocols for UnitedHealthcare Nursing Home Plans**

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

**Definitions** – Capitalized terms used in this protocol but not otherwise defined will have the same meaning as in your agreement with us.

**UnitedHealthcare Nursing Home Plan**: A Medicare Advantage Institutional Special Needs Plan benefit plan that:
(a) exclusively enrolls special needs individuals who are institutionalized (as such term is defined in 42 CFR 422.2);
(b) is issued by UnitedHealthcare Insurance Company or by one of UnitedHealthcare’s affiliates; and (c) is offered through our UnitedHealthcare Medicare Solutions business unit, as indicated by a reference to Nursing Home Plan or Erickson Advantage in the plan name listed on the face of the valid ID card of any UnitedHealthcare Nursing Home Plan Institutional Customer eligible for and enrolled in such benefit plan.

**UnitedHealthcare Nursing Home Plan Customer**: A Medicare beneficiary who permanently resides in a Skilled Nursing Facility and is enrolled in a UnitedHealthcare Nursing Home Plan.

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

**Physician Assistant**: A health care professional licensed to practice medicine with physician supervision. Physician assistants are trained in intensive education programs accredited by the Commission on Accreditation of Allied Health Education Programs.
**Primary Care Physician (PCP):** A professional who meets all of the following criteria: (a) a Doctor of Medicine or a Doctor of Osteopathy or another health care professional as authorized under state law, Skilled Nursing Facility bylaws and the applicable benefit plan to admit or refer patients to Skilled Nursing Facility for covered services; (b) who has been selected by or assigned to a UnitedHealthcare Nursing Home Plan Customer to provide and/or coordinate the UnitedHealthcare Nursing Home Plan Customer’s covered services; (c) whose practice includes internal medicine, family or general practice; and (d) who participates in UnitedHealthcare’s network.

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

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

**UnitedHealthcare Nursing Home Plan Primary Care Physician protocols**

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

The Primary Care Physician will cooperate with and be bound by these additional protocols:

1. Attend Primary Care Physician orientation session and annual Primary Care Physician meetings thereafter.
2. Conduct face-to-face initial and ongoing assessments of the medical needs of UnitedHealthcare Nursing Home Plan Customers, including all assessments mandated by regulatory requirements.
3. Deliver health care to UnitedHealthcare Nursing Home Plan Customers at their place of residence in collaboration with the Primary Care Team.
4. Family Care Conferences - Participate in formal and informal conferences with responsible parties, family and/or legal guardian of the UnitedHealthcare Nursing Home Plan Customer to discuss the UnitedHealthcare Nursing Home Plan Customer’s condition, care needs, overall plan of care and goals of care, including advance care planning.
5. Primary Care Team collaboration and coordination - Collaborate with other members of the Primary Care Team designated by UnitedHealthcare and any other treating professionals to provide and arrange for the provision of covered services to UnitedHealthcare Nursing Home Plan Customers. This includes, but is not limited to, making joint visits with other Primary Care Team members to UnitedHealthcare Nursing Home Plan Customers and participating in formal and informal conferences with Primary Care Team members and/or other treating professionals following a scheduled UnitedHealthcare Nursing Home Plan Customer reassessment, significant change in plan of care and/or condition.
6. Collaborate with UnitedHealthcare when a change in the Primary Care Team is necessary.
7. Provide UnitedHealthcare a minimum of 45 calendar days prior notice when discontinuing delivery of covered services at any facility where UnitedHealthcare Nursing Home Plan Customers reside.
8. When admitting a UnitedHealthcare Customer to a hospital, immediately notify the PCP and UnitedHealthcare Nursing Home Plan or Payer of the admission and reasons for such admission (i.e., if the admission is for an emergency or for observation).

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

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

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

1. Attend training and orientation meetings as scheduled by UnitedHealthcare Nursing Home Plan.
2. Deliver health care to UnitedHealthcare Nursing Home Plan Customers at their place of residence in collaboration with a Primary Care Physician, including making joint visits to UnitedHealthcare Nursing Home Plan Customers in the facility on a regular basis.

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

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

5. Collaborate and communicate with UnitedHealthcare Nursing Home Plan’s designated Director of 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:
      · Schedule a meeting at the facility, if possible;
      · Obtain further history;
      · Agree on type and frequency of future contacts; and
      · Discuss advance directives.
   j. Perform clinical and quality initiative documentation as directed.

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

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

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

Acquisition for administration by physicians and other health care professionals

- This protocol applies to the acquisition, including prescription ordering, clinical coverage review, and purchase, of Botox®, Dysport®, Gel-One®, Hyalgan®, Myobloc®, Orthovisc®, Supartz®, Synagis®, Xeomin and Xolair® by physicians and other health care professionals.

- This protocol does not apply when Medicare or another health plan is the primary payer and UnitedHealthcare is the secondary payer.

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

- 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).
- 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.

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

You must acquire Botox®, Dysport®, Gel-One®, Hyalgan®, Myobloc®, Orthovisc®, Supartz®, Synagis®, Xeomin® and Xolair® from a participating specialty pharmacy provider in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare.
Requests for prescriptions of Botox®, Dysport®, Gel-One®, Hyalgan®, Myobloc®, Orthovisc®, Supartz®, Synagis®, Xeomin® and Xolair® should be submitted to the participating specialty pharmacy using the applicable enrollment request forms that are available at UnitedHealthcareOnline.com → Tools & Resources → Pharmacy Resources → Prescription Enrollment Forms, Protocols & Administrative Guides. The specialty pharmacy will dispense these drugs in compliance with the UnitedHealthcare Drug Policy and the Customer's benefit plan and eligibility, and bill us accordingly. The specialty pharmacy will bill UnitedHealthcare for the medication. Physicians will only need to bill UnitedHealthcare the appropriate code for administration of the medication and should not bill us for the medication itself. The specialty pharmacy will advise the Customer of any medication cost share responsibility and arrange for collection of any amount due prior to dispensing of the medication to the physician office.

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

**Administrative actions for non-network acquisition of Botox®, Dysport®, Gel-One®, Hyalgan®, 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®, 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**

Since July 2007, the prescribing information for Xolair has included a black box warning on the risk of anaphylaxis that has been reported to occur after as early as the first dose of Xolair but also has occurred beyond 1 year of regularly administered Xolair treatment. The labeling advises that patients should be observed closely for an appropriate period of time after Xolair administration and Xolair should only be administered in a health care setting by physicians or other health care professionals.

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

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

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

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

- This protocol applies to the provision and billing of specific specialty pharmacy medications covered under a Customer’s medical benefit.

- This protocol prohibits specialty pharmacy or home infusion providers from providing non-contracted services for a therapeutic category, even if the specialty pharmacy or home infusion provider is contracted for other medical benefit medications and services, and billing us as a non-participating or non-contracted specialty pharmacy or home infusion provider.

- This protocol does not apply when the administration of specialty medications is conducted in an office setting by a physician or other health care professional who procures and bills directly to us for the specific specialty medications.
Coverage of self-infused/injectable medications under the pharmacy benefit

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

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

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

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 3 options for checking eligibility:
   - On UnitedHealthcareOnline.com, using bar code or swipe card technology or keying in the Customer’s information.
   - Via electronic data interchange (EDI) using the Eligibility & Benefit Inquiry & Response (270/271).
   - By calling the Enterprise Voice Portal at (877) 842-3210 or the Customer Care number on the back of the Customer’s health care ID card.

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

2. When applicable, notify us in accordance with the 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) Gateway and Clearinghouse Connections** – Both participating and non-participating 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 for UnitedHealthcare, Affiliates, and Strategic Alliances can be found on UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions → Electronic Claims. UnitedHealthcare contracts generally require you to conduct business with us electronically and contain requirements regarding electronic claim submission specifically. Please review your agreement with us and abide by its requirements. While some claims may require supporting information for initial review, we have reduced the need for paper attachments for referrals/notifications, progress notes, ER visits and more. We will request additional information when needed. For more information and tips for submitting claims electronically, visit UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions → Electronic Claims. If you need additional information on EDI, contact the EDI Support Line at (800) 842-1109, Option 3 or go to UnitedHealthcareOnline.com → Contact Us → Electronic Data Interchange (EDI) Claims → EDI Issue Submission.

5. Enroll in Electronic Payments and Statements (EPS) to receive payments 5-7 days faster.

When you enroll in EPS, payments are electronically deposited into one or more bank account(s) which you designate. Explanations of Benefits (EOBs) that match each daily/weekly consolidated deposit are available on UnitedHealthcareOnline.com → Claims & Payments → Electronic Payments and Statements, where you can review, store and print hard copies to use for manual posting. Or, you can take the next step by downloading the data version of the EOB, which is the 835/Electronic Remittance Advice (ERA) free of charge from our website at UnitedHealthcareOnline.com. To receive the 835 directly from your clearinghouse, you should enroll for ERA with UnitedHealthcare via your clearinghouse. The 835 file can be programmed to automatically post payments into your system.

EPS is the preferred method for receiving payments and statements and results in faster and easier payment processing for you. If you have not yet enrolled, learn more and start receiving electronic payments and statements now by visiting UnitedHealthcareOnline.com → Quick Links → Electronic Payments & Statements or by contacting us at (866) 842-3278, Option 5. Please note that EPS is not yet available for all UnitedHealthcare plans and Affiliates. For a list of available payers, please refer to the frequently asked questions (FAQs) on UnitedHealthcareOnline.com.

**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 (CPT is a registered trademark of the American Medical Association) and HCPCS procedure codes.

**Note:** Only bundling logic and other claims processing edits are available under this option. Pricing and payment calculations for professional Commercial claims are available under the Pre-Determination of Benefits option.

Allow enough time for your claims to process and check the status online before sending second submissions or tracers. Check the status online at UnitedHealthcareOnline.com → Claims & Payments → Claim Status. If you do need to submit a second submissions or tracers, be sure to submit them electronically no sooner than 45 days after original submission.

Complete claims include the information listed below under the Complete claims and encounter data submission requirements in this section. We may require additional information for particular types of services, or based on particular circumstances or state requirements.

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

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

### Complete claims and encounter data submission requirements

- Customer’s name
- Customer’s address
- Customer’s gender
- Customer’s date of birth (dd/mm/yyyy)
- Customer’s relationship to subscriber
- Subscriber’s name (enter exactly as it appears on the Customer’s health care ID card)
- Subscriber’s ID number
- Subscriber’s employer group name
- Subscriber’s employer group number
- Rendering Physician, Health Care Professional, Ancillary Provider, or Facility Name
- Rendering Physician, Health Care Professional, Ancillary Provider, or Facility Representative’s Signature
- Address where service was rendered
- Physician, Health Care Professional, Ancillary Provider, or Facility “remit to” address
- Phone number of Physician, Health Care Professional, Ancillary Provider, or Facility performing the service (provide this information in a manner consistent with how that information is presented in your agreement with us)
- Physician, 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-9-CM diagnostic codes by specific service code to the highest level of specificity (it is essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item)
• Charge per service and total charges
• Detailed information about other insurance coverage
• Information regarding job-related, auto or accident information, if available
• Retail purchase cost (or a cumulative retail rental cost) greater than $1,000 for DME
• Current NDC (National Drug Code) 11-digit number for all claims submitted with drug codes. The NDC number must be entered in the 24D field of the CMS-1500 Form or the LIN03 segment of the HIPAA 837 Professional electronic form
• Method of Administration (Self or Assisted) for Hemophilia Claims – the method of administration must be noted and submitted with the claim form with applicable J-CODES and hemophilia factor, in order to enable accurate reimbursement. Method of administration is either noted as self or assisted

**Additional information needed for a complete UB-04 or CMS-1450 form:**
• Date and hour of admission
• Discharge date and hour of discharge
• Customer status-at-discharge code
• Type of bill code (3 digits)
• Type of admission (e.g., emergency, urgent, elective, newborn)
• Current 4-digit revenue code(s)
• Current principal diagnosis code (highest level of specificity) with the applicable Present on Admission (POA) indicator on hospital inpatient claims per CMS guidelines
• Current other diagnosis codes, if applicable (highest level of specificity), with the applicable Present on Admission (POA) indicator on hospital inpatient claims per CMS guidelines
• Current ICD-9-CM or its successor procedure codes for inpatient procedures
• Attending physician ID
• For outpatient procedures, the appropriate revenue and CPT or HCPCS codes
• For outpatient services, the specific CPT or HCPCS codes and appropriate revenue code(s) (e.g., laboratory, radiology, diagnostic or therapeutic)
• Complete box 45 for physical, occupational or speech therapy services (revenue codes 0420-0449)
• Submit claims according to any special billing instructions that may be indicated in your agreement with us
• On an inpatient hospital bill type of 11x, the admission date and time should always reflect the actual time the Customer was admitted to inpatient status
• If charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, a nominal monetary amount ($01 or $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.
ICD-10 - One-Year Delay to October 1, 2014
Current ICD-9 codes sets used to report medical diagnosis and inpatient procedures will be replaced by ICD-10 code sets effective 10/1/2014. Documents and claims for all service and hospital inpatient procedures performed on or after the compliance deadline must use ICD-10 diagnosis and inpatient procedure codes. Also note that documents and claims services for inpatient procedures provided before the compliance date must use ICD-9 codes. Learn more about ICD-10 at UnitedHealthcareOnline.com and select the HIPAA 50101 and ICD-10 quick link in the top right section of the screen where you’ll find education, tools and resources designed to support the ICD-10 transition.

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.

• Credentialing/Contracting: NPI and NUCC taxonomy indicator(s) are collected as part of credentialing, re-credentialing, 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 (NPI). Also, see definitions in the UB-04 Data Specifications Manual. Updated information for HIPAA 837P, 8371 and CMS 1500 Professional Claim Form will be available as updated on UnitedHealthcareOnline.com.

Medicare Advantage benefit plan claim processing requirements
Section 1833 of the Social Security Act prohibits payments to any Provider unless the provider has provided sufficient information to determine the “amounts due such Provider.” To that end, UnitedHealthcare applies various claims processing edits based on National and Local Coverage Determinations, the Medicare Claims Manual, National Correct Coding Initiative (NCCI), and other applicable guidance from CMS, including but not limited to the Official ICD 9-CM Guidelines for Coding and Reporting. These edits are designed to provide UnitedHealthcare with sufficient information to determine:
• The correct amount to be paid;
• Whether the Provider is authorized to perform the service;
• Whether the Provider is eligible to receive payment;
• Whether the service is covered, correctly coded, and correctly billed to be eligible for reimbursement;
• Whether the service is provided to an eligible beneficiary; and
• Whether the service was provided in accordance with CMS guidance.

Providers participating in our Medicare Advantage network must comply with all CMS guidance regarding coding, claims submission, and reimbursement rules. For example, all participating Medicare providers must report Serious Adverse Events by populating Present on Admission (POA) indicators on all acute care inpatient hospital claims and ambulatory surgery center outpatient claims, where applicable. In the instance that the “Never Event” has not been reported, we will attempt to determine if any charges filed with us meet the criteria, as outlined by the National Quality Forum (NQF) and adopted by CMS, as a Serious Reportable Adverse Event. To the extent that a provider fails to comply with these requirements, that provider’s claim will be denied and will be a provider’s liability; the provider 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 healthcare providers, including delegated/capitated claims and encounters are required to adopt the 837 Version 5010 format for dates of service on and after January 1, 2012. Incomplete submissions including blank data fields will result in rejection of the claim or encounter submission. Note that a National Provider Identification (NPI) is a required data element on all submissions. Rejections will be returned to the provider for correction and resubmission.

**Hospice – Medicare Advantage**

When a Medicare Advantage Customer elects hospice, CMS pays Medicare Certified Hospice providers for all covered services related to the Medicare Advantage Customer’s terminal illness. Claims for hospice services should be billed directly to CMS. For services covered under Medicare Part A and Medicare Part B that are not related to the Medicare Advantage Customer’s terminal issue, claims must be billed to the applicable Medicare Administrative Contractor.

UnitedHealthcare is not financially responsible for these claims; however, UnitedHealthcare may be financially responsible for any additional or optional supplemental benefits under the Medicare Advantage Customer’s benefit plan such as eyeglasses and hearing aids. Additional and optional supplemental benefits are not covered by Medicare and are not related to the Customer’s terminal condition, e.g. eyeglasses, hearing aids.

**Claim submission tips**

**Estimating treatment costs**

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

The Claim Estimator tool provides a fast and simple way to obtain your Commercial professional claim predeterminations through UnitedHealthcareOnline.com → 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.

Special note regarding UnitedHealthcare HRA enrollees: Once logged into the Patient Eligibility section of UnitedHealthcareOnline.com, the “HRA Balance” field will be displayed if the 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. A complete list of Payer IDs for UnitedHealthcare, Affiliates and Strategic Alliances can be found at UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions → Electronic Claims. Alternatively, you may submit claims to the address on the back of the Customer’s health care ID card.

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

Consumer account cards and qualified medical expenses

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

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

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

- Face lifts
- Liposuction
- Hair transplants
- Hair removal (electrolysis)
- Breast augmentation or reduction. Note: Surgery or procedures that are necessary to ameliorate a deformity arising from a congenital abnormality, and reconstructive surgery following a mastectomy for cancer, may be qualified medical expenses.
- Teeth whitening and similar cosmetic dental procedures
- Advance expenses for future medical care
- Weight loss programs (note, however, that disease-specific nutritional counseling may be covered)
- Illegal operations or procedures

An expense can be defined as a “qualified medical expense”, but might not be covered under a Customer’s benefit plan. For updated information regarding qualified medical expenses, please consult the Internal Revenue Service (IRS) website at: irs.gov or call the IRS toll-free phone number at (800) TAX-FORM; (800) 829-3676.
Pass-through billing/CLIA requirements/reimbursement policy
If you are a physician, practitioner or medical group, you must only bill for services that you or your staff perform. Pass-through billing is not permitted and may not be billed to our Customers.

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

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

Special reporting requirements for certain claim types

Reporting requirements for anesthesia services
• One of the CMS-required modifiers (AA, AD, QK, QX, QY, QZ, G8, G9 or QS) must be used for anesthesia services reporting.
• For electronic claims 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 from coverage outpatient laboratory services that were not ordered by a participating physician. Our benefit plans may also cover such services differently when a portion of the service (e.g., the draw) occurs in the physician’s office, but the analysis is performed by a laboratory provider. In addition, many state laws require that most, if not all, laboratory services are ordered by a licensed physician.

Therefore, all laboratory claims and/or encounters must include the NPI number of the referring physician, in addition to the other elements of a complete claim and/or encounters 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 section of this Guide.

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

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

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 drug and medical policies, please see UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Policies.

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

**Erythropoietin (For Commercial Customers)**

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

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

The MEA segment should be reported as follows:

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

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

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

For EPO claims submitted on a UB04 claim form, an Hct level is not required.

Additional information is available online at UnitedHealthcareOnline.com → Clinician Resources → Cancer → Oncology → Erythropoietin (EPO) Drug Policy

**Overpayments**

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

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

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

When we determine that a claim was paid incorrectly, we may make claim reconsiderations without requesting additional information from the network physician, health care professional, facility or ancillary provider. In the case of an overpayment, we will implement a claim reconsideration and request a refund at least 30 days prior to implementing a claim adjustment, or as provided by applicable law or your agreement with us. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional or correct information is needed, we will ask you to provide it.

If you disagree with the claim reconsideration, our request for an overpayment refund or a recovery made to recoup the overpayment, you can appeal the determination (see the Claim reconsideration and appeals section of this Guide).

**Subrogation and Coordination of Benefits**

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

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

2. **Coordination of Benefits (COB)** — COB is administered according to the Customer’s benefit plan and in accordance with applicable law. We accept secondary claims electronically. To learn more, go to UnitedHealthcareOnline.com → Tools & Resources → EDI Education for Electronic Transactions → Quick Tips 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 Issue Submission.

   **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; or
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/resubmit**

Submit a new CMS-1500 or UB-04 CMS-1450 (or their electronic equivalent) indicating the correction being made. When using paper, please attach the UnitedHealthcare Claim Reconsideration form located on UnitedHealthcareOnline.com → Tools & Resources → Forms. Check Box number 4 for resubmission of a corrected claim.

When correcting or submitting late charges on a CMS-1500, UB-04 CMS-1450 or 837 institutional claims resubmit all original lines and charges as well as the corrected or additional information. When correcting UB-04 CMS-1450 or 837 Institutional claims, use bill type xx7, Replacement of Prior Claim. Do not submit corrected or additional charges using bill type xx5, Late Charge Claim. Hand-corrected claim re-submissions will not be accepted.

**Claim reconsideration and appeals process and resolving disputes**

**Claim reconsideration does not apply to California Commercial, refer to Provider Dispute Resolution (PDR)**

**Step 1: Claim Reconsideration**

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

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

- **Online:** When attachments are not needed, go to UnitedHealthcareOnline.com → Claims & Payments → Claim Reconsideration. When attachments are needed, please use Optum Cloud Dashboard. More information is available at UnitedHealthcareOnline.com → Tools & Resources → Health Information Technology → Optum Cloud Dashboard.

- **Paper:** You may use the form that is found on UnitedHealthcareOnline.com → Tools & Resources → Forms → UnitedHealthcare Claim Reconsideration Request Form. The form should be mailed to the claim address on the back of the Customer’s health care ID card. In certain states such as Arizona, use of this form is not required, but is strongly encouraged. If you are submitting a form for a claim which was denied requesting medical documentation:
  1. Complete the Claim Reconsideration Request Form and check “Previously denied/closed for Additional Information” as your reason for request.
  2. Provide a description of the documentation being submitted along with all pertinent documentation. 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.

**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 Research Project.

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.
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 Explanation of Benefits (EOB) or Provider Remittance Advice (PRA). Attach all supporting materials such as Customer-specific treatment plans or clinical records to the formal appeal request, based on the reason for the request. Include information which supplements your prior adjustment submission that you wish to have included in the appeal review.

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

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

**Note:** All proof of timely filing must also include documentation that the claim is for the correct 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* section below and in your agreement with us.

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

**Medicare Advantage hospital discharge appeal rights protocol**

Medicare Advantage Customers have the statutory right to appeal their hospital discharge to a Quality Improvement Organization (QIO) for immediate review.

The QIO notifies the facility and UnitedHealthcare of an appeal.

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

- When the facility completes the DNOD, the facility will deliver the DNOD to the Medicare Advantage Customer, or his or her representative, as soon as possible but no later than 12:00 p.m. local time of the day after the QIO notification of the appeal. The facility will fax a copy of the DNOD to the QIO and UnitedHealthcare.
Resolving disputes – agreement concern or complaint

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

If your concern or complaint relates to a matter involving UnitedHealthcare administrative procedures, 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.

| AL  | Jefferson County, AL   |
| AK  | Anchorage, AK          |
| AZ  | Maricopa County, AZ    |
| AR  | Pulaski County, AR     |
| CA  | Los Angeles County, CA San Diego County, CA San Francisco County, CA |
| CO  | Arapahoe County, CO    |
| CT  | Hartford County, CT New Haven County, CT |
| DE  | Montgomery County, MD  |
| DC  | Montgomery County, MD  |
| FL  | Broward County, FL Hillsborough County, FL Orange County, FL |
| GA  | Gwinnett County, GA    |
| HI  | Honolulu County, HI    |
| ID  | Boise, ID Salt Lake County, UT |
| IL  | Cook County, IL        |
| IN  | Marion County, IN      |
| IA  | Polk County, IA        |
| KS  | Johnson County, KS     |
| KY  | Fayette County, KY     |
| LA  | Jefferson Parish, LA   |
| ME  | Cumberland County, ME  |
| MD  | Montgomery County, MD  |
| MA  | Hampden County, MA Suffolk County, MA |
| MI  | Kalamazoo County, MI Oakland County, MI |
| MN  | Hennepin County, MN    |
| MS  | Hinds County, MS       |
| MO  | St Louis County, MO Jackson County, MO |
| MT  | Yellowstone County, MT  |
| NE  | Douglas County, NE     |
| NV  | Clark County, NV Washoe County, NV Carson City County, NV |
| NH  | Merrimack County, NH Hillsboro County, NH |
| NJ  | Essex County, NJ       |
| NM  | Bernalillo County, NM  |
| NY  | New York County, NY Onondaga County, NY |
| NC  | Guilford County, NC    |
| ND  | Hennepin County, MN    |
| OH  | Butler County, OH Cuyahoga County, OH Franklin County, OH |
| OK  | Tulsa County, OK       |
| OR  | Multnomah County, OR   |
| PA  | Allegheny County, PA Philadelphia County, PA |
| RI  | Kent County, RI        |
| SC  | Richland County, SC    |
| SD  | Hennepin County, MN    |
| TN  | Davidson County, TN    |
| TX  | Dallas County, TX Harris County, TX Travis County, TX |
| UT  | Salt Lake County, UT   |
| VT  | Chittenden County, VT Washington County, VT Windham County, VT |
| VA  | Montgomery County, MD  |
| WA  | King County, WA        |
| WV  | Montgomery County, MD  |
| WI  | Milwaukee County, WI Waukesha County, WI |
| WY  | Laramie County, WY     |
Compensation

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

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

For Medicare Advantage Customers, you must follow the protocol outlined in the section below and use the Advanced Notice of Non-Coverage Form referenced. In addition, for Medicare Advantage Customers, a Notice of Denial of Medical Coverage must be provided to the Customer advising the Customer when a service is not covered. In the event we are responsible for issuing the Notice of Denial of Medical Coverage, you should make sure that the Customer has received the Notice prior to providing any requested non-covered service.

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

- We have provided general notice through an article in a newsletter or bulletin, or information provided on UnitedHealthcareOnline.com, (including clinical protocols, medical and drug policies) either that we will not cover a particular service or that a particular service will be covered only under certain circumstances not present with the Customer; or
- We have made a determination that the planned services are not covered services and have communicated that determination to you on this or a previous occasion.
- For Medicare Advantage benefit plans, CMS has published guidance, through National Coverage Determinations, Local Coverage Determinations, or other CMS guidance, indicating that the service may not be covered in certain circumstances. You are required to review the Medicare Coverage Center. You must not bill our Customer for non-covered services in cases in which you do not comply with this protocol.

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

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

**Customer financial responsibility**

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

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

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

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

For Medicare Advantage Customers, you will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Medicare Advantage Customer who is eligible for both Medicare and Medicaid, or his or her representative, or against the Medicare Advantage organization for Medicare Part A and B cost sharing (e.g., copayments, deductibles, coinsurance) when the state is responsible for paying such amounts. You will either: (a) accept payment made by or on behalf of the Medicare Advantage organization as payment in full; or (b) bill the appropriate state source for such cost sharing amount.

**Coverage Determinations and Utilization Management Decisions**

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

The coverage decisions are made based on:

- For Commercial Customers, the appropriateness of care and services and the existence of coverage as defined within the contract our Commercial Customer’s employer has with UnitedHealthcare or,
- For Medicare Advantage Customers, the definition of “reasonable and necessary” within Medicare coverage regulations and guidelines.
- The staff of UnitedHealthcare, its delegates, and the physicians making these coverage decisions are not compensated or otherwise rewarded for issuing non-coverage decisions.
- UnitedHealthcare and its delegates do not offer incentives to physicians to encourage underutilization of care or services or to encourage barriers to care and service.

Hiring, promoting or terminating practitioners or other individuals are not based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial of benefits.
Preventive Care

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

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


For more information please visit:

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


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

Hospital audit services

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

The following sections, Hospital requirements and access, Audit findings and exit conference and Post-audit procedures are specific to our Standard Hospital Bill Audit (as described in the following paragraph), in accordance with the National Hospital Billing Audit Guidelines UnitedHealthcare may conduct other audits, or make other records requests, in addition to Standard Hospital Bill Audits.

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

**Hospital requirements and access**

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

The hospital will provide one of the following:

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

**Audit findings and exit conference**

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

- The document findings will list all discrepancies noted during the course of the audit, including: item, unit cost, number charged, number documented, discrepancy, overcharge, undercharge, unbilled charge or disallowed/unbundled charge.
- During this conference, the hospital representative will have the opportunity to present any conflicting audit findings. If additionally required by 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 – Extrapolation
As part of our payment integrity responsibility to evaluate the appropriateness of paid claims, we may conduct a systematic review of paid claims. In cases where reviewing all medical records for a particular code would be burdensome on you, we may select and audit a statistically valid random sample (SVRS) of claims, or a smaller subset of the SVRS, in order to obtain an estimate of the proportion of claims that were, in fact, paid in error. The estimated proportion—referred to as the error rate—may then be projected across the relevant universe of claims to determine any overpayment, as permitted by law or regulation. You may appeal the initial overpayment findings or alternatively, if only a subset of the SVRS sample was reviewed, cooperate by supplying the full sample of medical records represented in the SVRS. Should you request a more comprehensive audit, we will select a larger sample of claims, re-estimate the error rate based on the payments made in that sample, and extrapolate our findings across the relevant universe of claims to determine the amount of overpayment, if any. Any Overpayment Disputes will be handled as outlined in this Guide and in your agreement with us.

Medicare Advantage risk adjustment data
The risk adjustment data you submit to us must be accurate and complete.

• Remember that risk adjustment is based on ICD-9-CM (or its successor) diagnosis codes, not CPT codes.

• Therefore, it is critical for your office to refer to the correct ICD-9-CM (or its successor) coding manual and code accurately, specifically and completely when submitting claims 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 UnitedHealth Group for CMS Risk Adjustment consideration are subject to federal and/or internal audit. CMS or we may select certain medical records to review to determine if the documentation and coding are complete and accurate. Please provide any medical records requested in a timely manner. It is expected that the medical record submitted for audit will be a full disclosure of all available medical documentation for the services rendered to the Customer.

Protocol for Notice of Medicare Non-Coverage (NOMNC)

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

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

The standardized form and instructions regarding the NOMC may be found on the CMS website at 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.

Any appeals of such service terminations are called “fast track” appeals and are reviewed by the QIO. You must provide requested records and documentation to us or the QIO, as requested, no later than by close of business of the day that you are notified by us or the QIO if the Customer has requested a fast track appeal.

Quality Management and Health Management Program Information

Complex Case and Disease Management programs

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

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

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

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

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

**Disease Management Programs**

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

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

Our programs include:

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

For some programs, Customers may receive:

- A comprehensive assessment by specially-trained registered nurses to help determine the appropriate level and frequency of interventions.

* Limited to eligible UnitedHealthcare River Valley and NHP Customers.
• Educational mailings, newsletters and tools such as a HealthLog to assist them in tracking their physician visits, health status and recommended targets or other screenings.

• Information on gaps in care and encouragement to discuss treatment plans, goals and results with their physician. Physicians with patients in moderate intensity programs may receive information on their patient’s care opportunities.

• Transitional case management when high risk patients are discharged from a hospital.

• Outbound calls for the highest risk individuals to address particular gaps in care. You will be notified when patients are identified for the high-risk program.

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

For UnitedHealthcare Community Plan Customers, please refer to the UHCCommunityPlan.com. For Health Care Professionals, find your state specific Provider Administrative Manual.

**Additional Care, Wellness, and Behavioral Health Programs**

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

**Case Management programs**

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

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

**Complex Medical Conditions programs**

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

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

**Decision Support programs**

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

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

**Wellness programs**

**Healthy Back:** The Healthy Back program is a consumer-based program that provides support and guidance to navigate the health care system while improving access to superior care. It includes a phone-based coaching program enhanced with online back pain management tools to maximize outcomes and control costs.
**Healthy Weight:** The Healthy Weight program is an intense weight management coaching solution focused on changing behaviors and lifestyles to achieve long lasting weight loss, reduced health risks, and an improved quality of life.

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

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

**Behavioral Health programs**

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

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

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

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

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

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

The UnitedHealth Premium® physician designation program uses clinical 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 26 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. Although the quality and cost efficiency evaluations are performed separately, 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 do not have enough data to assess quality.

New in 2014, we are introducing the UnitedHealth Premium Tier 1 symbol to identify doctors 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.

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 → 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.

**View360™ online**

Quickly discover clinical care opportunities to improve patient health. View360™ Online, where available, gives physicians and their practices a new tool to monitor and update the status of preventive screening measures for their patients who are UnitedHealthcare members.

View360 monitors month-to-month changes in physician submitted claims data to identify potential care opportunities for patients with Commercial and Medicare Advantage and Medicaid benefits who receive care from the following UnitedHealthcare-contracted primary care physicians and specialists who are medical doctors or doctors of osteopathy:

- Primary Care - General Practice
- Primary Care - Internal Medicine
- Primary Care - Family Practice
- Pediatrician
- Nephrologist
- Allergist
- Neurologist
- Cardiologist
- Pulmonologist
- Geriatrician
- Endocrinologist
- Rheumatologist
- Obstetrician/Gynecologist
- Ophthalmologist
The program shares patient care opportunities and health histories through a secure interactive website, noting Customers who may be due for recommended treatments, screenings or exams, consistent with national quality guidelines. The information is available in both summary and detailed forms, and is presented through a single or multi-physician view in a manner consistent with applicable state and federal patient privacy laws.

For example, if a law precludes disclosure of certain types of sensitive information without a Customer's consent or authorization, that information will not be disclosed through the View360 tool.

To learn more about View360 and access the web-based tools, please visit UnitedHealthcareOnline.com → Clinician Resources → View360. If you have questions, please contact us via email at View360@uhc.com, or by calling the UnitedHealthcare Health Care Measurement Resource Center at (866) 270-5588.

**Oncology/Hematology - UnitedHealthcare Cancer Registry**

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

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

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

**Why should I submit UnitedHealthcare Cancer Status Forms?**

Submitting the UnitedHealthcare Cancer Status Form allows you to contribute clinical staging information to the UnitedHealthcare Cancer Registry. This information will be used to conduct ongoing Oncology Care Analysis in the area of cancer care. Oncology Care Analysis results will be leveraged to identify national quality improvement opportunities. UnitedHealthcare previously shared the Oncology Care Analysis reports with oncologists. These reports combined the clinical data supplied by oncologists and incorporated into our Cancer Registry with UnitedHealthcare claims data. The report compared patient care data to UnitedHealthcare claims data. The report compared patient care data to recognized and widely accepted treatment guidelines for 3 conditions: breast, colorectal and lung cancer.

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

**Clinical and 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:

<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 Foundation/American Heart</td>
</tr>
<tr>
<td>Acute Myocardial Infarction without ST Elevation</td>
<td>American College of Cardiology Foundation/American Heart</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>
</tbody>
</table>
### Important behavioral health information

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

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

<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) 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-9 V79.0 or ICD – 10Z13.89 code.

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

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

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

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

United Behavioral Health has developed an online Preventive Health Program that offers up-to-date, relevant information and practice tools to support your treatment of major depressive disorder, alcohol and drug abuse and addiction and ADHD. A convenient, reliable and free source of pertinent health information, the Preventive Health Program includes:

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

Physicians and other health care professionals may access the program via UnitedHealthcareOnline.com → Tools & Resources → Products & Services → United Behavioral Health or at http://prevention.liveandworkwell.com.

**The importance of collaboration between primary physicians and behavioral health clinicians**

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

It is important to determine if a behavioral health clinician is treating a Customer with these and other illnesses. If so, it is helpful to coordinate care with the behavioral health clinician. Coordination of care takes on greater importance for Customers with severe and persistent mental health and/or substance abuse problems. This is especially true when medications are prescribed, when there are co-existing medical/psychiatric symptoms and when Customers have been hospitalized for a medical or psychiatric condition.

Communication between clinicians can also maximize the efficiency of diagnosis and treatment, while minimizing the risk of adverse medication interactions for Customers being prescribed psychotropic medication. It can also help reduce the risk of relapse for Customers with substance abuse disorders or psychiatric conditions.

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

**Psychiatric consults for medical patients**

Please contact United Behavioral Health if you would like to arrange a psychiatric consultation for a Customer in a medical bed, are unclear whether a consultation is warranted, or want assistance with any needed authorization. We can be reached by calling the phone number on the back of the Customer’s health care ID card.

**Together, improving health care quality 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.

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

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

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

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

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

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

Accreditation is required for the following procedures: CT scan, MRI, Nuclear Medicine/Cardiology, PET scan and Echocardiography, in order to avoid the potential reimbursement reductions described below. This accreditation requirement applies to global and technical service claims. The accreditation process takes approximately 6 to 9 months to complete. This Imaging Accreditation Protocol promotes compliance with nationally recognized quality and safety standards.
Upon notice from us, failure to obtain accreditation will affect your right to be reimbursed for procedures rendered using these modalities. As a result, an administrative claim reimbursement reduction for global and technical service claims, in part or in whole, will occur.

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

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

**General administrative requirements**

**Access standards**

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

<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-specific regulations.

**After-hours care**

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

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

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

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

**Arrange substitute coverage**

If you are unable to provide care and are arranging for a substitute, we ask that you arrange for care from other physicians and health care professionals who participate with UnitedHealthcare so that services may be covered under the Customer’s in-network benefit. We encourage you to go to UnitedHealthcareOnline.com to find the most current directory of our network physicians and health care professionals.
Continuity of Customer Care following termination of your participation

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

Additional Medicare Advantage requirements

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

• You may not discriminate against Customers in any way based on health status.
• You must allow Customers to directly access screening mammography and influenza vaccination services.
• You may not impose cost-sharing on Customers for the influenza vaccine or pneumococcal vaccine or certain other preventive services. For additional information, please refer to the Medicare Advantage Coverage Summary for Preventive Health Services and Procedures, available at UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → UnitedHealthcare Medicare Advantage Coverage Summaries.
• You must provide female Customers with direct access to a women’s health specialist for routine and preventive health care services.
• You must make sure that Customers have adequate access to covered health services.
• You must make sure that your hours of operation are convenient to Customers and do not discriminate against Customers and that medically necessary services are available to Customers 24 hours a day, 7 days a week.
• Primary Care Physicians must have backup for absences.
• You must provide services to Customers in a culturally competent manner, taking into account limited English proficiency or reading skills, hearing or vision impairment and diverse cultural and ethnic backgrounds.
• You must cooperate with our procedures to inform Customers of health care needs that require follow-up and provide necessary training to Customers in self-care.
• You must document in a prominent part of the Customer’s medical record whether the Customer has executed an advance directive.
• You must provide covered health services in a manner consistent with professionally recognized standards of health care.
• You must make sure that any payment and incentive arrangements with subcontractors are specified in a written agreement, that such arrangements do not encourage reductions in medically necessary services, and that any physician incentive plans comply with applicable CMS standards.
• You must cooperate with our processes to disclose to CMS all information necessary for CMS to administer and evaluate the Medicare Advantage Program, and all information determined by CMS to be necessary to assist Customers in making an informed choice about Medicare coverage.
• You must cooperate with our processes for notifying Customers of network participation agreement terminations.
• You must comply with our Medicare Advantage medical policies, quality improvement programs and medical management procedures.
• You must cooperate with us in fulfilling our responsibility to disclose to CMS quality, performance and other indicators as specified by CMS.

• You must cooperate with our procedures for handling grievances, appeals and expedited appeals.

**Medicare Compliance Expectations and Fraud, Waste and Abuse Training**

As part of an effective Compliance Program, the Centers for Medicare and Medicaid Services (CMS) requires Medicare Advantage (MA) Organizations and Part D Plan Sponsors, including UnitedHealthcare, to annually communicate specific Compliance and Fraud, Waste and Abuse (FWA) requirements to their “first tier, downstream, and related entities” (FDRs), which include contracted physicians, health care professionals, facilities and ancillary providers, as well as 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 members and sub delegates who are involved in the administration or delivery of UnitedHealthcare MA or Part D benefits or services within 90 days of hire and annually thereafter (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, governing body members and sub delegates who are involved in the administration or delivery of UnitedHealthcare MA or Part D benefits or services.

The training can come from CMS or from another source, subject to certain requirements. FDRs meeting the FWA certification requirements through enrollment in the fee-for-service Medicare program or accreditation as a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider are deemed by CMS rules to have met the training and education requirements.

It is our responsibility to make sure that your organization is provided with appropriate training. To facilitate that, we are providing 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 → Outreach and Education → MLN Products → MLN Provider Compliance, or UnitedHealthcareOnline.com → via the Fraud, Waste and Abuse and General Compliance Training Quick Link on the home page.

**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, 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, governing body members and sub delegates who are involved in the administration or delivery of UnitedHealthcare MA and Part D benefits or services to make sure that none are excluded from participating in Federal health care programs. FDRs must continue to review the federal 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

State level exclusion lists in the Frequently Asked Questions document at UnitedHealthcareOnline.com via the Fraud, Waste and Abuse and General Compliance Training Quick Link on the home page.

**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 more extensive than (though, fully compliant with) the National Committee for Quality Assurance (NCQA) and Centers for Medicare & Medicaid Services (CMS) requirements.

We are a member of the Council for Affordable Quality Healthcare (CAQH), and we use the CAQH Universal Provider DataSource (UPD) for gathering credentialing data for physicians and other health care professionals. The CAQH process is available to physicians and other health care professionals at no charge. The CAQH process results in cost efficiencies by eliminating the time required to complete redundant credentialing applications for multiple health plans, reducing the need for costly credentialing software, and minimizing paperwork by allowing physicians and other health care professionals to make updates online.

We have implemented the CAQH process as our single source credentialing application nationally, unless otherwise required in designated states. All physicians and other health care professionals applying to begin participating in our network and those scheduled for re-credentialing are instructed on the proper method for accessing the CAQH UPD.

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**

Our members 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 are also published each July for Commercial plans and each November for Medicare in the Network Bulletin found here: UnitedHealthcareOnline.com → Tools & Resources → News & Network Bulletin.
Inform Customers of advance directives
The federal Patient Self-Determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Under the federal act, physicians and providers including hospitals, skilled nursing facilities, hospices, home health agencies and others must provide written information to patients on state law about advance treatment directives, about patients’ rights to accept or refuse treatment, and about their own policies regarding advance directives. To comply with this requirement, we also inform Customers of state laws on advance directives through our Customers’ benefit material. We encourage these discussions with our Customers.

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

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

Medical record standards
A comprehensive, detailed medical record is vital to promoting high quality medical care and improving patient safety.

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 on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability or medical condition, sexual orientation, claims experience, medical history, evidence of insurability, disability, genetic information, or source of payment. You must maintain policies and procedures to demonstrate you do not discriminate in delivery of service and accept for treatment any Customers in need of the services you provide.

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

• Material changes to, cancellation or termination of, liability insurance;
• Bankruptcy or insolvency;
• Any indictment, arrest or conviction for a felony or any criminal charge related to your practice or profession;
• Any suspension, exclusion, debarment or other sanction from a state or federally funded health care program;
• Loss, suspension, restriction, condition, limitation, or qualification of your license to practice; For physicians, any loss, suspension, restriction, condition, limitation or qualification of staff privileges at any licensed hospital, nursing home, or other facility;
• Relocation or closing of your practice, and, if applicable, transfer of Customer records to another physician/facility.

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

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

Provide timely notice of demographic changes

Physician/health care professional verification outreach
UnitedHealthcare is committed to providing our Customers with the most accurate and up-to-date information about our network. We are currently undertaking an initiative to improve our data quality. This initiative is called Professional Verification Outreach (PVO).

Your office may receive a call from a member of our staff asking to verify your data that is currently on file in our provider database. Please be assured that this information is confidential and will be immediately updated in our database.

Proactive notification of changes
We ask that you notify us of changes to the following demographic information 30 calendar days prior to the effective date of the change: TIN changes, address changes, additions or departures of health care providers from your practice, and new service locations.

To change an existing TIN or to add a physician or health care provider
You must include your W-9 form to make a TIN change or to add a physician or other health care provider to your practice. To submit the change, please complete and fax the Provider demographic update fax form and the W-9 form to the appropriate fax number listed on the bottom of the fax form.

The W-9 form and the Provider demographic update fax form are available at UnitedHealthcareOnline.com → Tools & Resources → Forms.

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

To update your practice or facility information
You can make all other updates to your practice information by submitting the change directly through UnitedHealthcareOnline.com by using the Practice/Facility profile function found on the global navigation at the top of any web page. You can also submit your change by: (a) completing the Provider demographic update fax form and faxing the form to the appropriate fax number listed on the bottom of the form; or (b) calling our 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.
All Savers Supplement

Important information regarding the use of this Supplement

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

How to contact us

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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 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.

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 Claims appeals section below).

Claims appeals

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

ASIC Insureds:

Grievance Administrator
P.O. Box 31371
Salt Lake City, UT 84131-0371

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

**Health care ID card**

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.

**Sample ID Cards:**

**All Savers Insurance Company:**

![Sample ID Card Image]

**All Savers Insurance Company Alternate Funding:**

![Sample ID Card Image]

**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 for 2013 at care.diabetesjournals.org. To use the Quick Search in the Diabetes Care site, enter the article name in the Keyword(s) box: Standards of Medical Care in Diabetes 2013 and enter Year: 2013; Vol: 36; Pages: S11-S66.

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

(Leased Network Supplement) May apply to providers in AK, HI, ID, KY, ME, MI, MN, ND, SD, USVI, WI; reference your agreement for applicability

Important information regarding the use of this Supplement

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

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

Leased Supplement

Any reference in the Guide to a physician’s, health care professional, facility, or ancillary provider’s “agreement with us” refers to your participation agreement with the entity operating the leased network (your “Master Contract Holder”).

Several items that appear in the Guide are covered by your agreement with your Master Contract Holder, not the provisions stated in the Guide. Any reference to updating demographic information, submitting National Provider Identification information, credentialing or 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 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’s date of birth
• Customer’s gender
• Customer’s marital status
• Handicap status
• Death date of subscriber or dependent
• Customer benefit status
• Medicare plan code
• Medicare eligibility reason code
• Group or policy number
• 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
• Primary care physician (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 seeks services from the capitated provider.

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 6 month system window. This non-standard eligibility window will override the standard 6 month system window. The non-standard 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 October.

**15/30 Rule**

The capitation system uses a 15/30 rule to determine whether capitation is paid for the full month or not all. If the effective date of a change falls between the 1st and 15th of the month, the change is effective for the current month, and capitation is paid for that month. However, if the effective date falls on the 16th or later, the change is reflected the 1st of the following month and capitation is paid for the following month.
For purposes of 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 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 for that month, even though the Customer would be considered eligible for services.

**Retroactive Term**
A Customer retroactively terminated between the 1st and 14th 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-banking day, the capitation payment is delivered the next banking 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 banking 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.

The *Authorization Agreement Electronic Funds Transfer (EFT) Payments* form can be found at: UnitedHealthcareOnline.com → Log In → Library → Forms.

**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.hhs.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 Membership. 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.hhs.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.hhs.gov.
Premium Adjustments
UnitedHealthcare revenue is the monthly CMS payment for Customers enrolled in a Medicare Advantage Plan, less the following:

- Part B rebates, as defined below
- Payments for brokers and agent commissions/compensation, if any
- Premium taxes, if any
- Amounts paid by CMS for coverage of services that are not the financial responsibility of the medical group/IPA, including but not limited to, prescription drugs and supplemental benefits.

Any applicable items from above are subtracted from the total amount of premium received from CMS to create the premium amount used to calculate the provider’s percent of premium capitation.

Upon written request, we will provide actuarial data to the medical group/IPA as necessary to validate reductions in the calculation of our revenue under this section if the allocation of revenue is not specifically designated by CMS.

Part B Rebates
A Part B rebate is the amount of the Medicare Part B premium reduction to UnitedHealthcare Medicare Advantage Customers, plus the Social Security Administration administrative expense related to the reduction of Medicare Part B premium for these Customers.

CMS User Fee
CMS deducts a user fee from all Medicare Advantage plans to fund various education programs for persons eligible for Medicare. The user fee adjustment is reflected as a non-Customer specific adjustment by CMS in its payment to UnitedHealthcare. The user fee adjustment is allocated to every Customer.

The user fee rate can be modified by CMS on a monthly basis. However, typically the percentage is changed only 3 times per year.

Alternative Capitation Calculation Method
As specified by the contract, the calculation method may be as follows in lieu of a PM/PM calculation:

- Percent of premium – The percent of CMS premium calculation begins with the premium identified from the MMR, less any premium adjustments, and is multiplied by the contracted percentage.

Percent of CMS Premium Capitation
The percent of CMS premium calculation begins with the premium identified from the MMR:

- The CMS premium is adjusted for any premium adjustments.
- The user fee amount is then deducted to create the premium net of premium adjustments, and user fee.
- Contracted percentage amount.

Note: The CMS premium is calculated at the H Plan/PBP level. Any providers not part of the percentage of premium agreement are deducted at a member level detail. That detail can be reported back out to the contracted provider entity with the details of their payment received. Capitated Medical groups/IPAs and hospitals with a percentage of premium contract will receive their contracted percentage rate of this cap premium gross cap amount as the standard services capitation amount for each Customer.

Delegated Claims Process
UnitedHealthcare may delegate claims processing to medical groups/IPAs and hospitals (collectively referred to as “delegated entities” in this section) which have requested delegation and have shown through a pre-delegation assessment that they are capable of processing claims that are compliant with federal regulatory requirements.

Delegated entities are required to develop and maintain claims 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.

Delegated entities are also responsible for ensuring that all valid and complete claims are entered into the claims processing system.

**Claims Processing**

Contracted provider claims must be processed in accordance with the agreed upon contract rates and within federal regulatory requirements.

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 are to be paid within 30 calendar days of receipt.

**Interest Penalty Payment**

Delegated entities must also automatically pay applicable interest penalty on claims according to established federal regulatory requirements. The Centers for Medicare & Medicaid Services (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 (Medicare FFS) provider claims is as follows:

- Claims with dates of service prior to October 1, 2009 will be subject to pre-ACA timely filing rules;
- Claims with dates of service October 1, 2009 through December 31, 2009 received after December 31, 2010 will be denied as being past the timely filing deadline; and
- Claims with dates of service January 1, 2010 and later 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 delegated entity is financially responsible for providing all approved clinical and hospital services within a designated service area. 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 the financial risk of the delegated entity regardless of whether services were in or out of the delegated entity’s network of providers, unless your participation agreement states otherwise.

In most contractual arrangements, UnitedHealthcare has financial responsibility for OOA medical and hospital services provided on an urgent or emergent basis. UnitedHealthcare follows 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, UnitedHealthcare 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 legal and regulatory timeliness standards, it is important that misdirected claims are forwarded to the proper payer in accordance with 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 who the correct payor is, 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, claims processing compliance results on a monthly basis, 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
- Information systems changes or conversion
- 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 who do not achieve compliance within the established timeframes may be sanctioned until such time as they achieve compliance. Claims processing is a delegated function that is subject to revocation. Sanctions may consist of additional/enhanced auditing, on-site claims management, revocation, and/or 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 payor)
- 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 risk arrangement will determine which party is responsible for providing notification. The party that holds the 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 Notice of Denial of Payment templates to accurately document and issue a claim denial letter to a 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 their 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 organization, in this instance 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. (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, etc.).
• Well-defined internal dispute process in place, including a system for tracking disputes. Monitoring of PDR claims inventory soundly in place.
• 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, etc.).
• 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 group made an error on the original organization determination; Interest
is only applied on the additional amount paid; and interest 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 uphold PDR Determination Letter are 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.
- Notification given to the non-contracted provider of their further rights to a second level review by CMS’ provider Payment Dispute Resolution Contractor (PDRC), C2C, once the organization makes its internal decision on the initial payment dispute.
- 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.
- Process in place to identify similar claims for that contract year for the non-contracted provider who submitted a payment dispute to ensure that they are paid correctly.
- Ongoing training program in place for any component of the internal claim payment dispute process. Training to include educating all areas of the organization, including, but not limited to Customer Service, Claims, Appeals, etc.
- Internal compliance monitoring conducted on a consistent basis to ensure CMS requirements are met on non-contracted provider disputes
- 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.
- Expedited process in place to provide all materials and documentation requested by the PDRC (through the health plan). The organization must send all materials requested by the PDRC within 7 calendar days and ensure that it is received by the PDRC on or before the eighth day. The organization must respond timely to these requests to ensure that all relevant documentation is considered by the PDRC.
- Expedited process in place to effectuate PDRC underpayment decisions (made through the plan) to ensure meeting the 30 calendar day TAT required by the PDRC.
- Expedited process in place to send confirmation of effectuations to the PDRC (through the plan) to ensure meeting the 7 calendar day TAT required by the PDRC.

**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:
  
  UnitedHealthcare
  P.O. Box 6106
  Cypress, CA 90630

- Respond to UnitedHealthcare’s requests for information relevant to the Customer’s appeal or grievance within the designated timeframe.
- 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.

**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. Physician/provider and Customer complaints are important to the re-credentialing process because they help 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 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

In order for UnitedHealthcare 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.
In order for UnitedHealthcare 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.

We will continuously monitor encounter data submissions for quality and quantity. Submission levels below the desired monthly threshold of 100% 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 on a monthly basis at a minimum. As a capitated delegated entity processing claims on our behalf, it is our expectation that all encounter submissions are 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-9 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 make sure accuracy 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 501 837 and CMS-1500 and UB-04 submissions.

In order to minimize rejected claims and encounter data, physicians and health care providers need to 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 designated proxy (agent) 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 is designated as having 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 they believe 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 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 require 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. This is not the same as a modification denial, or non-authorization of a request for health care services. To facilitate timely processing of claims, the medical group/IPA referral authorization process should include claims processing guidelines for the referral provider.

**Note:** The medical group/IPA must submit authorization, if the referral is for services paid for by UnitedHealthcare (e.g., professional component for hemodialysis or chemotherapy drug administration).

**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-9-CM (or its successor) and/or CPT codes)
• Authorized services [including appropriate ICD-9-CM (or its successor) 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 preauthorization 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 Medicare Advantage Customer has direct access to an in-network physician for an annual flu vaccine. The medical group/IPA shall educate each Medicare Advantage 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/or
• 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, preauthorization, 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 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 services
once UnitedHealthcare or the delegated medical group/IPA has denied preauthorization, 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 portal 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, Medicare coverage guidelines (MCG), including National Coverage Determinations and Local Coverage Determinations are used to determine medical necessity of services requested. If other nationally-recognized criteria contradict MCG, UnitedHealthcare and delegated medical group/IPAs will follow MCG 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. Reference 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 approved prior to rendering services for a specified Customer. If a preauthorization 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 preauthorization has been approved for a particular date of service, physicians and health care providers may check on-line at UnitedHealthcareOnline.com. If the Customer is assigned to a delegated medical group/IPA, healthcare providers 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 healthcare 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 Definition

Emergency care is defined as health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and 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.

Emergency Medical Condition

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.

The Plan 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 the Plan 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 the organization, defined as the plan or its delegate, agree
to another arrangement.

• Based on contract, the delegate is financially responsible for:
  › ER and post-stabilization services in area
  › OOA services if responsible for OOA per contract

Medical Observation
UnitedHealthcare or their 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 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/IPAs contracted service area. These OOA services 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 risk (financial accountability) for OOA.

• Medical 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,
the 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/IPAs defined service area.

• The medical group/IPA shall notify UnitedHealthcare’s OOA department of all known OOA cases no later than
the 1st 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 to an in-area facility, the medical group/IPA must
work actively and collaboratively with UnitedHealthcare on the return of the Customer to an in-plan provider and
facility in a timely fashion.

• The medical group/IPA shall facilitate the return of the Customer to in-plan care 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 to an in-area facility.
    · 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 in-area 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, we do not delegate to the medical group/IPA the authority to refer or to authorize transplant services. Customers must be referred into the 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 or state law.
- 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 or state law.
- 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

Preauthorization 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 care services 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).

Preauthorization Protocol - For any service which requires a preauthorization, 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 Preauthorization Request Form. Incomplete forms will not be accepted. The Preauthorization Request Form can be found at UnitedHealthcareOnline.com.
- 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 require 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 professional 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 CMS Standard Notice of Denial of Medical Coverage (NDMC) 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 a UnitedHealthcare 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 the plan or its delegated IPA/medical group. Medicare carriers and intermediaries 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 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, 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 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 semi-annual reports as outlined in the delegation agreement.
Mid-Atlantic Regional Supplement

(May apply to providers in DE, DC, MD, PA, VA, WV; reference your agreement for applicability)

Important information regarding the use of this Supplement

This Mid-Atlantic Regional Supplement (“Supplement”) applies to services provided to Customers enrolled in Medical Doctor’s Practice Association, Inc. (“M.D. IPA”) or Optimum Choice, Inc. (“Optimum Choice”). In the event of any inconsistency between the Guide found on UnitedHealthcareOnline.com – regarding payments policies and protocols and this Mid-Atlantic Regional Supplement, the Supplement will prevail for the products described in this section.

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 Primary Care Physician (PCP) who arranges or coordinates their care, except emergency services, network OB/GYN and routine eye refraction care.</td>
<td>In-network benefits: Customers choose a PCP who arranges or coordinates their care, except emergency services, network OB/GYN and routine eye refraction care Products may also 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 Primary Care Physician 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>In-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 precertify or preauthorize some procedures or services?</td>
<td>Yes; please view section on Preauthorization and precertification process located within this Supplement. A complete list of codes requiring preauthorization can be located on UnitedHealthcareOnline.com → Tools and Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Protocols</td>
<td>Yes, please view section on Preauthorization and precertification process located within this supplement. A complete list of codes requiring preauthorization can be located on UnitedHealthcareOnline.com → Tools and Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic Protocols</td>
</tr>
</tbody>
</table>

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 members.

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>Primary Care Physician Requirement</td>
<td>The OCI HSA product requires each UnitedHealthcare Customer to choose a primary care physician.</td>
</tr>
<tr>
<td>Primary Care Physician Referrals to Network Specialists</td>
<td>The Customer’s primary care physician generates referrals for specialty care and hospital care.</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>Services for Customers enrolled in OCI 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 Member Health Care ID Card</td>
<td>The OCI HSA product name and Customer’s primary care physician 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 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. benefit name is displayed in both the upper and lower right corners of the card. Be sure to use the phone numbers and addresses noted on these health care ID cards. Please note the following unique features on these ID cards:

1. 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 authorization requirements is now listed on the back of the cards.

Sample health care ID cards for M.D. IPA and Optimum Choice benefit plans
(Please note that some Customers may have ID cards which indicate M.D. IPA Preferred or Optimum Choice Preferred benefits).

MD IPA Sample ID Card:

![MD IPA Sample ID Card]

Optimum Choice Sample ID Card:

![Optimum Choice Sample ID Card]
Laboratory Services

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

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

Please refer to UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Mid-Atlantic 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 on the Customer’s Primary Care Provider’s office location, the health care ID card will note:

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

Referrals and Authorizations

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

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

5. The referral is valid only:
   › When it is signed and dated on or prior to the service date (paper referrals).
   › When it is created and submitted on or prior to the service date (electronic referrals).

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

6. Retroactive referrals are not valid.

7. The Customer may present the referral form or the electronic referral number to the specialist at the time of the visit, or the PCP’s office can mail or fax the written paper referral.

8. Exceptions to the Referral Rules: There are exceptions to the general referral rules. Some services require precertification 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 call the number on the Customer's health care ID card for verification of Chiropractic services 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 an authorization.

   › **Fracture Care:** A referral for fracture care is global and is valid for 6 months from the date of the referral.

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

   For additional information on the Laboratory protocol, go to: UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → 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 Region Healthplan Protocols → Radiology Services.

Clinical service guidelines

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

Certain services require preauthorization or precertification. To contact us regarding preauthorization/precertification for these procedures and services call (877) 842-3210 and choose option #6 to obtain preauthorization for M.D.IPA and Optimum Choice Customers. The Clinical Services staff is available during the business hours of 8:30 a.m. to 5:30 p.m. EST.

Preauthorization and precertification requirements

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

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

A list of the most current procedure codes associated with the services defined below can be found at: UnitedHealthcareOnline.com → Tools & Resources → Protocols → Mid-Atlantic Healthplan Protocols → Preauthorization Code List.

<table>
<thead>
<tr>
<th>Procedures &amp; services</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bariatric Surgery</td>
<td>Bariatric Surgery and specific obesity-related whether scheduled as inpatient or outpatient. As a reminder, bariatric surgery and other obesity services are not covered in some benefit.</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>Many of our benefit plans only provide coverage for behavioral health services through a designated behavioral health network. Therefore, it is important for you to call the number on the Customer’s health care ID card when referring for any mental health or substance abuse/substance use services.</td>
</tr>
<tr>
<td>Bone Growth Stimulator</td>
<td>Use of either electronic stimulation or ultrasound to heal fractures.</td>
</tr>
<tr>
<td>Procedures &amp; services</td>
<td>Explanation</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>BRCA Genetic Testing Program</strong></td>
<td>BRCA 1 and BRCA 2 (Breast Cancer Susceptibility) are genetic tests performing DNA sequencing to look for known gene mutations that are associated with the development of breast and ovarian cancer. BRCA testing requires a Prior Authorization prior to performing the DNA sequencing. The ordering provider provides notice to the laboratory which would conduct the test, and the laboratory in turn provides notice to UnitedHealthcare. Genetic counseling is a service that Customers may elect to receive if they would like a board-certified genetic counselor to explain the BRCA testing, and help them make decisions about the clinical indications for such testing. Once we receive Prior Authorization for BRCA testing from the lab, Customers will receive a letter outlining the available genetic counseling service and how to access that service. As a reminder, genetic testing and/or genetic counseling services are not covered in some benefit plans. For services listed in this section, fax to (866) 255-0959.</td>
</tr>
<tr>
<td><strong>Breast Reconstruction (Non Mastectomy)</strong></td>
<td>Reconstruction of the breast other than following mastectomy.</td>
</tr>
<tr>
<td><strong>Cardiology Services</strong></td>
<td>Cardiac Angioplasty and Coronary Artery Bypass Graft requires preauthorization. UnitedHealthcare’s Radiology and Cardiology Notification Programs do NOT apply to M.D. IPA or Optimum Choice Customers. Please follow the precertification and preauthorization requirements listed above.</td>
</tr>
<tr>
<td><strong>Capsule Endoscopy</strong></td>
<td>Non-invasive procedure in which an ingested capsule containing a miniature video camera takes a video recording of the mucosal lining of the esophagus or small bowel as it moves through the gastrointestinal tract.</td>
</tr>
<tr>
<td><strong>Chiropractic Services</strong></td>
<td>Manipulative treatment, also known as mobilization therapy or “adjustment,” refers to manual therapy employed to soft or osseous tissues for therapeutic purposes. Some benefit plans provide coverage for chiropractic services while others do not. Therefore, it is important for you to call the number on the Customer’s health care ID card for any chiropractic services.</td>
</tr>
<tr>
<td><strong>Clinical Trial</strong></td>
<td>A rigorously controlled study of a new drug or a new medical device or other treatment on eligible human subjects, subject to oversight by an external Institutional Review Board (IRB) of the facility performing the clinical trial.</td>
</tr>
<tr>
<td><strong>Cochlear Implants and Other Auditory Implants</strong></td>
<td>A medical device (including a portion that is surgically implanted) within the inner ear and an external portion, to help persons with profound sensor neural deafness to achieve conversational speech.</td>
</tr>
<tr>
<td><strong>Congenital Heart Disease</strong></td>
<td>Congenital Heart Disease-related services: For questions related services listed in this section, call the number on the back of the health care ID card. ICD-9-CM (or its successor): 745.0 through 747.81 CPT: 33251, 33254, 33255, 33256, 33257, 33258, 33259, 33261, 33404, 33414, 33415, 33416, 33417, 33476, 33478, 33500, 33501, 33502, 33503, 33504, 33505, 33506, 33507, 33600, 33602, 33606, 33608, 33610, 33611, 33612, 33615, 33617, 33619, 33641, 33645, 33647, 33660, 33665, 33667, 33675, 33676, 33677, 33681, 33684, 33688, 33690, 33692, 33694, 33697, 33702, 33710, 33720, 33722, 33724, 33726, 33730, 33732, 33735, 33736, 33737, 33750, 33755, 33756, 33762, 33764, 33766, 33767, 33768, 33770, 33771, 33774, 33775, 33776, 33777, 33778, 33779, 33780, 33781, 33786, 33788, 33802, 33803, 33820, 33822, 33840, 33845, 33851, 33852, 33853, 33917, 33920, 33924, 93501, 93524, 93526, 93527, 93528, 93529, 93530, 93531, 93532, 93533, 93541, 93542, 93543, 93544, 93545, 93555, 93556, 93561, 93562, 93580, 93581.</td>
</tr>
<tr>
<td><strong>Cosmetic &amp; Reconstructive</strong></td>
<td>Cosmetic procedures that change or improve physical appearance, without significantly improving or restoring physiological function. Reconstructive procedures that either treat a medical condition or improve or restore physiologic function. We require Prior Authorization for such services whether scheduled as inpatient or outpatient.</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment (DME) – greater than $1,000</strong></td>
<td>DME with a retail purchase cost or a cumulative rental cost over $1,000. Prosthetics are not DME (see separate Prosthetics and Orthotics notification requirement in this grid). Some Home Health Care services may qualify under the DME requirement but is not subject to the $1000 retail purchase or cumulative retail rental cost threshold (see separate Home Health Care Services requirement in this grid).</td>
</tr>
<tr>
<td>Procedures &amp; services</td>
<td>Explanation</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>End Stage Renal Disease/ Dialysis Services</td>
<td>Services for the treatment of End Stage Renal Disease (ESRD), including outpatient dialysis services (as defined by, but not limited to, the revenue and CPT codes below), require Prior Authorization. CPT: 90935, 90937 – hemodialysis 90945, 90947 – peritoneal 90999 – unlisted dialysis procedure, inpatient or outpatient Revenue Codes: 304 – Non routine Dialysis 800 – 804, 809 – Renal Dialysis 820 – 821, 829 – Hemo/op or home 830 – 831, 839 – Other outpatient/peritoneal dialysis 840 – 841, 849 – Capd/op or home 850 – 851, 859 – Ccpd/op or home 880 – 882, 889 – Dialysis/misc HCPCS codes: S9335, S9339 For the most current listing of UnitedHealthcare contracted dialysis facilities, please refer to UnitedHealthcareOnline.com or call us at (877) 842-3210 and select option 6 for precertification for OCI and M.D. IPA. In an effort to maximize Customer benefit coverage, we ask that you refer to UnitedHealthcare contracted dialysis facilities whenever possible. Note that your agreement with us may include restrictions on referring Customers outside the UnitedHealthcare network.</td>
</tr>
<tr>
<td>Home Health Care – Nutritional &amp; Private Duty Nursing</td>
<td>The following services based in the home required Prior Authorization or Advance Notification: Enteral Formula/Pumps Skilled Nursing in the home Private Duty Nursing</td>
</tr>
<tr>
<td>Hyperbaric Oxygen Treatment (Outpatient)</td>
<td>Non-emergent hyperbaric oxygen treatments.</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>Surgical removal of the uterus (inpatient or outpatient).</td>
</tr>
<tr>
<td>Intensity Modulated Radiation Therapy (IMRT)</td>
<td>Fax the completed UnitedHealthcare IMRT Data Collection form and all supporting information to (866) 255-0959. The UnitedHealthcare IMRT Data collection form can be found at: UnitedHealthcareOnline.com</td>
</tr>
<tr>
<td>Infertility</td>
<td>Diagnostic and treatment services related to inability to achieve pregnancy.</td>
</tr>
<tr>
<td>Injectable Medication</td>
<td>Excludes chemo therapy drugs. Refer to the Injectable medications link in this Supplement for a list of drugs requiring preauthorization.</td>
</tr>
<tr>
<td>Inpatient Admissions</td>
<td>All inpatient admissions require Prior Authorization.</td>
</tr>
<tr>
<td>Joint Replacement</td>
<td>Outpatient and inpatient joint replacement procedures in addition to total hip and knee.</td>
</tr>
<tr>
<td>MR-guided Focused Ultrasound (MRgFUS) to treat Uterine Fibroid</td>
<td>MR-guided focused ultrasound procedures and treatments, as defined by but not limited to: MR-guided focused ultrasound is a covered service for certain benefit plans, subject to the terms and conditions of those benefit plans, which generally are as follows: The physician and/or facility must confirm coverage of the service for the Customer The hospital and/or facility must be contracted with UnitedHealthcare Customers have no out-of-network benefits for MRgFUS. The Customer must consent in writing to the procedure acknowledging that UnitedHealthcare does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective. The Customer must agree in writing to hold UnitedHealthcare harmless if he or she is dissatisfied with the results of treatment. The consent form can be found at: UnitedHealthcareOnline.com → Tools &amp; Resources → Policies, Protocols and Guides → Medical &amp; Drug Policies and coverage Determination Guidelines. The physician and facility must have demonstrated experience and expertise in MRgFUS, as determined by UnitedHealthcare. The physician and facility must follow US Food and Drug Administration (FDA) labeled indications for use.</td>
</tr>
<tr>
<td>Muscle Flap Procedure</td>
<td>A muscle or portion of muscle that can be transferred with its blood supply to another part of the body for reconstructive purposes.</td>
</tr>
<tr>
<td>Procedures &amp; services</td>
<td>Explanation</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Non-Emergency Transport – Air, Land, Other</td>
<td>Non-urgent ambulance transportation (by air, land, other) between specified locations.</td>
</tr>
<tr>
<td>Orthognathic Surgery</td>
<td>Treatment of maxillofacial (jaw) functional impairment.</td>
</tr>
<tr>
<td>Orthotics - greater than $1,000</td>
<td>Orthotics with a retail purchase cost or a cumulative rental cost over $1000. Some of our Customers have benefit plans which may have different requirements. Please refer to the benefit documentation for the list of covered services.</td>
</tr>
<tr>
<td>Out-of-Network Services</td>
<td>A referral from a network physician, or health care provider to a hospital, physician, or other health care provider who is not contracted with UnitedHealthcare. Please note that your agreement with UnitedHealthcare may include restrictions on directing Customers outside the health plan service area. Your patients who use non-network physicians, health care professionals, or facilities may have increased out-of-pocket expenses or no coverage. Prior Authorization is required when a network physician or health care professional directs a Customer to a facility, physician, or other health care professional who does not participate in the UnitedHealthcare network, where a Customer’s benefit plan has benefits for out-of-network services.</td>
</tr>
<tr>
<td>Physical Therapy/ Occupational Therapy (PT/OT)</td>
<td>Required when services are performed at an outpatient clinic. Since the Customer’s benefit plan may require a pre-service coverage review, please call number on the Customer’s health care ID card to fulfill the advance notification requirement. Physical Therapy and Occupational Therapy requires authorization after the 8th visit. If performed at a hospital outpatient facility, authorization is required from the 1st visit.</td>
</tr>
<tr>
<td>Potentially Unproven Services</td>
<td>Services, including medications, that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.</td>
</tr>
<tr>
<td>Prosthetics - greater than $1,000</td>
<td>Prosthetics with a retail purchase cost or a cumulative rental cost over $1000.</td>
</tr>
<tr>
<td>Proton Beam Therapy</td>
<td>Focused radiation therapy that uses beams of protons (tiny particles with a positive charge).</td>
</tr>
<tr>
<td>Radiology Services</td>
<td>Includes the following services: CT - Brain, Chest, Musculoskeletal, Colonography, MRI - Brain, Heart, Chest, Musculoskeletal, PET Scans (non-cancer diagnoses). Virtual procedures. UnitedHealthcare’s Radiology and Cardiology Notification Programs do NOT apply to M.D. IPA or Optimum Choice Customers. Please follow the precertification and preauthorization requirements listed above.</td>
</tr>
<tr>
<td>Septoplasty/ Rhinoplasty</td>
<td>Treatment of nasal functional impairment and septal deviation.</td>
</tr>
<tr>
<td>Sleep Apnea Procedures &amp; Surgeries</td>
<td>Maxillomandibular Advancement or Oral-Pharyngeal Tissue Reduction for Treatment of Obstructive Sleep Apnea. Applies to inpatient or outpatient, including but not limited to: Palatopharyngoplasty - oral pharyngeal reconstructive surgery includes laser-assisted uvulopalatoplasty (laup).</td>
</tr>
<tr>
<td>Sleep Studies</td>
<td>Sleep laboratory-assisted and related studies, including polysomnography, to diagnosis sleep apnea and other sleep disorders. Excludes sleep studies performed in the home.</td>
</tr>
<tr>
<td>Specific Medications as Indicated on the Prescription Drug List (PDL)</td>
<td>Call (800) 711-4555 when prescribing medications that require Prior Authorization. These medications are so designated on the PDL. To view the Prescription Drug List PDL, visit UnitedHealthcareOnline.com → Tools &amp; Resources → Pharmacy Resources.</td>
</tr>
<tr>
<td>Speech Therapy Services</td>
<td>Required when services are performed at an outpatient clinic. Since the Customer’s benefit plan may require a pre-service coverage review, please call number on the Customer’s health care ID card to fulfill the Advance Notification requirement. Speech Therapy requires authorization after 8th visit. If performed at a hospital outpatient facility, authorization is required from the 1st visit.</td>
</tr>
<tr>
<td>Spinal Stimulator for Pain Management</td>
<td>Spinal cord stimulators when implanted for pain management.</td>
</tr>
<tr>
<td>Spinal Surgery</td>
<td>Inpatient and outpatient spinal surgeries.</td>
</tr>
<tr>
<td>Procedures &amp; services</td>
<td>Explanation</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Transplant of tissue</td>
<td>Organ or tissue transplant or transplant related services prior to pre-treatment or evaluation.</td>
</tr>
<tr>
<td>or organs</td>
<td></td>
</tr>
<tr>
<td>Vagus Nerve Stimulation</td>
<td>Implantation of a device that sends electrical impulses into one of the cranial nerves.</td>
</tr>
<tr>
<td>Vein Procedures</td>
<td>Removal and ablation of the main trunks and named branches of the saphenous veins in the treatment of venous disease and varicose veins of the extremities.</td>
</tr>
<tr>
<td>Ventricular Assist Devices</td>
<td>A mechanical pump that takes over the function of the damaged ventricle of the heart and restores normal blood flow.</td>
</tr>
</tbody>
</table>

**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 nonparticipating physician, health care practitioner or facility.

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

**Inpatient Admission Notification**

Preauthorization/precertification is required for all elective inpatient admissions for all M.D. IPA and Optimum Choice members; it is the admitting physician's responsibility to obtain the relevant preauthorization or precertification. However, the facility should verify that preauthorization has been obtained prior to the Admission. Payment may be denied to the facility and attending physician for services rendered in the absence of preauthorization. Please remember preauthorization or precertification does not guarantee coverage or payment. All final decisions concerning coverage and payment are based upon Customer eligibility, benefits and applicable state law.

It is the responsibility of the facility to notify UnitedHealthcare within 24 hours after actual weekday admission (or by 5:00 p.m. local time on the next business day if 24 hour notification would require notification on a weekend or federal holiday). For weekend and federal holiday admissions, notification must be received by 5:00 p.m. local time on the next business day.

For emergency admissions when a Customer is unstable and not capable of providing coverage information, the facility, should notify UnitedHealthcare as soon as the information is known and communicate the extenuating circumstances.

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

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

- The information submitted to UnitedHealthcare regarding the service to be delivered to the Customer was fraudulent or intentionally misrepresentative;
- 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;
- A planned course of treatment for the patient that was approved by UnitedHealthcare was not substantially followed by the provider; or
On the date the preauthorized or approved service issued through preauthorization was delivered the Customer was not covered by UnitedHealthcare and the provider could have verified the Customer's eligibility status by utilizing UnitedHealthcare's 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 prior authorization is obtained and admission notification is not made by the facility in a timely manner, payment reductions will be limited to hospital room and board charges when applicable.

**Provide Admission Notification to Health Services via phone at (800) 962-2174 or via fax at (800) 352-0049.**

All participating facilities are required to notify the applicable health plan of an admission of a Customer within 24 hours or the next business day following a weekend or federal holiday, whichever comes first. The health plan will initiate a case review upon receipt of your notification. If notification is not provided in a timely manner, the health plan may still review the case and request additional medical information. If you fail to notify in a timely manner, the health plan may retroactively deny 1 or more days based upon its case review. In the event a Customer receiving outpatient services needs an inpatient admission, the facility must notify the health plan as noted above. Emergency room services that culminate in a covered admission will be payable as part of the inpatient stay provided the facility has notified the health plan of the admission as noted above.

**Delay in service**

Facilities that provide inpatient services must maintain appropriate staff resources and equipment to make sure that covered services are provided to Customers in a timely manner. A Delay in Service is defined as any delay in medical decision-making, test, procedure, transfer, or discharge that is not caused by the clinical condition of the Customer. Services should be scheduled the same day as the physician's order. However, procedures in the operating room, or another department requiring coordination with another physician, such as anesthesia, may be performed the next day, unless emergent treatment was required. A delay may result in sanction of the facility by the health plan and non-reimbursement for the delay day(s), if permissible under state law.

A Clinical Delay in Service will be assessed for any of the following reasons:

- A failure to execute a physician order in a timely manner that will result in a longer length of stay.
- Equipment needed to execute a physician's order is not available.
- Staff needed to execute a physician's order is not available.
- A facility resource needed to execute a physician's order is not available.
- Facility does not discharge the patient on the day the physician's discharge order is written.

**Concurrent review**

Review is conducted on-site at the facility or telephonically for each day of the stay using nationally-accepted criteria. You must cooperate with all requests for information, documents or discussions from the health plan for purposes of concurrent review including, but not limited to, clinical information on patient status and discharge planning. When criteria are not met, the case is referred to a medical director for determination. The health plan will deny payment for hospital days that do not have a documented need for acute care services. The health plan requires that physicians' progress notes be charted for each day of the stay. Failure to document will result in denial of payment to the hospital and the physician.

**Hospital post-discharge review**

When a Customer has been discharged before notification to the health plan can occur or before information is available for certification of all the days, a post-discharge review will be conducted. A health plan representative will request the Customer's records from the Medical Records Department or via a telephonic review and review each non-certified day for appropriateness and acuity.
Inpatient Days that do not meet acuity criteria will be referred to a medical director for determination and may be retrospectively denied. Delays in service or days that do not meet criteria for level of care may be denied for payment.

**Hospital-to-hospital transfers**

The hospital must notify the health plan of a request for hospital-to-hospital transfer. In general, transfers are approved when there is a service available at the receiving hospital that is not available at the sending hospital; the Customer would receive a medically appropriate change in the level of care at the receiving facility; or the receiving facility is in-network and has appropriate services for the Customer.

If any of the conditions above are not met, coverage for the transfer will be denied. Services at the receiving hospital will be approved if:

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

**Injectable medications**

**Drugs that require both preauthorization and the use of a specific vendor:** This protocol applies to the acquisition, including prescription ordering and purchase of these specialty medications by physicians and other healthcare professionals. You must acquire these specialty medications from a participating specialty pharmacy provider in our specialty pharmacy network, except as otherwise authorized by UnitedHealthcare. The specialty pharmacy will bill UnitedHealthcare for the medication. Physicians will only need to bill UnitedHealthcare for the appropriate code for administration of the medication and should not bill us for the medication itself. The specialty pharmacy will advise the Customer of any medication cost share responsibility and arrange for the collection of any amount prior to dispensing of the medication to the physician office. For a listing of specialty pharmacy provider(s), please refer to UnitedHealthcareOnline.com → Tools and Resources → Pharmacy Resources → Prescription Enrollment Forms, Protocols & Administrative Guides.

**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. For additional policies and information, call (800) 355-8530.

For a listing of specialty pharmacy codes, please refer to UnitedHealthcareOnline.com → Tools & Resources → Protocols → Mid-Atlantic Healthplan Protocols and Preauthorization → Preauthorization Code List.

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

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

**Claims process**

Please refer to the *Prompt claims processing* section in the main section of this Guide for detailed information about our claims process. Claims for specialist services that require referrals must be submitted on paper accompanied by a copy of the referral unless the referral was done electronically through UnitedHealthcareOnline.com. 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 Number 87726. For claim reconsiderations for M.D. IPA and Optimum Choice, please send your request for reconsideration to the address on the back of the Customer’s health care ID card or follow the instructions on the Provider Remittance Advice (PRA) or on the correspondence received from UnitedHealthcare. Instructions are also available on the UnitedHealthcareOnline.com → Claims & Payments → Claim Reconsideration.

**Appeals and reconsideration processes**

**Clinical appeals**
To appeal an adverse decision (a decision by us not to preauthorize or precertify a service or procedure or a denial of payment because the service was not medically necessary or appropriate), you must submit a formal letter outlining the issues and submit supporting documentation. The denial letter will provide you with the filing deadlines and the address to use to submit the appeal. In the event a Customer designates a healthcare professional to appeal the decision on the Customer’s behalf a copy of the Customer’s written consent is required and must be submitted with the appeal.

**Claim Denial Reconsideration Request Process**

**UnitedHealthcare Requests Additional Information:** At times we need additional information to complete the processing of your claim. You will receive written notice of the information requested. The information you send will help expedite to finalize your claim. The letter will provide you with the filing deadlines and the address to submit the additional paper information. A copy of the letter should be returned along with the requested documentation.

**Ways to Send a Reconsideration Form:** At times you may identify additional information or communication that we need to be advised about on a previously submitted claim. Claim reconsideration request forms are located at UnitedHealthcareOnline.com → Claims & Payments → Claim Reconsideration → Claim Reconsideration Request Form.

There are 4 methods of communication for reconsiderations to best serve your needs.

- **Optum Cloud Dashboard**– This application allows the provider to submit claim reconsideration electronically with supporting documentation. This cloud-based website has new features and functionality for physicians and health care professionals. To access the Optum Cloud Dashboard go to UnitedHealthcareOnline.com → Help → Optum Cloud Dashboard.

- **UnitedHealthcareOnline Portal** – This functionality on UnitedHealthcareOnline.com allows physicians and health care professionals to submit an electronic reconsideration. UnitedHealthcareOnline.com → Claims & Payments → Claim Reconsideration → Claim.

- **Paper** – All paper reconsideration forms should be sent with supporting documents to the address listed on the on the back of the Customer's health care ID card. When using a cover letter the subject line should state “Reconsideration”.

- **Customer Call Center** – The customer call center is available for your convenience. Utilize the phone number on the back of the Customer’s health care ID card as the numbers vary by the members plan.

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

**Primary care physician (PCP)**
The PCP is the primary provider of medical services for Customers. This includes preventive care and chronic care. The PCP is responsible for coordinating all care that Customers may need through the Network Specialists. This includes Referrals to consultant Specialists, Home Health Care, and testing facilities such as Radiology and Laboratory Centers. PCPs are reimbursed for medical services through capitation or fee-for-service payments. Primary Care Physicians are required to submit encounter data for services covered under capitation.

When a Customer enrolls in a M.D. IPA or Optimum Choice benefit plan, he or she is asked to select a PCP. The collective group of Customers who have chosen a specific PCP is referred to as the PCP Panel. UnitedHealthcare of the Mid-Atlantic region may close any PCP panel if any Customer complains about access, or if UnitedHealthcare of the Mid-Atlantic region identifies a quality related issue.
Note: For all requests relating to panel status (i.e., Open/Closed to New/Existing Patients), the physician is required to contact their Network Account Representative 30 days prior to any action. To locate your Network Account Representative, please go to at 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.

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

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 either looking at the assigned physician on the health care identification card, by calling professional services at (877) 842-3210 or by visiting UnitedHealthcareOnline.com → Patient Eligibility & Benefits. If a Customer has selected another physician that is not a part of the physician’s practice as the member’s PCP the physician should request the Customer contact the Customer Service number on the Customer’s health care identification 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 fifth day of the month. The PMPM is calculated by multiplying the fixed monthly rates (detailed in the Capitation Rate Schedule contained in your agreement) times the number of Customers who have selected or been assigned to a PCP within the practice.

Payment Rules:

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

**Bill above**
In addition to the capitation payments, certain covered services are eligible for reimbursement. To obtain a copy of this information, please contact your Network Account Representative. To locate your Network Account Representative, please go to UnitedHealthcareOnline.com → Contact Us and reference the Network Contacts section under Related Links.
### Important information regarding the use of this Supplement

This Neighborhood Health Partnership ("NHP") Supplement applies to services provided to Customers enrolled in NHP benefit plans. In the event of any inconsistency between the Guide and this NHP Supplement, the NHP Supplement and all protocols and payment policies found on myNHP.com will prevail for NHP Customers.

### 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><strong>Appeals</strong></td>
<td>Attn: Appeals Dept. P.O. Box 5210 Kingston, NY 12402-5210</td>
<td>• Reconsiderations and appeals</td>
</tr>
<tr>
<td><strong>Claims</strong></td>
<td>Electronic Payer ID 95123 or 96107 P.O. Box 5210 Kingston, NY 12402-5210</td>
<td>• Submit claims and claims attachments</td>
</tr>
<tr>
<td><strong>Customer Care</strong></td>
<td>Phone: (877) 972-8845 For the hearing impaired, please call the National Relay Center number (800) 828-1120. Customer Service hours: 8 a.m.-6 p.m. ET Automated Referral Line (IVR System) Phone: (877) 972-8845</td>
<td>• Check Customer eligibility information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Verify benefits</td>
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<tr>
<td></td>
<td></td>
<td>• Check claim(s) status</td>
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<td></td>
<td></td>
<td>• Request Referrals to Specialist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Obtain status of Referrals</td>
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<tr>
<td></td>
<td></td>
<td>• Verify eligibility &amp; benefits</td>
</tr>
<tr>
<td><strong>Electronic Data Interchange (EDI) Support</strong></td>
<td>Phone: (866) 509-1593</td>
<td>• Obtain information on submitting claims electronically</td>
</tr>
<tr>
<td><strong>Home Health Care, Durable Medical Equipment and Home Infusion Services</strong></td>
<td>Univita Phone: (866) 374-4326 Fax: (800) 831-4264 or (800) 722-4148</td>
<td>• Obtain Precertification for services</td>
</tr>
<tr>
<td><strong>Mental Health Services</strong></td>
<td>United Behavioral Health (UBH) Phone: (800) 817-4705</td>
<td>• Obtain information and Precertification for mental health services</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>OptumRx Prior Authorization Phone: (800) 711-4555 OptumRx Phone: (888) 739-5820 Fax: (800) 837-0959</td>
<td>• Obtain information about pharmacy services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Call for medications requiring prior authorization (PA)</td>
</tr>
<tr>
<td><strong>Physical, Occupational and Speech Therapy</strong></td>
<td>OptumHealth Phone: (800) 873-4575 Fax: (248) 733-6070</td>
<td>• Obtain Precertification for physical therapy (PT)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Occupational therapy (OT)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Speech therapy (ST)</td>
</tr>
<tr>
<td><strong>Podiatry - Foot and Ankle Network (FAN)</strong></td>
<td>Phone: (305) 558-0444 Fax: (305) 557-3810</td>
<td>• Obtain information about podiatry services</td>
</tr>
<tr>
<td><strong>Quality Managed Healthcare, Inc.</strong></td>
<td>Phone: (954) 236-3143 Fax: (954) 236-3254</td>
<td>• Obtain information about chiropractic services</td>
</tr>
<tr>
<td><strong>Radiology/Cardiology CareCore National</strong></td>
<td>Phone: (866) 242-9546</td>
<td>• Precertification of radiology/cardiology services</td>
</tr>
<tr>
<td><strong>Substance Abuse Services</strong></td>
<td>United Behavioral Health (UBH) Phone: (800) 817-4705</td>
<td>• Obtain information and Precertification for substance abuse services</td>
</tr>
<tr>
<td><strong>Transplant Services</strong></td>
<td>OptumHealth Phone: (888) 936-7246 Fax: (855) 250-8157</td>
<td>• Precertification of transplant services</td>
</tr>
<tr>
<td><strong>Utilization Management (UM)</strong></td>
<td>Phone: (800) 550-5568 Precertifications: Fax (800) 731-2515 or (800) 729-1574 Obstetrical: Fax (800) 731-7954 Hospital Admissions: Fax (800) 731-2430</td>
<td>• Request Precertifications</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Obtain status of Precertifications</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 Customer’s NHP ID card will indicate what type of plan the Customer has and all applicable copayments. Below is a sample of the NHP health care ID card.

Sample ID card

Definitions

Emergency medical condition – Acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the health of the individual. With respect to a pregnant patient who is having contractions, an emergency exists when there is inadequate time to affect safe transfer to another hospital prior to delivery or may pose a threat to the health and safety of the patient or unborn child.

Emergency services – Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable laws, by other appropriate personnel under the supervision of a physician, to determine whether an Emergency Medical Condition exists.

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 – Provider of health care goods and services including, without limitation, physicians, hospitals, skilled nursing facilities, home health agencies, and ancillary service providers, who has contracted with NHP.

Precertification/Post-Certification – Certain professional services must be certified in order for such services to be paid.

Primary Care Physician (PCP) – Physician, duly credentialed in accordance with the policies and procedures of NHP, who has agreed to provide Primary Care Services to Customers in accordance with the terms of an agreement with NHP. Primary Care Services include without limitation, health promotion and maintenance, treatment of illness and injury, early detection of disease and Referrals to Participating Providers when appropriate.

Referral – PCP is responsible for determining when a Customer should be sent for Specialty Care. The PCP must comply with NHP’s Referral policies, procedures, and protocols as described in this Supplement. Except in the case of Emergency Services or when otherwise Precertified by NHP, PCPs shall refer Customers only to Participating Providers for covered services.

Specialist – Participating Provider duly credentialed in accordance with the policies and procedures of NHP and with the terms of an agreement with NHP.

Urgent – Waiting the routine time period for a standard Referral could seriously jeopardize the life or health of the Customer or the ability of the Customer to regain maximum function; or, in the opinion of a physician with knowledge of the Customer’s medical condition, would subject the Customer to severe pain that cannot be adequately managed without the care or treatment.
Eligibility and Referrals

Verify eligibility and Referrals of all NHP Customers before rendering any services, in the following ways:

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

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

Through myNHP.com you may:

• Verify Customer’s Primary Care Physician
• Obtain key Customer and claims statistics
• Verify Customer eligibility
• Submit a Referral (only PCPs can submit Referrals through myNHP.com)
• Check Referral/Precertification status
• View claims status

Support

NHP’s website was designed to be easy to use with helpful tips and prompts. If you need further assistance, you can email us your questions or concerns by using the Contact Us link on the portal or call Customer Care at (877) 972-8845.

Site login and password

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

IVR system & Referrals

To check Customer eligibility through our IVR System, call (877) 972-8845. You may call NHP’s automated Customer Care 24 hours a day, 7 days a week. You will need the Customer’s 7-digit ID number to obtain the following Customer information:

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

IVR system automated Referral instructions

The NHP IVR System will simplify the process for routine Specialist Referrals for the PCP office staff. The IVR System is used to enter routine Referrals to Participating Specialists. Only a PCP can refer a Customer to a Specialist. A Specialist cannot refer to another Specialist.

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

The NHP IVR System uses the 12-digit PCP and Specialist numbers which are printed in the IVR listing found in the myNHP.com website, and the Customer’s 7-digit ID number printed on the ID card. PCPs will require a password and can only refer to Specialists.
A Referral letter will be generated and mailed to the Specialist and Customer within 24 hours after entry of the Referral. Referrals processed through the NHP IVR System are not guarantees of eligibility, benefit limitations, or coverage at the time of service. The authorization shall in no way limit or otherwise restrict the physician’s ultimate responsibility for patient care and the provision of medical services.

**To enter or verify a Referral, call (877) 972-8845**

- The system will prompt you to the automated system. Press the correct prompt and follow directions.
- Changes to the Referral can only be made at the specific prompt; once you go to another Referral or exit the system, the Referral can no longer be deleted or changed.

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

**Specialties for which a Referral cannot be processed through the IVR system:**

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

In addition, there are services that require Precertification or Referral and cannot be processed through the IVR System. Please refer to the *Precertification process* and *Precertification list* section of this Supplement for a complete list.

**Participating Provider responsibilities**

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

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>PCP</th>
<th>Specialist Physician</th>
<th>Hospital or Ancillary Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing coverage by a Participating NHP provider, 24 hours a day, 7 days a week.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Providing or arranging for covered services to plan Customers.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Accepting assigned Customers without discrimination or any screening of such Customers based on health status.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing appropriate preventive measures including, but not limited to, routine physical examinations, immunizations, hypertension screening and PAP smears.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing Customers care and/or treatment without discrimination or any screening based on health status.</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Arranging for appropriate Referrals to Participating Specialists for services not normally provided within the PCP’s (your) scope of training and credentials.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Providing covered services to plan Customers only upon receiving the appropriate Referral from an NHP PCP or health plan UM Department.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Informing the PCP of the Customer’s care which include any testing, hospitalizations, or other care that is ordered or arranged to ensure continuity of care. For Specialist, this includes consulting with the Customer’s PCP with respect to the Customer’s care treatment and communicating the results of the consultation to the PCP having responsibility for the ongoing care of a particular Customer, and providing a written report to the PCP within 7 days of the examination of the Customer.</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Obtaining any required Referrals and Precertifications.</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Retaining active and unrestricted admitting privileges at one or more participating hospitals.</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Responsibility

Except in the case of Emergency Services, providing covered services to Customers only upon receiving the appropriate Referral or Precertification from a PCP or NHP, as may be required.

Maintaining medical records relating to plan Customers in such a form as required by NHP guidelines and accepted medical practice.

Providing medical records as needed for compliance with state and federal laws and regulation and protect patient confidentiality.

Participating and cooperating with reasonable reviews and continuing education programs as requested by NHP.

Adhering to all applicable state and federal statutes, regulations and CMS guidelines and requirements.

Cooperating with NHP’s UM, Quality Management, policies and procedures and Customer Grievance policies, procedures and protocols.

Collecting applicable copayment, coinsurance, and deductibles only, and accepting NHP’s reimbursement as a payment in full.

Not requiring a Customer to pay a “membership fee” or other fee in order to access your services; not refusing any Customer based on failure to pay such fee.

Not billing the Customer for services other than non-covered services and coinsurance, deductibles and copayments including missed appointments.

Communicating freely with Customers regarding the treatment options available to them, including medication treatment options and regardless of benefit coverage limitations.

Submitting encounter/claims data for capitated or global services.

Arranging for appropriate Referrals to Participating hospitals and physicians so that all services are provided by Participating Providers within the network.

Precertification process

Precertification Decision Timeframes:

To efficiently and appropriately process requests for procedures that require Precertification, NHP’s UM team encourages our providers to submit information at the time service is requested. Please be sure to provide all the necessary information with your request. NHP UM can process Precertification requests within the guidelines below, if complete information is provided.

If a request is received with insufficient information to make a determination, NHP UM will contact the provider to submit the necessary information. If this requested information is not received by the decision due date, a decision will be made with the information that was made available to NHP UM. Notification of the outcome will be sent to the Customer, PCP, and requesting provider.

Refer to the Precertification list below for a complete list of services requiring Precertification. For urgent requests, please call Medical Management (800) 550-5568.

<table>
<thead>
<tr>
<th>Authorization Type</th>
<th>Definitions</th>
<th>Examples</th>
<th>UM decision time frame with complete information</th>
</tr>
</thead>
</table>
| Pre-service non-urgent | Any prior request for service that is of non-urgent nature. | • Elective surgery  
• Sleep Study  
• Diagnostic tests (CT Scan, MRI, MRA)  
• CareCore National (866) 242-9546 | 15 calendar days of receipt of request. |
| Pre-service urgent | Any prior request for service. | • A request for suture removal follow up ER visit. | 72 hours of receipt of request. |
| Concurrent urgent | Any urgent request for an extension of a previously approved ongoing course of treatment over a period. | • Request for Authorization of a Customer admitted on an emergency basis. | 24 hours of receipt of request. |
| Post service | A request for authorization on a previously rendered service. | • Emergent hospital admission to non participating facility. | 30 calendar days of receipt of request. |
Precertification Requirements:

• All NHP Customers require Precertification for the services listed on the Precertification list.

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

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

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

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

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

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

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

Precertification list

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

| DME, Home health and Home Infusion services: | Univita: (866) 374-4326 |
| Podiatry Services: | (For all Florida counties excluding: Highlands, Orange, Seminole, Osceola, Flagler, Lake and Volusia) Foot and Ankle Network (FAN): (305) 558-0444 |
| Substance abuse and mental health treatment: | United Behavioral Health (UBH) at (800) 817-4705 |
| Transplant: | OptumHealth: (866) 300-7736 |
| Outpatient Therapy PT/OT/ST: | OptumHealth: (800) 873-4575 |
| Radiology/Cardiology/Nuclear Imaging Services: | CareCore National: (866) 242-9546 or www.carecorenational.com |

Precertification list of services

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

• Inpatient: hospital (including observation), psychiatric, rehab, and SNF.

• Surgery and invasive procedures: performed in an outpatient hospital or ambulatory facility (with the exception of Colonoscopies for members 50 years of age and older; and sigmoidoscopies).

• Diagnostic catheterization procedures including, for example, coronary arteriogram, left heart catheterizations and combined left-right heart catheterizations. For all places of service other than emergency rooms, urgent care centers and inpatient hospital. (CareCore National (866) 242-9546).
• Electrophysiology Implants, including for example, pacemaker and automated implantable cardio-defibrillators. For all places of service, even if the inpatient admission has been authorized. CareCore National (866) 242-9546.

• Outpatient Stress Echocardiogram and Outpatient Echocardiogram except for emergency rooms and urgent care centers. CareCore National (866) 242-9546.

• Sleep Study

• MRI, MRA, CT Scans, CTA scans, PET scans: CareCore National (866) 242-9546 or www.carecorenational.com.

• Lung volume reduction surgery procedures, even if the inpatient admission has been authorized.

• 30 Day Event Monitor

• Nuclear Medicine Imaging, including without limitation: CareCore National (866) 242-9546 or www.carecorenational.com.
  › Pulmonary perfusion/ventilation
  › Venous imaging
  › Nuclear bone scans
  › Bone marrow imaging
  › Thyroid imaging
  › Liver/Spleen imaging
  › Brain imaging

• Nuclear stress tests, including without limitation thallium, technetium, Cardiolite, Myoview, sestamibi; and myocardial perfusion and ejection fraction, and wall motion studies. Nuclear stress tests encompass nonpharmacological (exercise) and pharmacological stress tests, including without limitation, adenosine, persantine and dobutamine: CareCore National: (866) 242-9546 or www.carecorenational.com.

• DME: Univita (866) 374-4326

• Insulin Pumps and supplies

• Prosthetic and orthotic devices

• Home healthcare: Univita (866) 374-4326

• Outpatient therapy: physical, occupational, speech: OptumHealth (800) 873-4575

• Outpatient: Cardiac and Pulmonary rehab

• Hyperbaric oxygen treatment

• Wound care

• Mental health/substance abuse: UBH (800) 817-4705

• Dialysis

• Oncology Services

• Chemotherapy (chemotherapeutic agents regardless of indication), radiation therapy, transfusions, infusions

• Chronic Specialist care

• Pain management

• Hospice

• Total OB Care, including one screening OB ultrasound for fetal anatomy performed between 13-24 weeks of gestation. All ultrasounds performed for specific clinical indications require a separate authorization and are reviewed for medical necessity.
• Biophysical profiles and amniocentesis
• Drugs: Refer to Drug Prior Authorization (PA) section of this Supplement
• Laboratory services
• Any services not provided by LabCorp, Inc., and not listed in the Clinical Laboratory Services section
• Dermatology:

<table>
<thead>
<tr>
<th>CPT</th>
<th>Procedure</th>
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</thead>
<tbody>
<tr>
<td>77401 – 77416</td>
<td>Grenz X-ray therapy</td>
</tr>
<tr>
<td>14000 – 14350</td>
<td>Adjacent Tissue Transfer</td>
</tr>
<tr>
<td>15000 – 15401</td>
<td>Free skin grafts</td>
</tr>
<tr>
<td>15570 – 15738</td>
<td>Flaps</td>
</tr>
<tr>
<td>15740 – 15776</td>
<td>Other flaps and grafts</td>
</tr>
<tr>
<td>15780 – 15879</td>
<td>Other procedures</td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

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.

Specialty Referral process
The PCP is responsible for determining when he or she should refer the Customer for “specialty care”. Initial Referrals can only be initiated by the PCP. All Referrals must be made to Participating Providers. Referrals to a Specialist may be necessary:
• When a Customer fails to respond to current medical treatment,

• To confirm or establish a Customer’s diagnosis and/or treatment modality,

• To provide diagnostic studies, treatments or procedures that range beyond the scope of the PCP. PCPs may make Referrals to Specialist according to the 3 levels below.

Referrals should be requested through the NHP website at myNHP.com or the IVR system for automated Referrals by calling (877) 972-8845. Certain specialty Referrals are not available through the website or the IVR, and are listed in the Specialties for which a Referral cannot be processed through the IVR system section.

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.

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 Precertification 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 and diagnostic tests and any treatment that will be performed by the Specialist and billed by the Specialist on the same day as the consultation. Specialized diagnostics and treatments that are identified on the Precertification 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 Precertification list are not covered as part of this Referral.

**Specialty Referral Guidelines:**

• Once the specialty services have been properly authorized, the Customer may schedule an appointment with the Specialist. The PCP’s office staff may also schedule the specialty appointment depending on the particular health care needs of the Customer.

• Faxed or mailed Referrals will be date-stamped by NHP and processed in the order received and/or severity of the request as defined below. Urgent Referrals (See Definitions section of this Supplement for Urgent) will be handled on a priority basis. Such cases should be handled through the NHP website, IVR or Medical Management. (See the Precertification list.)

• Should there be a question/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 retention in the Customer’s medical record.

• Specialist claims will not be paid without a Referral being on file. It is imperative that all Referrals are submitted in a timely fashion.

• The Specialist should re-verify the Customer’s eligibility at the time of visit. This may be done by calling Customer Care at (877) 972-8845.

• **IMPORTANT:** Reimbursement for services that have not been authorized 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.
Referral form:
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 to ensure prompt review. 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.

Services that do not require a Referral:
- Chiropractic (subject to benefit limitations)
- Dermatology (5 visits per calendar year)
- Gynecology
- Podiatry (subject to the Precertification list requirement)
- Alcohol/chemical dependency treatment, (subject to the Precertification list requirement)
- Mental health (Subject to the Precertification list requirement)

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

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 Precertification form (treatment plan) to NHP UM.
- The PCP may submit the Precertification form which is available on myNHP.com. The treatment plan must include the following information:
  - Date of request
  - PCP name
  - Customer name and health care ID number
  - Customer date of birth
  - Specialist name, phone number, and specialty
  - Pertinent medical information substantiating the need for additional visits
  - Number of additional visits requested and the time frame for the visits
- The Precertification form may be faxed to NHP UM: (800) 731-2515 or (800) 729-1574.
- Upon receipt of the Precertification form, UM will review for medical necessity and appropriateness of care. A letter will be sent to the PCP, Specialist, and Customer with the outcome of the decision. This letter should be filed in the Customer’s medical record.
- If the Precertification form treatment plan is authorized, it will be valid for a specific number of visits and/or treatments. Once the specific number of visits or authorized time frame have been reached, whichever comes first, a new Precertification form treatment plan must be submitted for additional visits to be authorized. This is necessary to make sure proper claims payment.
- The Specialist should re-verify the Customer’s eligibility at each visit to make sure that the Customer is still eligible under the health plan.

Out-of-network specialty Referrals
Out-of-Network specialty Referrals are only approved when the services required are not available within the network to ensure continuity of care (as determined by the health plan). All Out-of-Network specialty Referrals must be Precertified.

If services are requested as Urgent, as defined in Definitions in this Supplement, it will be processed within 24 hours upon receipt of request.
Out-of-network Referrals may be requested by calling NHP. All providers must contact NHP UM for authorization at (800) 550-5568. Upon receipt of the Referral by NHP UM, the data will be reviewed and, if approved, entered into the system to ensure payment of the Specialist claims.

Should there be a question/concern regarding the Referral (i.e., eligibility, coverage, or medical necessity), the NHP UM staff will notify the PCP's office staff. The PCP will be verbally notified of the authorization and a letter will be mailed to the Customer and the Specialist for retention in the Customer's records. The PCP’s office must receive approval before sending the Customer to the Specialist.

**Obstetrical Referrals:**

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

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

**Hospital admissions:**

All admissions must be to participating hospitals, unless an out-of-network admission has been approved by the plan or it is an emergency.

All inpatient admissions require Precertification by NHP UM. All observations and emergency admissions require post-certification within 1 business day; including admissions after outpatient surgery or observation care. Only a PCP or a NHP designated hospitalist may serve as the admitting physician for inpatient services, unless NHP has provided prior written authorization for a particular Specialist or category of Specialist to serve as the admitting physician for the Customer.

1. Participating Providers must be used for all services required during the hospital stay unless Precertified by NHP UM.
2. Notify NHP UM for hospital Precertification review. Phone: (800) 550-5568 Fax: (800) 731-2515 or (800) 729-2430.
3. NHP approved criteria are used for all hospital reviews. All questionable cases are referred to the medical director for review. Please refer to the criteria grid under UM Decisions.
4. Upon completion of the medical review, either a certification or a denial letter will be sent to the PCP, Specialist (if applicable), Customer, and the hospital.
5. Concurrent review will be conducted through the hospital stay by NHP Clinical Health Services. The attending physician may be contacted during the review process for additional information as necessary.
6. Discharge planning will be coordinated through the Inpatient Care Manager (ICM) in cooperation with the physician and the hospital discharge planning staff.
7. If the treating physician would like to discuss a case with a physician advisor, please call NHP Utilization Review.
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 before sending the specimen to LabCorp, Inc., the provider will be reimbursed a blood draw fee.

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

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

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

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

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

NHP laboratory procedure list I

May be performed by any NHP Participating Provider, regardless of the specialty:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81000</td>
<td>Urinalysis, non-automated, with microscopy, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity urobilinogen, any number of these constituents, with microscopy non-automated</td>
</tr>
<tr>
<td>81001</td>
<td>Urinalysis, automated, with microscopy</td>
</tr>
<tr>
<td>81002</td>
<td>Urinalysis, non-automated, without microscopy</td>
</tr>
<tr>
<td>81003</td>
<td>Urinalysis, automated, without microscopy</td>
</tr>
<tr>
<td>81005</td>
<td>Urinalysis, qualitative or semiquantitive, except immunoassays</td>
</tr>
<tr>
<td>81007</td>
<td>Urinalysis, bacteriuria screen, by non-culture technique, commercial kit (specify type)</td>
</tr>
<tr>
<td>81015</td>
<td>Urinalysis, microscopic only</td>
</tr>
<tr>
<td>81025</td>
<td>Urine pregnancy test</td>
</tr>
<tr>
<td>82270</td>
<td>Blood, occult; feces, 1-3 simultaneous determinations</td>
</tr>
<tr>
<td>82947</td>
<td>Glucose quantitative, blood (except reagent strip)</td>
</tr>
<tr>
<td>82948</td>
<td>Glucose blood, reagent strip</td>
</tr>
<tr>
<td>82962</td>
<td>Glucose blood, one-touch monitor</td>
</tr>
<tr>
<td>84703</td>
<td>Gonadotropin, chorionic (hCG); qualitative</td>
</tr>
<tr>
<td>85008</td>
<td>Manual blood smear examination without differential parameters</td>
</tr>
<tr>
<td>85009</td>
<td>Differential WBC count, buffy coat</td>
</tr>
<tr>
<td>85013</td>
<td>Spun microhematocrit</td>
</tr>
<tr>
<td>85014</td>
<td>Blood count, other than spun hematocrit</td>
</tr>
<tr>
<td>85018</td>
<td>Blood count, hemoglobin</td>
</tr>
<tr>
<td>85025</td>
<td>Hemogram and platelet count, automated, and automated complete differential WBC count (CBS)</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>85610</td>
<td>Prothrombin time</td>
</tr>
<tr>
<td>85730</td>
<td>Thromboplastin time, partial (PTT) plasma or whole blood</td>
</tr>
<tr>
<td>86308</td>
<td>Heterophile antibodies; screening</td>
</tr>
<tr>
<td>86317</td>
<td>Immunoassay for infectious agent antibody, quantitative, not elsewhere specified</td>
</tr>
<tr>
<td>86403</td>
<td>Particle agglutination, antibody (rapid strep screen)</td>
</tr>
<tr>
<td>86580</td>
<td>Skin test, tuberculosis, intradermal</td>
</tr>
<tr>
<td>86585</td>
<td>Tuberculosis, tine test</td>
</tr>
<tr>
<td>87070</td>
<td>Culture, bacterial, definitive (throat or nose)</td>
</tr>
<tr>
<td>87081</td>
<td>Culture, bacterial, screening only, for single organisms</td>
</tr>
<tr>
<td>87084</td>
<td>Culture, presumptive, pathogenic organism, screening only by commercial kit, with colony est from density chart</td>
</tr>
<tr>
<td>87086</td>
<td>Culture, bacteria, urine, quantitative, colony count</td>
</tr>
<tr>
<td>87088</td>
<td>Culture, bacterial, urine, commercial kit</td>
</tr>
<tr>
<td>87177</td>
<td>Smear, primary source, with interpretation, wet and dry mount, for ova and parasites</td>
</tr>
<tr>
<td>87184</td>
<td>Sensitivity study, antibiotic, disk method, per plate (12 or fewer disks)</td>
</tr>
<tr>
<td>87205</td>
<td>Smear, primary source, with interpretation, routine stain for bacteria, fungi, or cell types</td>
</tr>
<tr>
<td>87210</td>
<td>Smear, primary source, with interpretation, wet mount with simple stain, for bacterial, fungi, ova and/or parasites</td>
</tr>
<tr>
<td>87430</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semi quantitative, multiple step method; Streptococcus, group A</td>
</tr>
<tr>
<td>89055</td>
<td>Leukocyte Cout, Fecal</td>
</tr>
<tr>
<td>87880</td>
<td>Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group A</td>
</tr>
<tr>
<td>87804</td>
<td>Infectious agent antigen detection by immunoassay with direct optical observation; Influenza</td>
</tr>
<tr>
<td>89230</td>
<td>Sweat collection by iontophoresis</td>
</tr>
</tbody>
</table>

**Specialty specific and outpatient facility laboratory procedure list II**

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

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematology</td>
<td>85007</td>
<td>Blood smear, microscopic examination with manual differential WBC count</td>
</tr>
<tr>
<td></td>
<td>85025</td>
<td>Automated CBC/platelet/complete differential</td>
</tr>
<tr>
<td></td>
<td>85027</td>
<td>Automated hemogram and platelet count</td>
</tr>
<tr>
<td></td>
<td>85060</td>
<td>Blood smear, peripheral</td>
</tr>
<tr>
<td></td>
<td>87430</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>89230</td>
<td>Sweat collection by iontophoresis</td>
</tr>
<tr>
<td></td>
<td>38220</td>
<td>Bone marrow, aspiration only</td>
</tr>
<tr>
<td></td>
<td>85097</td>
<td>Bone marrow, smear interpretation only, with or without differential cell count</td>
</tr>
<tr>
<td></td>
<td>38221</td>
<td>Bone marrow biopsy, needle or trocar</td>
</tr>
<tr>
<td></td>
<td>G0306</td>
<td>Complete CBC, automated (HG B, HCT, RBC, WBC w/o platelet count)</td>
</tr>
<tr>
<td></td>
<td>G0307</td>
<td>Complete CBC, automated (HG B, HCT, RBC, WBC)</td>
</tr>
<tr>
<td>Urology/Infertility</td>
<td>Semen Analysis:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>89257</td>
<td>Sperm identification from aspiration (other than seminal fluid)</td>
</tr>
<tr>
<td></td>
<td>89260</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>89261</td>
<td>Sperm isolation, complex prep</td>
</tr>
<tr>
<td></td>
<td>89300</td>
<td>Presence and/or motility of sperm including Huhner test (post-coital)</td>
</tr>
<tr>
<td>Specialty</td>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Urology/Infertility continued</td>
<td>89310</td>
<td>Motility and count</td>
</tr>
<tr>
<td></td>
<td>89320</td>
<td>Complete (volume, count, motility and differential)</td>
</tr>
<tr>
<td></td>
<td>89325</td>
<td>Sperm antibodies</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>89060</td>
<td>Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)</td>
</tr>
<tr>
<td></td>
<td>85651</td>
<td>Sedimentation rate, erythrocyte: non-automated</td>
</tr>
<tr>
<td>Infectious Disease</td>
<td>85652</td>
<td>Sedimentation rate automated</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>87110</td>
<td>Chlamydia culture</td>
</tr>
<tr>
<td></td>
<td>89330</td>
<td>Sperm evaluations cervical mucus penetration, with or without Spinnbarkeit test</td>
</tr>
<tr>
<td>General Surgery/ Radiology/ Endocrinology</td>
<td></td>
<td><strong>Fine needle aspiration with or without preparation of smears:</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10021 Superficial tissue (e.g., thyroid, breast, prostate)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10022 Deep tissue under radiologic guidance</td>
</tr>
<tr>
<td>All Outpatient Facilities</td>
<td>82247</td>
<td>Bilirubin, total (for members under 30 days old, if LabCorp, Inc unable to draw)</td>
</tr>
<tr>
<td></td>
<td>82248</td>
<td>Bilirubin, direct (for members under 30 days old, if LabCorp, Inc unable to draw)</td>
</tr>
<tr>
<td></td>
<td>82800</td>
<td>Blood gases (ABG) X pH only</td>
</tr>
<tr>
<td></td>
<td>82803</td>
<td>Blood gases (any combination of pH, pCO2, pO2, CO2, HC03)</td>
</tr>
<tr>
<td></td>
<td>82805</td>
<td>With oxygen saturation, by direct measurement, except pulse oximetry</td>
</tr>
<tr>
<td></td>
<td>82810</td>
<td>Bloodgases, oxygen saturation only</td>
</tr>
<tr>
<td></td>
<td>82820</td>
<td>Hemoglobin X oxygen affinity (pO2 for 50% saturation with oxygen)</td>
</tr>
<tr>
<td></td>
<td>83850</td>
<td>Antibody screen, RBC, each serum technique</td>
</tr>
<tr>
<td></td>
<td>86860</td>
<td>Antibody elution (RBC), each elution</td>
</tr>
<tr>
<td></td>
<td>86870</td>
<td>Antibody identification RBC antibodies, each panel for each serum technique</td>
</tr>
<tr>
<td></td>
<td>86900</td>
<td>Blood typing, ABO</td>
</tr>
<tr>
<td></td>
<td>86901</td>
<td>Blood typing (Rh)</td>
</tr>
<tr>
<td>All Outpatient Facilities (continued)</td>
<td>86903</td>
<td>Antigen screening for compatible blood unit using patient serum, per unit screened</td>
</tr>
<tr>
<td></td>
<td>86904</td>
<td>Antigen screening for compatible blood unit using patient serum, per unit screened</td>
</tr>
<tr>
<td></td>
<td>86905</td>
<td>RBC antigens, other than ABO or Rh (D), each</td>
</tr>
<tr>
<td></td>
<td>86906</td>
<td>RH phenotyping complete</td>
</tr>
<tr>
<td></td>
<td>87070</td>
<td>Microbiology, any other source</td>
</tr>
<tr>
<td></td>
<td>87430</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>89190</td>
<td>Nasal smear for eosinophils</td>
</tr>
<tr>
<td></td>
<td>89230</td>
<td>Sweat collection by iontophoresis</td>
</tr>
<tr>
<td>Hematology/Oncology/Neurology/Pediatrics</td>
<td></td>
<td><strong>Lumbar puncture:</strong></td>
</tr>
<tr>
<td></td>
<td>82947</td>
<td>Glucose, quantitative</td>
</tr>
<tr>
<td></td>
<td>84155</td>
<td>Protein, total, except refractometry</td>
</tr>
<tr>
<td></td>
<td>85007</td>
<td>Blood count, manual differential WBC count</td>
</tr>
<tr>
<td></td>
<td>89050</td>
<td>Cell count, miscellaneous body fluids, except blood</td>
</tr>
<tr>
<td></td>
<td>82948</td>
<td>Glucose; quantitative, blood (except regent strip)</td>
</tr>
<tr>
<td>Cardiology/Cardio-Vascular/Thoracic Surgery</td>
<td>85610</td>
<td>Pro thrombin time</td>
</tr>
<tr>
<td></td>
<td>85730</td>
<td>Thromboplastin time, partial (PTT); plasma or whole blood</td>
</tr>
<tr>
<td>Pediatrics &amp; Family Medicine</td>
<td>82247</td>
<td>Bilirubin, total (for members under 30 days old)</td>
</tr>
<tr>
<td></td>
<td>82248</td>
<td>Bilirubin, direct (for members 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.

You are required to refer laboratory services to LabCorp, except as otherwise authorized by NHP. Services can be obtained by either sending the Customer to a LabCorp drawing center or by obtaining the laboratory specimen from the Customer and then sending the specimen to LabCorp.

To get more information on local LabCorp sites in your area, you can:

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

- 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.

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

NHP reimburses providers for phlebotomy, unless the provider is reimbursed under a capitation methodology or the laboratory service is performed in the physician’s office. Claims must be submitted using a valid CPT code. LabCorp requires the following to make sure accurate testing and billing:

- Customer’s NHP health care ID number
- LabCorp requisition forms with all required fields completed specific test orders using test codes
- Diagnosis (ICD-9) 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 one or more of the following administrative actions:

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

It is the intent of NHP to work with Participating 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 (PA)**

NHP's pharmacy benefit manager is UnitedHealthcare Pharmacy, which uses OptumRx for certain pharmacy benefit services. In order to promote appropriate utilization, NHP requires a Prior Authorization (PA) for selected medications dispensed through the pharmacy (prescription drug benefit) and/or incident to a physician's service (medical benefit) to be eligible for coverage. PA criteria have been established with input from physicians and consideration of current medical literature.

The PA list and criteria are dynamic and reflect the Pharmacy & Therapeutics (P&T) Committee’s review and responsiveness to the needs of plan members and Participating Providers. For a plan member 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 incident to a physician's service). PA does not guarantee coverage.

For a full description of our clinical programs on medications dispensed through the outpatient pharmacy benefit, please refer to UnitedHealthcareOnline.com as noted below. To determine medications available through the Pharmacy benefit and any PA that may be required, please consult the NHP Prescription Drug List Consumer Reference Guide.

**Outpatient Pharmacy information** on UnitedHealthcareOnline.com:

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

**NHP Prescription Drug List Consumer Reference Guide:**

MyNHP.com → Members → Pharmacy → 2014 Prescription Drug List (PDL).

All infusions and chemotherapeutic agents administered through the medical benefit require prior authorization, regardless of the indication. In addition, the following table summarizes medical drugs requiring PA for NHP members as well as the requirements for the outpatient medications listed above.
<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actemra (tocilizumab)</td>
<td>Coverage is provided for intraliesional treatment of refractory or recurring external condylomata acuminata in patients 18 years of age or older.</td>
</tr>
<tr>
<td>Alferon</td>
<td>Coverage is provided for treatment of adults with moderate to severe plaque psoriasis.</td>
</tr>
<tr>
<td>Benlysta (belimumab)</td>
<td>Coverage is provided for Enzyme Replacement.</td>
</tr>
<tr>
<td>Intravenous bisphosphonates Reclast, Boniva, Zometa</td>
<td>Coverage is provided for osteoporosis, Paget’s disease and related disorders.</td>
</tr>
<tr>
<td>Intravenous Iron Infusions Infed, Venofer, Ferrlecit, Feraheme, Dexferrum, Nulicit</td>
<td>Coverage is provided for treatment of patients with documented iron deficiency in whom oral administration is unsatisfactory or not possible.</td>
</tr>
<tr>
<td>Intravesicular Instalations BCG, Theracys</td>
<td>Bladder cancer and chronic cystitis.</td>
</tr>
<tr>
<td>Neupogen/ Neulasta*</td>
<td>Coverage is provided for treatment of neutropenia and in bone marrow transplantation.</td>
</tr>
<tr>
<td>Prolia</td>
<td>Coverage is provided for the treatment of osteoporosis.</td>
</tr>
<tr>
<td>Aralast, AralastNP, Prolastin, Prolastin C, Zemaira</td>
<td>Coverage is provided for a diagnosis of congenital alpha 1-antitrypsin deficiency with emphysema.</td>
</tr>
<tr>
<td>Sodium Hyaluronic Acid</td>
<td>UnitedHealthcareOnline.com → Quick Links → Policies, Protocols and Administrative Guides Policies → Medical &amp; Drug Policies and Coverage Determination Guidelines → Sodium Hyaluronate. Buy and Bill or Specialty Pharmacy.</td>
</tr>
<tr>
<td>Gel-One, Hylgan, Othovisc &amp; Supartz</td>
<td>Sodium Hyaluronate. Required to obtain through Specialty Pharmacy.</td>
</tr>
<tr>
<td>Sodium Hyaluronic Acid</td>
<td>UnitedHealthcareOnline.com → Quick Links → Policies, Protocols and Administrative Guides Policies → Medical &amp; Drug Policies and Coverage Determination Guidelines → Sodium Hyaluronate. Buy and Bill or Specialty Pharmacy.</td>
</tr>
<tr>
<td>Stelara (ustekinumab)</td>
<td>Stelara (ustekinumab)</td>
</tr>
<tr>
<td>Synagis</td>
<td>UnitedHealthcareOnline.com → Quick Links → Policies, Protocols and Administrative Guides Policies → Medical &amp; Drug Policies and Coverage Determination Guidelines → Synagis</td>
</tr>
<tr>
<td>VEGF Inhibitors</td>
<td>Ophthalmologic Policy Vascular Endothelial Growth Factor (VEGF) Inhibitors.</td>
</tr>
<tr>
<td>Avastin, Lucentis, Eylea, Macugen</td>
<td>Treatment of Substance Dependence.</td>
</tr>
<tr>
<td>Vivitrol</td>
<td>Coverage is provided for the treatment of adult patients with Dupuytren’s contracture with a palpable cord.</td>
</tr>
</tbody>
</table>

*Also available through Pharmacy Benefit with Prior Authorization.*
Pharmacy Drug PA Requests
OptumRx

• Phone: (800) 711-4555
• OptumRx Fax (non-specialty meds): (800) 527-0531
• OptumRx Fax (specialty meds): (800) 853-3844

NHP Medical Drug PA Requests

• Phone: (877) 488-5576
• Fax: (800) 731-6984

Drugs which are considered to be self-injectable are not covered in the Participating Provider’s office.

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 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 those of NHP. Once a panel is closed, it may not be opened to allow only select Customers to enter.
Claims inquiries and appeals

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

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

  **Note**: Not intended as claims coverage guidelines.

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

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

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.

As of the date this Supplement was published, the OneNet service area includes Delaware, Maryland, North Carolina, Pennsylvania, Virginia, Washington D.C., and West Virginia. 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. OneNet PPO is not a OneNet Payer.
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 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. OneNet offers its Clients access to a network of physicians, health care practitioners and facilities offering medical, behavioral health and workers’ compensation services.

OneNet Clients include, but are not limited to:

- Insurance Carriers
- Self-Funded Groups
- Union Health and Welfare Funds
- Third Party Administrators
- Workers’ Compensation Insurers and Administrators

While OneNet administers the network and the repricing of the claims using contracted rates, and our clients are responsible for the administration of the health plan accessing the OneNet network. The following provides a summary of a few key roles and responsibilities of OneNet and its clients:

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<th>What OneNet Does</th>
<th>What OneNet Clients Do</th>
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<td>Designs and administers health plans</td>
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<tr>
<td>Ensures OneNet Clients comply to contractual agreements</td>
<td>Establishes and maintains benefits and eligibility information of health plan Members (OneNet does not receive this information)</td>
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<td>Assists providers in resolving issues between them and their clients</td>
<td>Provides ID cards (ID cards are not used for Workers’ Compensation)</td>
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<td>Reviews and approves client ID cards</td>
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<td>Reprices claims</td>
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If you need assistance or have any questions, OneNet Customer Care is available by calling (800) 342-3289, or you may e-mail us at maprofessionalservices@uhc.com. You may also access our website at www.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.

| OneNet Corporate Offices | 800 King Farm Blvd, 6th Floor  
|                         | Rockville, MD 20850 |
| OneNet Customer Care    | (800) 342-3289  
|                         | e-mail: maprofessionalservices@uhc.com |
| Website:                | www.onenetppo.com  
|                         | Information about OneNet, online directories, guidelines, and links to UnitedHealthcareOnline.com for claim pricing sheets and client listings (login required). |
| Claim Submission        | 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 ID card. |
| Our standard claims mailing address | OneNet PPO/MAMSI Claims  
|                         | P.O. Box 934  
|                         | Frederick, MD 21705-0934 |
| Fee Schedule Appeals    | OneNet Appeals Attention: CRA Team  
|                         | P.O. Box 934  
|                         | Frederick, MD 21705-0934 |
| Claim Payment Appeals   | OneNet does not adjudicate or pay claims. Please direct payment appeals to the OneNet Client at the telephone number found on the Participant’s ID card or on the OneNet Client’s EOB. |
| Questions about your UnitedHealthcare Contract | Please contact your UnitedHealthcare Provider Representative. |

Health Care ID Cards

Health care identification (ID) cards for OneNet Participants differ in appearance because each OneNet Client issues its own card. 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 ID cards produced under other UnitedHealthcare commercial plans.

Sample ID Cards 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
- Eligibility and/or benefits telephone number
- Group number
- Group/Payer name
- Claims address
- UM information (if applicable)

The Participant’s ID card may list copayments (if any) and will list a benefits and/or eligibility telephone number.

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 ID Card requirement is services provided to Participants accessing providers though the OneNet PPO Workers’ Compensation Network. ID cards are not issued or used for OneNet Workers’ Compensation Participants. You should not expect Participants accessing the OneNet Workers’ Compensation Network to present an 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 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 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 www.onenetppo.com

The OneNet PPO website, www.onenetppo.com includes information for providers about OneNet, as well as general health resources, forms and guidelines, and our online directory of participating physicians, health care professionals, hospitals and facilities. Our site also includes links to UnitedHealthcareOnline.com, where you can view your OneNet claims repricing and obtain a listing of OneNet Clients (login required).
Because OneNet is not a OneNet Payer, and because neither OneNet nor its parent company, UnitedHealthcare, maintains benefits and eligibility information of OneNet Clients, many of the tools available at UnitedHealthcareOnline.com for other Commercial products cannot be used for OneNet Customers. These include, but are not limited to:

- Review of eligibility, benefits or HRA balances for OneNet Customers
- View patient personal health records
- Submit Advance Notifications
- Look at 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 www.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 in the referring specialty is not available 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.

**Help Make Sure Our Participants Can Find You**

Periodically, you may wish to search our online directory to make sure your listed information is current and accurate. If you find an error in your own directory listing, please submit the change to UnitedHealthcare, following the guidelines described in the *Provide timely notice of demographic change* section of the UnitedHealthcare Guide.

**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 participating 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 www.onenetppo.com, or by calling OneNet Customer Care at (800) 342-3289. In the event that you require a specific laboratory test for which you believe no participating laboratory is available, please contact OneNet Customer Care to confirm that 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.

**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 Participants ID card. Please contact the health plan at the benefits and eligibility number listed on the 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 ID card if the Participant has access to the MAPSI network. If you believe that 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 is not the OneNet Payer. OneNet reviews claims for completeness and accuracy, and applies claim pricing in accordance with your contracted fee schedule. OneNet then forwards the claim to the appropriate OneNet Client for adjudication.

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 repriced.
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 are 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; 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 Workers’ Compensation Claims**

Reimbursement to you by the applicable OneNet Client for covered services rendered to customers pursuant to a OneNet PPO, LLC workers’ compensation benefit program, shall be the lesser of: (i) OneNet PPO, LLC fee schedule; (ii) your usual and customary charge for such services; or (iii) the applicable state’s workers’ compensation fee schedule, in effect from time to time.

**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 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 HICF-1500 or 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 HICF-1500; hospitals and facilities use Box 9D on HICF-1500 or Box 50 on UB-04) and send them to the OneNet claims address listed on the Participant’s ID card.

Claims must 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 ID card. OneNet claims should not be submitted using UnitedHealthcare’s Connectivity Directory available at 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**

The following clearinghouses have an established connection to OneNet PPO:

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<tr>
<th>Clearinghouse</th>
<th>Claim Types</th>
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<tr>
<td>Allscripts</td>
<td>HICF &amp; UB</td>
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<tr>
<td>Capario</td>
<td>HICF</td>
</tr>
<tr>
<td>Emdeon (formally WebMD)</td>
<td>HICF &amp; UB</td>
</tr>
<tr>
<td>OptumInsight</td>
<td>HICF &amp; UB</td>
</tr>
<tr>
<td>Practice Insight</td>
<td>HICF</td>
</tr>
<tr>
<td>Real Med</td>
<td>HICF</td>
</tr>
<tr>
<td>RelayHealth</td>
<td>HICF &amp; UB</td>
</tr>
<tr>
<td>SSI Group, Inc.</td>
<td>HICF &amp; UB</td>
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</tbody>
</table>

The most up-to-date version of the EDI Reference Guide is available at www.onenetppo.com. If you use another clearinghouse, or if you have any questions, 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 claims cannot be estimated using the UnitedHealthcare online Claim Estimator. To estimate the repricing of a claim, please contact OneNet Customer Care. Eligibility and benefits are not considered in repricing estimates and are therefore not a guarantee of payment or coverage of a specific amount.
- Submit claims on a red HICF-1500 or a 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.
- 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 inquiries, 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 our website at www.onenetppo.com. OneNet providers can go to www.onenetppo.com and click the link in the Providers section to view the status of your claim and view copies of their OneNet claim pricing sheets. The link will connect you to UnitedHealthcareOnline.com, where OneNet claims can be viewed and printed using the site’s claim status tool. Pricing sheets show the allowed amount of your claims after the application of your OneNet contracted rate. 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, 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. 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 ID card or at the contact information listed on the OneNet Client’s EOB. A listing of OneNet Clients and contact information is also available online, or you may 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 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 the OneNet Payer still believes a refund should be provided, the OneNet Payer will forward the information to OneNet for further review, and OneNet will work with you and the OneNet Payer to resolve the issue.

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

To ensure administrative costs for our physicians, health care practitioners, Hospital, Facilities, OneNet Clients and OneNet do not exceed the amount being appealed, repricing that resulted in either an overpayment or underpayment of 5 dollars ($5.00) or less will not be adjusted.

OneNet strives to accurately reprice all claims, and will gladly make adjustments when a claim that has been repriced inaccurately results in significant underpayment or overpayment for services.
Resolving Disputes
If you have a concern or complaint about a OneNet Client Payer, please use your best efforts to resolve the issue directly with the OneNet Client. If you are unable to resolve the issue directly, please contact OneNet Customer Care. OneNet believes in providing service to both its Clients and participating providers, and will do our best to help facilitate a resolution to any issues that you cannot resolve.

If the issue is not resolved to your satisfaction, please follow the resolution processes outlined in Resolving disputes - agreement 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 the cases where you know that services may not be covered, the Participant’s written consent should include a statement that the OneNet Payer has determined that the services are not covered and that 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 Claim Estimator available on UnitedHealthcareOnline.com cannot be used to estimate OneNet claims. Likewise, OneNet claims cannot be submitted for real time processing through the claim submission feature on UnitedHealthcareOnline.com.

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 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 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 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 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 Quality Management and Health Management Programs**

The following exceptions apply to the *Quality Management and Health 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.

- View 360 – HEDIS Gaps in Care reports are not available for OneNet Participants.

- 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.

- 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.
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.

- Admitting physician's telephone number and physician Tax ID number and/or NPI.
- Name of the hospital and the expected admission date.
- Diagnose or reason for admission.

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 www.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.

OneNet Client Listing

OneNet Clients are required to include the telephone numbers for Participant eligibility, benefits verification and pre-certification (when applicable) on the Participant’s ID card. As an added convenience to participating providers, OneNet also maintains a Client Listing that includes the names of its clients and the benefits, eligibility and pre-certification instructions or telephone numbers for each, as well as contact information for claims payment.

OneNet’s Client Listing is subject to change. Our current list is posted at UnitedHealthcareOnline.com in the OneNet Claim Status search section. You may also call OneNet Customer Care at (800) 342-3289 to request that a copy be faxed or e-mailed to you.

Information included on the OneNet Client Listing is considered confidential and proprietary, and should only be used by OneNet providers for administrative purposes.
Important Information Regarding the Use of this Supplement

This Supplement applies to all covered services which you provide to Members under a commercial benefit plan insured by or receiving administrative services from Oxford.

For services provided to Members 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 us section located in the front of this Supplement. It is a comprehensive contact list, which includes telephone and fax numbers, as well as website and mailing addresses. This list is referenced frequently throughout the Supplement and was designed as a helpful one-stop repository of all important contact information.

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 policy changes

A monthly Policy Update Bulletin summarizing all recently approved and/or revised policies is available for your reference at OxfordHealth.com. This online communication provides 30 days advance notice of medical policy updates and gives you access to new and/or revised policies, in their entirety, along with an overview or summary of changes, 30 days prior to implementation.

A new Policy Update Bulletin is published on the first calendar day of every month and can be accessed via OxfordHealth.com → Providers or Facilities → Tools & Resources → Practical Resources → Medical and Administrative Policies → Policy Update Bulletin.

You can also request a paper copy of a medical policy by writing to:

Oxford Policy Requests and Information
48 Monroe Turnpike
Trumbull, CT 06611
# How to contact Oxford Commercial

## Contact information and resources

### Commercial Products

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<tr>
<td>Administrative Appeals</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>
</tr>
<tr>
<td>Automated Voice Portal</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. For a Quick Reference guide, go to OxfordHealth.com → Providers or Facilities → Tools &amp; Resources → Manage Your Practice → Administrative Ease → Voice Portal Quick Reference. Available options:</td>
<td>• Check patient eligibility and benefits • Submit referrals • Check the status of referrals and Prior Authorization requests • Check the status of claims</td>
</tr>
<tr>
<td>Behavioral Health Department</td>
<td>Phone: (800) 201-6991</td>
<td>• Prior Authorization for services • Obtain referrals for mental health and substance abuse services</td>
</tr>
<tr>
<td>Cardiac Catheterization Prior Authorization</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</td>
<td>• Request Prior Authorization</td>
</tr>
<tr>
<td>Cardiology Utilization Review/Medical Necessity Review</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 → Practical Resources → Medical and Administrative Policies → Cardiology Procedures Requiring Precertification</td>
<td>• Request Utilization/Medical Necessity review • Check procedures requiring Prior Authorization</td>
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<tr>
<td>Centers for Disease Control (CDC) National AIDS hotline</td>
<td>Phone: (800) 232-4636</td>
<td>• Anonymous counseling and HIV testing program information</td>
</tr>
<tr>
<td>Chiropractic Services – OptumHealth</td>
<td>Provider Services/Claims- Phone: (800) 985-3293 Online: myoptumhealthphysicalhealth.com</td>
<td>• Fax treatment care plans • Physician claim/authorization questions as well as • Inquiries about claims status, claims payment, authorization status, first level appeals • Submit Prior Authorization requests</td>
</tr>
<tr>
<td>Claim submission-Initial</td>
<td>Electronic Claims: Commercial Claims Payer ID: 06111 Learn more on OxfordHealth.com → Providers or Facilities → Tools &amp; Resources → Manage Your Practice → Electronic Data Interchange (EDI) Paper Claims: UnitedHealthcare Attn: Claims Department P.O. Box 29130 Hot Springs, AR 71903</td>
<td>• Submit claims electronically or on paper</td>
</tr>
<tr>
<td>Claim Submission Corrections/Resubmissions</td>
<td>Physician claims: Mail corrections and a participating provider claim review form to: Oxford Corrected Claims Department P.O. Box 29137 Hot Springs, AR 71903 Facility claims: Submit corrections electronically.</td>
<td>• Submit corrected claims</td>
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<tr>
<td><strong>Claim status</strong></td>
<td>Online: OxfordHealth.com → Providers or Facilities → Transactions → Check Claims. Electronic Data Interchange (EDI) 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) online</td>
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<tr>
<td><strong>Claims – request for reconsideration</strong></td>
<td>Online: Optum Cloud Dashboard (1 claim) Forms: Oxfordhealth.com → Providers or Facilities → Tools &amp; Resources → Manage Your Practice → Forms →  • Participating Claims Review Request Form (1-19 claims) • Participating Provider Claims Research Project (20 or more claims)</td>
<td>• Submit requests for reconsideration</td>
</tr>
<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>
</tr>
<tr>
<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>
<tr>
<td>** Credentialing and Recredentialing**</td>
<td>Phone: United Voice Portal at (877) 842-3210 Email: <a href="mailto:Credentialing.status@optumhealth.com">Credentialing.status@optumhealth.com</a> Online: UnitedHealthcareOnline.com → Tools &amp; Resources → Policies, Protocols and Guides → Credentialing &amp; Recredentialing Plan. New Jersey only: Online: state.nj.us/health or caqh.org 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>
</tr>
<tr>
<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>
</tr>
<tr>
<td><strong>Crisis Intervention Hotline – New Jersey</strong></td>
<td>Phone: within New Jersey (800) 624-2377 Outside of New Jersey area phone: (973) 926-7443</td>
<td>• Available 24 hours a day, 7 days a week, toll-free phone number is only accessible when calling from New Jersey</td>
</tr>
<tr>
<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>
</tr>
<tr>
<td><strong>Electronic Solutions Support (Commercial)</strong></td>
<td>Phone: (800) 599-4EDI (4334) Assistance with electronic solutions for your administrative needs, and helpful information regarding Electronic Data Interchange (EDI). Transaction Code Sets: uhcnational.com → HIPAA and EDI → Transactions &amp; Code Sets → Companion Documents.</td>
<td>• Learn the benefits of electronic transactions  • Resolve problems with your practice management vendor or clearinghouse  • Understand your electronic claims tracking reports  • Provide information on Electronic Payments (EFT) and Electronic Remittance Advice (ERA)</td>
</tr>
<tr>
<td><strong>Eligibility and Benefits</strong></td>
<td>Online: OxfordHealth.com → Providers or Facilities → Transactions → Check Eligibility &amp; Benefits. Electronic Data Interchange (EDI) 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 patient eligibility and benefits</td>
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<tr>
<td><strong>Fraud Hotline</strong></td>
<td>Phone: (866) 242-7727</td>
<td>• Report fraudulent activity</td>
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<tr>
<td>HIPAA compliance and security</td>
<td>Online: uhcnational.com → HIPAA and EDI → security For additional information on granting remote access to your EMR system: <a href="mailto:emrcdsa@uhc.com">emrcdsa@uhc.com</a>.</td>
<td>• Standards on confidentiality of electronic records • Examples of safeguard areas</td>
</tr>
<tr>
<td>Infertility Services – OptumHealth</td>
<td>Phone: (877) 512-9340 Fax: (855) 536-0491</td>
<td>• Prior Authorization for all outpatient services</td>
</tr>
<tr>
<td>Inpatient admission</td>
<td>Online: OxfordHealth.com → Providers or Facilities → Transactions → Submit: • Direct/Elective Admit • ER Admit • Maternity Delivery Admit • Precert Requests Electronic Data Interchange (EDI) Phone: (800) 666-1353 Fax: (800) 303-9902</td>
<td>• Submit Admission Notifications and Prior Authorization requests</td>
</tr>
<tr>
<td>Inpatient and Outpatient-Clinical Services</td>
<td>Phone: (800) 666-1353</td>
<td>• Inpatient admissions and Outpatient procedures • Services for which review is delegated in whole or in part to a vendor, including CareCore National, 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</td>
</tr>
<tr>
<td>Internal appeals-Claims payment disputes</td>
<td>Mail: Oxford Member Appeals Department P.O. Box 29136 Hot Springs, AR 71903 Forms: Oxfordhealth.com → Providers or Facilities → Tools &amp; Resources → Manage Your Practice → Forms • Participating Claims Review Request Form (1-19 claims) • Participating Provider Claims Research Project (20 or more claims)</td>
<td>• Dispute the payment of a claim</td>
</tr>
<tr>
<td>Laboratory information: Laboratory Corporation of America (LabCorp) Client services</td>
<td>Phone: Patient service center locator number for Members (888) LABCORP • North New Jersey (800) 223-0631 • South New Jersey (800) 633-5221 • New York (800) 223-0631 • Connecticut (800) 631-5250 Complete list of participating laboratories: Online: OxfordHealth.com → Providers or Facilities → Tools &amp; Resources → Practical Resources → Laboratory Services.</td>
<td>• List of available laboratories • Inventory of patient service centers</td>
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<tr>
<td>Member Appeals (Commercial Products)</td>
<td>Mail: Oxford Member Appeals Department P.O. Box 29134 Hot Springs, AR 71903 Online: Oxfordhealth.com → Providers or Facilities → Tools &amp; Resources → Manage Your Practice → Forms → Participating Claims Review Request Form</td>
<td>• File appeal on Member’s behalf</td>
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<tr>
<td>Medical Necessity Appeals Commercial Products</td>
<td>Mail: Oxford Clinical Appeals Department P.O. Box 29139 Hot Springs, AR 71903</td>
<td>• File a standard medical necessity appeal</td>
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<tr>
<td>Network Bulletin</td>
<td>Online: UnitedHealthcareOnline.com → Tools &amp; Resources → News → Network Bulletin Email: Sign up to receive the Network Bulletin via email in the News section of the UnitedHealthcareOnline.com home page</td>
<td>• Important information on Oxford protocol and policy changes is included in the Affiliates section of this bi-monthly online publication.</td>
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### Commercial Products

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| **Oxford On-Call**<sup>®</sup> (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 notification** | Phone: (800) 711-4555  
Available 24 hours per day, 7 days per week including holidays | • Obtain medication notification/Prior Authorization for Members |
| **Physical and occupational therapy – OptumHealth – Prior Authorization** | 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  
• Inquiry about authorizations, In-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 | • 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 facsimile form, which can be found on OxfordHealth.com → Providers or Facilities → Tools & Resources → Manage Your Practice → Forms.  
Electronic Data Interchange (EDI) | • 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 “Prior Authorization” when prompted.  
Online: OxfordHealth.com → Providers or Facilities → Transactions → Check → Precert Status.  
Electronic Data Interchange (EDI) | • Verify Prior Authorization status |
Email: Sign up to receive the Network Bulletin via email in the News section of the UnitedHealthcareOnline.com home page | • Oxford Quality Management Program information is included in this bi-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: CareCareNational.com  
24 hours a day 7 days a week  
Medical policy: OxfordHealth.com → Provider → Tools & Resources → Practical Resources → Medical and Administrative Policies → Radiology or Radiation Procedures Requiring Precertification | • Request Prior Authorization for radiology radiation therapy procedures  
• Check procedures requiring Prior Authorization |
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<td><strong>Radiology and Radiation Therapy 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</td>
<td>• Request Utilization/Medical Necessity review</td>
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<tr>
<td><strong>Referral Submission</strong></td>
<td>Phone: Provider Services or Voice Portal: (800) 666-1353 (Mon.-Fri., 8 a.m. - 6 p.m. ET). Say “referral” when prompted. Online: OxfordHealth.com → Providers or Facilities → Transactions → Submit Referrals. Electronic Data Interchange (EDI)</td>
<td>• Submit referral requests</td>
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<tr>
<td><strong>Referral Verification</strong></td>
<td>Phone or Voice Portal: (800) 666-1353 Online: OxfordHealth.com → Providers or Facilities → Transactions → Check → Referrals Electronic Data Interchange (EDI)</td>
<td>• Verify referral status • Note: Submitted referrals are available immediately for inquiry; this includes those submitted electronically and those initiated by Oxford On-Call®.</td>
</tr>
<tr>
<td><strong>Roster of Participating Physicians, Other Health Care Professionals and facilities</strong></td>
<td>Phone: (800) 666-1353 Online: OxfordHealth.com → Providers or Facilities → Search: • Doctor • Hospital</td>
<td>• 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 an in-network basis.</td>
</tr>
<tr>
<td><strong>Second Level Member Appeals</strong></td>
<td>Mail: UnitedHealthcare Grievance Review Board P.O. Box 29134 Hot Springs, AR 71903</td>
<td>• File a second level Member appeal</td>
</tr>
<tr>
<td><strong>Service Solutions</strong></td>
<td>OxfordHealth.com → Providers or Facilities → Tools &amp; Resources → Practical Resources → How to Guide: Service Solutions for UnitedHealthcare (CT, NJ, NY and RI)</td>
<td>• Information about features on UnitedHealthcareOnline.com, OxfordHealth.com and UHCCommunityPlan.com • When and where to call or write to us • Frequently Asked Questions</td>
</tr>
<tr>
<td><strong>Specialty Pharmacy Referral Line</strong></td>
<td>Phone: (888)739-5820</td>
<td>• Obtain specialty pharmacy benefit program information Patient education • Create personalized specialty medication plans</td>
</tr>
<tr>
<td><strong>Termination Requests</strong></td>
<td>Phone: (800) 666-1353 Physicians and other Healthcare professionals Mail: Certified mail, return receipt requested to; 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</td>
<td>• 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.</td>
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<td>Website Commercial</td>
<td>OxfordHealth.com</td>
<td>• Determine whether a CPT code requires Prior Authorization (up to 12 codes at one time)</td>
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<td></td>
<td>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 &amp; Resources → Manage Your Practice → Administrative Ease → Quick Reference View the schedule of instructor-led webcast training sessions at OxfordHealth.com → Providers or Facilities → Tools &amp; Resources → Manage Your Practice → Administrative Ease → Electronic Solutions Training Schedule Web Help Desk at: (800) 811-0881</td>
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### Member Eligibility and Benefits

#### Member health care identification (ID) cards

Each Member is given a health care ID card that is for identification only and does not establish eligibility for coverage. The Member should present his/her card when requesting any type of covered health care service. We suggest that each time you check a Member’s health care ID card; you also request a photo identification to minimize any risk of an unauthorized use of the Member’s card.

#### Sample health care ID card:

![Sample health care ID card](image)

#### Confirming eligibility and benefits

Checking your patient’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 & 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 Online, Voice Portal and Vendor solutions, please refer to OxfordHealth.com → Providers or Facilities → Tools & Resources → Manage Your Practice → Administrative Ease. Here you will find quick reference guides and instructions to assist you.

**Oxford Networks**

All providers contracted with Oxford participate in the Freedom Network. The Liberty Network is a smaller subset of the Freedom Network and is only available for Members of New York and New Jersey Oxford plans.

**Small Business Health Options Program (SHOP)**

In New York State, the Small Business Health Options Program (SHOP) Exchange Product and the Off Exchange Individual Exchange Product offered by UnitedHealthcare will be based on our Oxford Liberty Network. Providers participating in Liberty will also participate in the New York SHOP Product and the Off Exchange Individual Exchange Product, and must follow the same protocols, and will receive the same reimbursement. Members will present with a New York SHOP health care ID card or a New York Off Exchange Individual ID Card that will also reference Oxford Liberty. Members will adhere to the Liberty Plan guidelines as defined by the Liberty Gated EPO plan descriptions. Oxford’s Liberty Plan Gated EPO is an in-network only product and requires a referral for specialist visits. Any questions can be directed to Oxford Customer Service at (800) 444-6222.

**Determining the primary payer among Commercial plans**

When a Member 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, Member or subscriber or retiree is primary over the plan that covers the individual as a dependent.

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 Members who are Medicare beneficiaries according to federal Medicare program guidelines.

We have primary responsibility if the Member 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.
Member Rights and Responsibilities
For the entire list of Member Rights and Responsibilities, go to OxfordHealth.com → Providers or Facilities → Tools & Resources → Practical Resources → Medical and Administrative Policies → Managed Care Act Disclosure Materials → Member Handbook.

Primary care physician (PCP) selection
All HMO products require Members to select a PCP to provide primary care services and coordinate the Member’s overall care. In addition, female Members may also select an obstetrician/gynecologist (OB/GYN) whom that female Member may see without a referral from her PCP.

Selection - Members can only select a PCP within their network (e.g., a Liberty PlanSM Member must select a Liberty Network participating PCP).

Gated plans – These are plans in which all covered services* performed by in-network physicians and/or other in-network health care professionals, other than those covered services performed by the Member’s PCP or OB/GYN, require: (a) a referral from the Member’s PCP to an in-network provider; or (b) Prior Authorization from the plan, obtained by the Member’s PCP, approving an in-network exception,** for the Member to receive covered services from an out-of-network provider at the Member’s in-network level of benefits. Members of gated plans will have “In-Network Referral Required” printed on the back of their ID card.

• For gated plans with in-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 Member’s out-of-network benefits and cost sharing requirements.

Non-gated plans - These are plans in which all covered services* performed by in-network physicians and/or other in-network health care professionals do not require a referral from the Member’s PCP to an in-network provider, but do require Prior Authorization from the plan, obtained by the Member’s PCP, approving an in-network exception,** for the Member to receive covered services from an out-of-network provider at the Member’s in-network level of benefits. Members of non-gated plans will have “No Referral Required” printed on the back of their ID card.

• For non-gated plans with in-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 Member’s out-of-network benefits and cost sharing requirements.

Newly enrolled Members who may need transitional care or continuity of care
When a new Member enrolls with us, the Member may qualify for coverage of transitional care services rendered by his/her non-participating physicians or other health care professionals. If the Member has a life-threatening disease or condition, or a degenerative and disabling disease or condition, the transitional care period is 60 days.

If the Member 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, Members may call Customer Service at (800) 444-6222.

* 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 in-network provider available to provide covered services to a Member.
Referrals and Prior Authorization

Referral policies and guidelines
Our physician contracts require referrals be issued to participating physicians and other health care professionals for Members with a gated plan, except in cases of emergency or when there are no participating physicians or other health care professionals who can treat the Member's condition. If you would like to direct a Member 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 Member 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.

A referral should be made only when, in your professional opinion, you believe it is medically appropriate and necessary. If you have 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.

For complete details log on to OxfordHealth.com → Tools & Resources → Practical Resources → Medical & Administrative Policies → Referrals.

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 to specialty care centers
Standing referrals to a network specialty care center may be requested if a Member 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 center 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 Member’s Certificate of Coverage.

Our Medical Director will consult with the Member’s PCP, the network specialty care center and the network specialist to determine if such a referral is appropriate. The referral will be provided pursuant to a treatment plan that will be developed by the specialty care center and approved by our Medical Director. The Member, 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 Member'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 Member’s condition;
• Appropriate with regard to standards of good medical practice;
• Not solely for the Member’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 Member’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:
  1. All procedures requiring Prior Authorization; however, an active referral* must also be on file for services to be covered in-network, depending on the Member’s benefits.
  2. Any change of treating physician or other health care professional, CPT codes or dates of service for the authorized service.
  3. All Member 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 Member, 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 Members by phone and in writing. All participating physicians and other health care professionals are responsible for calling the Member the same day that the provider receives notification of our determination.

• Neither Prior Authorization nor referral is required for Members 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.

• Members are responsible for notifying us of emergency facility admissions to a non-participating facility.

• We may require that a Member 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; Members 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 complete list of services requiring Prior Authorization, please go to OxfordHealth.com → Providers or Facilities → Tools & Resources → Practical Resources → Medical and Administrative Policies → 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
48 Monroe Turnpike
Trumbull, CT 06611

Changes to this list are announced at OxfordHealth.com → Providers or Facilities → Tools & Resources → Practical Resources → Medical and Administrative Policies → Policy Update Bulletin (published monthly).

* Not required when a Member is seeing their designated participating OB/GYN
Note:

• Certain services may not be covered within an individual Member'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 Member'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.

For those requests that do not meet the criteria for approval, you will be informed that the coverage determination requires further review by our Medical Director.

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 → Practical Resources → 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. Referral and Prior Authorization guidelines will apply 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 Prior Authorization status 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 Member'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 Member 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 Member by calling (800) 666-1353. A referral cannot be made to a non-participating provider without our approval.

If a Member asks you for a recommendation to a non-participating physician or other health care professional, you must tell the Member that you may not refer to a non-participating provider, and the Member must contact us to obtain the required Prior Authorization. The Member 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 Member 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 Member’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 Member’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 Members).

- Additionally, we may make the claim payment directly to the Member instead of to the non-participating facility. In such cases, the non-participating facility will be instructed to bill the Member for services rendered.

The Member will then be responsible for making payment to the non-participating physician or other health care professional for the full amount of the check mailed to them by us, in addition to any applicable copayment, deductible, coinsurance or other cost share allowances, according to the Member’s benefit plan.

- Members 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 Member 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 Member who does not have out-of-network benefits (HMO and EPO plan Members), 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 Members.

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 Member’s referral options with them in advance of the service, the Member 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 Members with OON benefits, these non-participating anesthesiologist claims will be paid at the OON benefit level. OON cost shares and deductibles will apply.
   - For Members with no OON benefits, there is no coverage for services provided by nonparticipating providers and Member’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 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. The participating gastroenterologist cannot balance bill the Member 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 → Practical Resources → Medical and Administrative Policies → Participating Gastroenterologists Utilizing Non-Participating Anesthesiologists for In-Office Procedures.

**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 hospitalization**

**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 others 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 effect a safe transfer of the woman or unborn child to another hospital before delivery.

**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 Member 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 Member’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 Prior 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 and emergency room admissions 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 Member from using ER services within our service area.

Coverage
We cover emergency room services for medical emergencies. The Member 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, may be covered when it takes place in the PCP’s office. Follow-up care in a specialist’s office may be covered and is subject to referral guidelines.

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.

Maternity
It is crucial that the Member, or the Member’s physician or other health care professional, notify us of a pregnancy as early as possible to ensure the proper application of benefits. Non-emergency maternity admissions should be authorized. Newborn coverage varies from plan to plan and state to state.

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 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 Member 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 Members directly face-to-face or telephonically.

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

• UnitedHealthcare uses 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**

• Must notify for all newborns admitted to Neonatal Intensive Care Unit (NICU) and who remain hospitalized after the mother is discharged.

• Concurrent inpatient stays (notification prior to discharge).

• The hospital is required to notify us of any patient that changes level of care. The Member 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 Member up to 90 days following the date of service, then we may deny or reverse the claim.

The hospital also must provide:

• Daily inpatient census log by 10 a.m.; the daily inpatient census log will reflect all admits and discharges through midnight the day prior.

• Notification of all admissions of our Members 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

• Preauthorization any transfer admissions of Members prior to the transfer unless the transfer is due to life-threatening medical emergency.

• Communication 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). Also responsible for verifying the accuracy of the admission and discharge dates for our Members listed on the EDR.

• The hospital is responsible for verifying the accuracy of the admission and discharge dates for our Members 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 Members and their medical records.
It is the responsibility of all physicians and other health care professionals to deliver letters of non-coverage to the Member 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)

Members - 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 Members).

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 Member 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 service. 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 Member 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 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.

* ALC only applies if the facility has a contracted rate.
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 Member’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.
- **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.

**Readmissions**

When a Member 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 Member 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 patient 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 Member for any portion of the covered services not paid for by us.

* Inpatient ALC must meet clinical criteria per clinical guidelines. Failure to satisfy these criteria can result in denial of coverage.
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 Member 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. If the admission is denied, the hospital will not have the reconsideration option; they must follow the standard appeal process. The hospital is required to provide admission notification and a daily inpatient census of all our Members.

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 for Appeal Rights.

Hospital records may be requested to validate ICD-9 codes and/or revenue codes billed by participating facilities for inpatient hospital claims. If the billed ICD-9 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 Member’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 Members.

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 Member consent and to share information with the primary care physician 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 Members 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 Member’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 Member’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 Member’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 patient service centers and laboratories to help patients 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.

**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, log into our website at Oxfordhealth.com as a provider or a facility and select Practical Resources → Laboratory Services → 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 or privileging program 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 radiology privileging list is applicable to Commercial plans (excluding Oxford USA/Plans). All X-rays performed at an urgent care facility are payable.

**Imaging requiring Prior Authorization**

The referring physician is responsible for contacting CareCore National Management Services, LLC 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 CareCore National 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 in the usual manner by calling in your request. If the CareCore National 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**

CareCore National 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 CareCore National for medical necessity review with a CareCore Medical Director. In the event that criteria has not been met the physician’s office as well as the Member will be notified in writing of the denial. Log into CareCoreNational.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 CareCore National 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 Members, 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 CareCore National’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 Member and the requesting physician within 5 business days of the decision. All authorization reference numbers are issued at the time of approval. CareCore National 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.

**Note:** Radiopharmaceuticals in excess of $50 will be reimbursed. Submission of an invoice detailing the cost and name of the administered material is still required.

**Cardiac Catheterization Procedures**

For Oxford products, there is a Prior Authorization and medical necessity review program for all outpatient Cardiac Catheterizations. Prior Authorization is managed through CareCore National, LLC. Our Cardiology policy does not permit Prior Authorization requests from persons or entities other than referring physicians.

On July 1, 2013, we implemented a new outpatient Prior Authorization requirement for Members with an Oxford product prior to a diagnostic cardiac catheterization. CPT codes 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, and 93461 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 CareCore National, LLC. Our Radiation Therapy 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 CareCore National 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 CareCore National for a radiation therapy course of treatment, corresponding claims may not be reimbursed.

Oxford has engaged CareCore National 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 CareCore National. To obtain Prior Authorization for a course of radiation therapy, providers must contact CareCore National at (877) 773-2884 or visit CareCoreNational.com

CareCore National 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 → Provider → Tools & Resources → Practical Resources → Medical and Administrative Policies → Radiation Therapy Procedures for CareCore National Arrangements.

Radiation therapy evidence-based guidelines and management criteria are available on CareCoreNational → CareCore 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 Members**

A review for medical necessity can be requested prior to rendering the service by contacting CareCore National at (877) 773-2884, or CareCoreNational.com. CareCore National 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 → Provider → Tools & Resources → Practical Resources → Medical and Administrative Policies → Radiology Procedures for CareCore National Arrangement or Radiation Therapy Procedures requiring Prior Authorization. The clinical criteria consistent with existing UnitedHealthcare and Oxford policy are available at CareCoreNational.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:

1. Reason for the procedure performed;
2. Patient's signs and symptoms;
3. Treatment, including type and duration;
4. Previous studies for the specific medical issue; and
5. 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 procedure that is being requested, for pre- and post-service review.

**Referrals**

Certain Oxford products require referrals for radiation therapy from the patient’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 Members will apply. For any service that is not approved for payment, we will offer all appropriate rights of appeal.

**Outpatient Cardiac Catheterization Utilization Review Process**

Oxford has delegated CareCore National, LLC to perform medical necessity review for outpatient cardiac catheterizations. Prior Authorization will not be required for services rendered in the emergency room, observation unit, urgent care facility, or during an inpatient stay.

The following CPT Codes will require pre-certification: 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460 and 93461. Pre-certification requirements can be verified through one of the following options:

Begin the Prior Authorization process online at CareCoreNational.com or by calling CareCore National toll-free at (877) 773-2884. When prompted, please provide the Member'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.

Call the number on the back of the Member's 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 CareCoreNational.com.

For more information, including the clinical criteria, please visit CareCoreNational.com → CareCore 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 Members 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 Services, 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 be received within 10 days from the initial date of service indicated on the Patient Summary Form. Forms received outside of this 10-day submission requirement will reflect an adjustment to the initial payable date.

**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 currently manages the following specialties:

- Orthopedic Surgery
- Pediatric Orthopedic Surgery
- Podiatry
- Neurosurgery
- Hand Surgery
- Physical Medicine Rehabilitation

* 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.
OrthoNet also manages the following specialties 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

**Chiropractic guidelines**

OptumHealth Care Solutions currently manages our chiropractic benefit. To receive the standard chiropractic benefit coverage, Members 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 Optum website at myoptumhealthphysicalhealth.com, within 3 business days and no later than 10 business days following the patient’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 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:** According to your contract with OptumHealth, the patient 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 Members who have the alternative medicine rider. If a Member does not have the 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 patients, consider whether a Tier 1 or Tier 2 alternative is appropriate if the patient is taking a Tier 3 medication currently.
The PDL is reviewed on an ongoing basis and updated at least twice per year to reflect advances in pharmaceutical care. Physician medications that require notification or Prior Authorization are noted with an “N” 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 determines whether supply limits or Prior Authorization/notification requirements are necessary. 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. The P&T Committee meets at least quarterly.

**Quality management and patient safety programs Drug Utilization Review (DUR)**
The majority of prescription claims are submitted electronically for payment. Within seconds, the Member’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 Member’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 Member 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 Member’s benefit plan design, select high-risk or high-cost medications may require advance notification 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 Member 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 Members 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 Members 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 Member is required to fill their prescription through a designated Mail Order Pharmacy, stay at retail with a lower-tier alternative or both.

Quality Management Programs
The Quality Management (QM) program focuses on ensuring access to the delivery of health care and services for all our Members 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 physician or other health care professional
- 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 physicians and other health care professionals
- Assessment of the medical qualifications of participating physicians and other health care professionals
- Continued improvement of Member health care and services
- Efforts to ensure patient safety* and confidentiality of Member 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

* For additional details on Patient and Hospital Safety, go to OxfordHealth.com → Oxford Programs → Patient Safety, this site requires you to log in using your provider ID and password.
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 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 Member 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 Member 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 state licensing boards, Office of the Inspector General and other sanctioning bodies or entities.

**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 Member’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 Member satisfaction, physician satisfaction, employer (client) 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 Member complaints regarding the provision of medical care and services; investigation may include verbal and written contact with the Member and the physician or other health care professional, as well as a review of relevant medical records and responses to potential concerns identified.
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 Members use to evaluate the demonstrated value and quality of different health plans.

Each year we collect data from a randomly selected sample of our Members’ 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 Members 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.

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.

Results of such quality-based medical record reviews are communicated in a number of ways. Aggregate scores are reported by region to the Medical Advisory Committee as well as via physician newsletters. In addition, interventions to promote improvement in documentation are developed and implemented based on these results.

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: UnitedHealthcareOnline.com → Tools & Resources → News → Network Bulletin.

Transferring Member medical records
If you receive a request from a Member to transfer their medical records, please do so within 7 days to ensure continuity of care. In order to safeguard the privacy of the Member’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 Member’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 Members 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

Network termination guidelines
If we choose to terminate the network participation of a physician or other health care professional, we will give the physician or health care professional a written termination notice. The termination notice will include the reason for the termination, an opportunity for a review or hearing consistent with state and federal requirements, and the effective date of the termination. If the credentialed practitioner or health care professional disagrees with the termination decision, he or she may request an appeal hearing or review. The hearing panel will be comprised of three physicians or health care professionals who were not involved with the initial determination and have representation from same/similar specialty.

Reassignment of Members who are in an ongoing course of care or who are being treated for pregnancy
We adhere to the following guidelines when notifying Members affected by the termination of a physician or other health care professional:

• All Members 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 Member require transitional care; the same notification procedures hold true for patients being seen regularly by a specialist who is terminated.*
• Patients 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.
• Patients 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.

Disciplinary policies and procedures

Disciplinary actions
Disciplinary action against a participating physician or other health care professional may be taken as a result of any adverse quality-of-care, credentialing, and/or administrative issue.

The following entities have the authority to recommend and implement disciplinary action:

• UnitedHealthcare National Provider Sanctions Committee (NPSC)
• UnitedHealthcare National Peer Review Committee (NPRC)
• Our Medical Director (in rare situations) may institute immediate disciplinary action

Notice of contract termination and appeal rights
We grant physicians and certain health care professionals the right to appeal certain disciplinary actions imposed by us. The appeals process is structured so that most appeals for terminations, not including non-renewal of the physician’s contract with us, can be heard prior to disciplinary action being implemented. In these cases terminations from the plan are effective as follows:

* CT Members - Transitional services may continue on an in-network basis for up to 120 days from the date of notice to the Member
NY Members - 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 Members - Transitional period varies depending on required services Members in this state must contact Customer Service for specific details.
• New York - 60 days after receipt of written notice to the physician
• Connecticut and New Jersey - 30 days after final written notice to the physician

Exceptions to above notification and termination time frames:
• Quality-of-care issues that may result in imminent harm to a Member
• Determination of fraud
• Denial of participation for failure to meet recredentialing criteria
• Final disciplinary action by a state licensing board or other governmental agency that impairs the physician's ability to practice

Appeal hearings
Physicians are entitled to a hearing before a panel of peers in response to termination from the health plan as a result of any disciplinary process except:
• Quality-of-care issues that may result in imminent harm to a Member or Members as determined by the National Peer Review Committee.
• Failure to meet recredentialing criteria that results in denial of participation with us that does not include nonrenewal of contract; additional information may be submitted.
• Non-renewal of contract.
• Final disciplinary action by a state licensing board or other governmental agency that impairs the physician's ability to practice, consistent with the applicable terms of the UnitedHealthcare Credentialing plan.

Filing a disciplinary action appeal
The practitioner must request an appeal in writing within 30 days of delivery of notice of the Disciplinary Action. Failure to submit an appeal within the 30 days will be deemed a waiver of any appeal rights. The physician should indicate whether or not he or she wishes a hearing or review. The physician is encouraged to submit any additional information about his/her case together with the appeal.

Reporting of disciplinary actions to regulatory agencies
Web-based reporting systems were implemented by the National Practitioner Data Bank (NPDB) to report disciplinary actions when required. In accordance with the Federal Health Care Quality Improvement Act of 1986 and accompanying regulations, we must report applicable disciplinary actions to the NPDB and the appropriate state licensing board(s).

The following actions are reported:
• Termination due to alleged mental or physical impairment, misconduct or impairment of patient safety or welfare
• Voluntary or involuntary termination of a contract or affiliation to avoid the imposition of disciplinary action
• Termination for determination of fraud
• Knowledge of any professional misconduct
• Any disciplinary action imposed for quality reasons that adversely affects the clinical privileges of a physician for a period longer than 30 days

Disciplinary actions are reported to the following state licensing boards within 30 days of obtaining knowledge of any of the above actions.

Connecticut
Connecticut Division of Medical Quality Assurance
150 Washington Street
Hartford, CT 06106
Telephone (860) 509-8000
The Quality of Care department is responsible for completing the reporting procedure to State Licensing Authority, National Practitioner Data Bank (NPDB), and Healthcare Integrity and Protection Data Bank (HIPDB), as applicable.

**Disciplinary action and appeals process for administrative and quality of care**

A physician or health care professional may request an appeal (fair hearing or review) after UnitedHealthcare takes adverse action to restrict, suspend or terminate their ability to provide health care services to a Member.

A notice will be provided within 30 calendar days after the adverse action is taken that will include the following:

- Final action will be reported to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank and appropriate state licensing board.
- A description of and reason for the action.
- Right to request an appeal in writing within 30 calendar days after receipt of the notice.
- A summary of the physician’s or health care professional’s appeal rights provided

After receipt of a request for an appeal, the physician or health care professional will be notified of the fair hearing or review date within 30 calendar days of the receipt of request for appeal, or within the timeframe required by applicable state law. The fair hearing or review will take place within 60 calendar days of the date UnitedHealthcare receives the request for appeal, or within the timeframe required by applicable state law.

**Claims, Reimbursement and Member 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 Member.
- 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.”

**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 need to provide proof of denial from the primary carrier and will have 90 days from the date of the primary carrier Explanation of Benefits to submit the claim to us.
• If the Member has a health benefits plan with a specific time frame regarding the submission of claims, the time frame in the Member’s Certificate of Coverage will govern. Claims submitted after the 90-day filing deadline that do not fit one of these exceptions will not be reimbursed; the reason stated will be “filing deadline has passed” or “services submitted past the filing date.”

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 → Transactions → Submit → Claims Submission Information. Appropriate state and federal guidelines are applied to determine whether the claim is complete and can be processed.

**Processing**

**Time frame for processing claims**

The state-mandated time frames for processing claims for our fully insured Members are listed below. The time frames are applied based upon the situs state of the Member’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) 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, you should bill the primary insurance company first and when you receive the primary carrier’s explanation of benefits (EOB), submit it to us along with the claim information. These claims must be submitted via paper claim with primary EOB attached. Oxford secondary claims cannot be sent electronically.

We participate in Medicare Crossover for all of our Members who have Medicare primary. This means Medicare will automatically pass the EOB to us electronically after the claim has been processed. We can then process the claim as secondary without a claim form or EOB from your office. When you receive your EOB 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 → Practical Resources → Medical and Administrative Policies → Modifiers.

**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 → Practical Resources → Medical and Administrative Policies → 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 tax ID number 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 → Manage Your Practice → Forms → W-9 / FTIN Form & Provider Demographic Update Form.

Electronic payments and explanations of benefits (EOBs)
We would like all providers to sign up for electronic payments and EOBs through PNC Remittance Advantage. For more information, refer to Oxfordhealth.com → Providers or Facilities → Tools & Resources → Manage Your Practice → Administrative Ease → Electronic Payments & Remittance Advice Fact Sheet or call PNC at (877) 597-5489, option 1.

Additional Copies of EOBs
Should you misplace an EOB and need another copy, you can obtain one by performing a claims status inquiry on Oxfordhealth.com → Providers or Facilities → Transactions → Check → Claims.

Claim reconsideration
If you disagree with the way a claim was processed or need to submit corrected information, you generally have 180 days from the date of the EOB to appeal the claim. If the claim is for a New Jersey Member you have 90 days from the date of the EOB. Refer to Internal appeals-Claims payment disputes and Claim Submission – Corrections/Resubmissions in the How to contact Oxford Commercial section at the beginning of this Supplement for more information.

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: www.health.ny.gov → Laws and Regulations (on the right under Site Contents) → Health Care Reform Act

Member billing
Balance billing policy
Physicians and other health care professionals in our network may not bill Members for unpaid charges above their specific Member cost sharing. 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 Member.
Member 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 Member’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 Members at the rates established in the attachment of the hospital contract.

Ancillary facility reimbursement - Reimburse ancillary health care professionals for services provided to Members at the rates established in the fee schedule or in attachment or schedule of the ancillary contract.

Payment Appeals

Participating physician and other health care professional appeals
Our administrative procedures for Members with an Oxford product require facilities, physicians or other health care professionals participating in our network to file an internal appeal before proceeding to arbitration under their contract. You must file your appeal request within 180 days of the date noted on the initial determination notification. On appeal, you must include all relevant clinical documentation, along with a Participating Provider Review Request Form. To request the review of a claim, please call Provider Services to speak to a Service Associate at (800) 666-1353.

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 Member 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 Member 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 Claims Review Request Form for Commercial Members with the “Appeal” box checked off. This form is available on our website: Oxfordhealth.com → Providers or Facilities → Tools & Resources → Manage Your Practice → Forms → Participating Claims Review Request Form.

Note: There is a separate appeal process for Member 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.

The decision in such arbitration is binding to you and to us, pursuant to your provider agreement. The appropriate arbitration authority, such as the AAA, will have processes in place for the prompt resolution of cases involving time sensitivity.
The 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 Members**

If you have a dispute relating to the payment of a claim for services that were rendered to a New Jersey Commercial plan Member on or after July 11, 2006, your individual dispute may be eligible for a two-step appeal process. 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:** 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 → Manage Your Practice → Forms → Participating Claims Review Request Form.

**Arbitration:** 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 PICPA
50 Square Drive, Suite 210
Victor, New York 14564
Fax number: (585) 425-5296

(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 Members**

This external appeals process applies only to services provided to Commercial Members who have coverage by virtue of a HMO or insurance plan licensed in New York State. This does not apply to the self-funded line of business.

**Retrospective review**

You may request an external appeal on your own behalf when we have made a retrospective final adverse determination.

**Internal medical necessity appeal**

When denied retrospectively by our Clinical Services department, a participating provider seeking to pursue an external appeal must first follow the first-level Member appeal process with our Clinical Appeals department. All requests for such internal retrospective appeals must be made within 180 days of receipt.
External appeal process
If the Clinical Appeals department upholds all or part of such an adverse determination, the Member or Member’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

Concurrent Review
If the Clinical Appeals Department upholds all or part of a concurrent review adverse determination, you may submit an
appeal on your own behalf.

• Providers requesting external appeals of concurrent adverse determinations (including when done as the Member’s
designee) may not balance bill the Member for the service.
• Payment of the fee for concurrent external appeal reviews has been revised as follows:
  • If our determination is upheld in whole, payment for the external appeal is your responsibility. Payment must be
made within 45 days from the date the determination is received (interest will begin to accrue after the 45-day
period).
  • If our determination is upheld in part, payment will be divided evenly between us and you. Payment must be paid
within 45 days from the date the determination is received (interest will begin to accrue after the 45-day period).
A hardship request may be made to the Department of Insurance once regulations have been adopted.
• For appeals you submit acting as the Member’s designee, the party responsible for paying the fee will depend
on whether the appeal is accepted as a Member appeal. If the appeal is accepted as a Member appeal, we will be
responsible for paying for the appeal.
• Please send external appeal requests to:

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 Members or their designees would like to file an appeal, they must hand-deliver or mail a written request within
180 days 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 Members
Members have the right to request an expedited appeal.
In order to request an expedited appeal, the Member 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 Member 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 Member appeals unit. If a Member would like to file an appeal on a claim determination, they must mail all administrative appeals to UnitedHealthcare Grievance Review Board. See *How to contact Oxford Commercial* section for address information.

**Second-level Member appeals for Members**

Members have the right to take a second-level appeal* to our Grievance Review Board (GRB). If the Member remains dissatisfied with the first-level appeal determination, the Member requests for a second-level appeal. Members 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 Members**

New York, New Jersey and Connecticut Members have the right to appeal a medical necessity determination to an external review agent. Members 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 Member’s certificate of coverage was issued, not where the Member resides.

**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
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

**New York**

Consumer Services Bureau
State of New York Insurance Department
25 Beaver Street
New York, NY 10004-2349
(212) 480-6400

* 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 Members on your panel who need assistance, even if the Member 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.
- 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 Member’s PCP
• Precertify 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 Members; if you believe consent is required from the specific Member, 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 Member has a non-gatekeeper plan and the service is covered and medically necessary.
• A referral is not on file and the Member 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 Member will be required to pay any deductible and/or coinsurance based on his/her out-of-network benefits.
• The Member 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 Member be balance billed.

Specialists as PCPs
A Member 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 Member’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 Member 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 Members with a gatekeeper plan.

Hospitals and ancillary facilities
A Member must be enrolled and effective with us on the date the hospital and ancillary service(s) are rendered. Once the facility verifies a Member’s eligibility with us (we will maintain a system for verifying Member status), that determination will be final and binding on us, except to the extent the Member 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 disenrolls the Member 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 Member or another payer. Furthermore, a Member 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 Member’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 Members
• 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 Members upon admission or on the day of admission*

* If the facility is unable to determine on the day of admission that the patient is our Member, the facility will notify us as soon as possible after discovering that the patient has coverage with us.
• 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 Members 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 Members 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 Members
• 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 Member cost of services

All services performed for Members 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 Member medical records and related patient information
• Patient-centered education
• Informed consent; including, advising a Member prior to initiating services when a particular service is not covered and disclosing to the Member 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 Member in need of the health care they provide. The organization and its physicians and other health care professionals must make public declarations (i.e., through posters or mission statements) of their commitment to nondiscriminatory behavior in conducting business with all Members. These documents should explain that this expectation applies to all personnel, clinical and nonclinical, in their dealings with each Member.

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 Members 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 Members 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. Members 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 Member 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 Members and to allow us to better manage the use of medical services. Practitioners may refer Members to these programs, or Members may self-refer to Oxfordhealth.com → Member → Tools & Resources → Managing Disease or by utilizing phone numbers below.

The Case Management/Disease Management programs below are comprehensive case management programs supported by registered nurses.

**Active Care EngagementSM (ACE)**

(877) 759-3059

The ACE program is a comprehensive clinical nurse case and disease management program for high-risk Commercial Members with heart failure, coronary artery disease and diabetes. We are contracted with Healthways, Inc. to manage the ACE program.

**Oxford Cancer Support ProgramSM (OCSP)**

(800) 835-8021

The OCSP is a clinical nurse case management program for Members over the age of 18, with an Oxford Commercial ASO product, who are diagnosed with cancer (excluding acute leukemia), and are in active treatment or end-stage management.

**Rare Chronic Care Program**

(866) 217-2921

Contracted with Accordant Health Services to deliver an integrated, comprehensive clinical nurse health case and disease management program for Commercial Members. Conditions addressed include myasthenia gravis, lupus, hemophilia, cystic fibrosis, and multiple sclerosis.

**Transplant Program**

(888) 936-7246

OptumHealth is contracted to manage all aspects of every transplant including Prior Authorization and coordination of services.

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* 28 CFR Sect. 36.303(c)
** 28 CFR Sect. 36.303(b)(1)
Population Health Programs (Oxford Member Programs)

**Better Breathing® Asthma Intervention Program**
(800) 665-4686
The asthma program is designed to emphasize patient education and promote compliance with the guidelines established through the National Institutes of Health.

**Living with DiabetesSM**
(800) 665-4686
Our diabetes program is structured to educate Members with diabetes and to improve their self-management by providing them with resources such as educational materials and support organizations, and is designed to educate physicians about current treatment guidelines set by the American Diabetes Association.

**Heart SmartSM Programs**

**Cardiovascular Disease**
(800) 665-4686
The Heart Smart cardiovascular disease (CVD) program is designed to address the health needs and concerns of Members who are at risk or at high risk for CVD (primary), and (secondary).

**Heart Failure**
(800) 665-4686
The Heart Smart heart failure (HF) population health management program is a comprehensive, population-based health management program for people with heart failure.

**Preventive Health Program**
(800) 665-4686
The program focuses on childhood and adolescent well care and immunizations, women’s health, (mammography, pap smears), colorectal screening, and adult immunizations.

**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 Members
- 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 Members 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
- Member 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 Members
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:

Preauthorization - UR decisions will be made and notice will be provided to you and the Member.

Concurrent review - UR decisions will be made and notice will be provided to the Member or the Member’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 Member’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
Member appeals must be submitted to us or our delegate within 180 days from the receipt of the initial adverse UR determination. While Member appeals may be initiated verbally by calling our Customer Service department at the number on the Member 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 Member or Member’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 Member 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 Member verbally and/or in writing. If the Member agrees to waive the internal UR appeal process, we will provide a written letter with information regarding filing an external appeal to the Member within 24 hours of the agreement to waive the internal appeal process.

Components of a Final Adverse Determination Notice
Each notice of final adverse determination will be in writing, dated and include the following components:

• A clear statement describing denial as applicable to the Member;
• A clear statement with the final adverse determination;
• The health care plan's contact person and his/her telephone number;
• Coverage type;
• The name and full address of the health care plan's utilization review agent;
• Agent’s contact person and his/her telephone number;
• A description of the health care service that was denied; and
• A statement that the Member may be eligible for an external 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:

- Interrater 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 Members 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 → Practical Resources → Clinical and Preventive Guidelines.

**Members’ rights to external appeal**

The Member 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 Member’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 Member’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 Member than any covered standard health service or procedure; or
  - A rare disease treatment for which the Member’s attending physician certifies that there is no standard treatment.
  - A clinical trial for which the Member 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 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 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.

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<td>uhcrivervalley.com → Providers</td>
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<td>• Check claims status</td>
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<td>• Find newsletters</td>
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<td>• Find other forms</td>
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<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</td>
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<td>Claims submission on paper</td>
<td>UnitedHealthcare of the River Valley Commercial</td>
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<td>P.O. Box 5230</td>
<td>• Submit paper claims in hard copy (as outlined in the Claims section of this Supplement).</td>
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<tr>
<td>Tax ID numbers (TIN)/ Provider ID</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 Contact</td>
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<tr>
<td>ID numbers</td>
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<td>our e-Business department for technical assistance about Tax or Provider ID numbers, or for more</td>
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<td>information go to uhcrivervalley.com.</td>
</tr>
<tr>
<td>Claims payment reconsideration requests</td>
<td>Phone: Midwest: (800) 747-1446</td>
<td>• Get help with questions regarding claims payment, or submit a reconsideration request.</td>
</tr>
<tr>
<td></td>
<td>Southeast: (800) 224-6602</td>
<td>• A copy of the claim and supporting documentation will be required for Reconsideration review Please</td>
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<td>Mail: UnitedHealthcare of the River Valley P.O. Box 5230</td>
<td>mark the claim as a “Payment Reconsideration” to ensure the claim is routed to the appropriate area for</td>
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<tr>
<td></td>
<td>Kingston, NY 12402-5230</td>
<td>review.</td>
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<td>• Determine Customer eligibility and benefits.</td>
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<td>• Check claim status.</td>
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<td>• Update facility/practice data.</td>
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<td>• Obtain information about the appeal submission process.</td>
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<tr>
<td>Enterprise Voice Portal</td>
<td>Phone: Illinois/Iowa/Wisconsin: (800) 747-1446;</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>
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<td>Tennessee/Virginia/Arkansas/Georgia: (800) 224-6602</td>
<td>(888) 242-9058</td>
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<tr>
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<td>Phone: (800) 747-1446 Ext: 65212</td>
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<tr>
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<td>Mail: UnitedHealthcare</td>
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<tr>
<td></td>
<td></td>
<td>Attn: Clinical Coverage Review</td>
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<tr>
<td></td>
<td></td>
<td>1300 River Drive, Suite 200</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Moline, IL 61265</td>
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</table>
| **Mental health, substance abuse, vision, or transplant services** | Illinois/Iowa/Wisconsin: (800) 747-1446  
Tennessee/Virginia/Arkansas/Georgia: (800) 224-6602 | • Inquire about a Customer's behavioral health, vision, or transplant services  
• Most mental health and substance abuse services must be approved (preauthorized) through the contracted mental health or substance abuse vendor. |
| **Skilled/extended Care**                     | Phone: Midwest: (800) 747-1446  
Southeast: (800) 224-6602  
Fax: Midwest: (888) 534-3258  
Southeast: (800) 880-5403 | • Request preauthorization for skilled/extended care |
| **Pharmacy services/ prescription drugs requiring preauthorization** | OptumRx Phone: (800) 711-4555  
uhcrivervalley.com → Pharmacy | • Request preauthorization for prescription drugs as outlined in this Supplement  
• View the prescription drug list (PDL) |
| **Preauthorization for end-of-life care and home health care including infusion services** | Phone: (800) 747-1446 Ext: 65212  
Fax: (800) 340-2184 | • Request preauthorization for home health care services by downloading a Home Health Authorization Form:  
uhcrivervalley.com → Providers → Forms → Home Health Authorization Form |
| **Out-of-network referrals**                  | Fax: (800) 299-3779  
Phone: (800) 747-1446 Ext: 65287  
Mail: UnitedHealthcare  
Attn: Clinical Coverage Review  
1300 River Drive, Suite 200  
Moline, IL 61265 | • Request an out-of-network (OON) referral by completing an OON Request Form, at:  
uhcrivervalley.com → Providers → Forms → Out-of-Network Referral Form |
| **Notification of inpatient admissions**      | Phone: Midwest: (800) 747-1446  
Southeast: (800) 224-6602  
Fax: Midwest: (888) 534-3258  
Southeast: (800) 880-5403 | • Notify us of inpatient admissions |
| **Disease Management**                       | Toll-Free Phone Number: (800) 369-2704, Option # 4  
Hours: 8:00 a.m. – 4:30 p.m. Central Time  
Toll-Free Fax Number: (866) 950-7759,  
Attn: CMT Coordinator  
E-mail: MailWebCDM@uhc.com  
Online: uhcrivervalley.com → Providers → Health Programs | • Request Disease Management services for your patients  
• Request Consumer and Provider Rights and Responsibilities  
• Provide information to the Care Management Tool (CMT) Coordinator |
| **Case Management**                          | Phone: (800) 369-2704, Ext 2 for Case Management | • Request Case Management services for your patients |
| **Outpatient Cardiac Catheterization Inpatient/ Outpatient Electrophysiology Implants, Outpatient Echocardiogram and Outpatient Stress Echocardiogram** | (866) 889-8054 CareCore National  
8:00 a.m.- 8:00 p.m., time zone specific | • Request preauthorization for services |
Claims

Claims format
All claims for medical or hospital services must be submitted using, as applicable, the CMS-1500 or UB-04, their successor forms for paper claims and HIPAA standard professional or institutional claim formats for electronic claims. The use of black ink is recommended when completing a CMS-1500 claim. Black ink on a red CMS-1500 claim will allow for optimal scanning into our claims processing system.

Electronic claims submission and billing
You should submit your claims electronically. Specific exceptions to this requirement are set forth below.

For electronic claims submission requirements, please see the River Valley Entities’ HIPAA Transaction Standard Companion Guide. The River Valley Entities’ HIPAA Transaction Standard Companion Guide is located at 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 for timely filed reconsideration requests.
- Claims submitted for Correct Coding Initiative (CCI) edit reconsideration.
- Claims submitted with unlisted procedure codes if sufficient information is not in the notes field.

Except as provided above, please do not send claims on paper or with claim attachments unless we request it.

Note: No special rules apply to electronic claims that append Modifier 59 or for claims for dental pre-treatment; however, as noted above certain pre-treatment claims must be submitted on paper.
Claims with special rules for electronic submission

• **Corrected Claims:** must include the words “corrected claims” in the notes field. Your software vendor can instruct you on correct placement of all notes.

• **Unlisted Procedure Code Claims:** must include a sufficient description in the notes field. If you are not able to do so you must submit a paper claim.

• **Claims That Require Dates of Service by Line Item:** Claims for occupational therapy, speech therapy, physical therapy, dialysis, mental health or substance abuse services require the date of service by line item. We do not accept span dates for these types of claims.

• **Secondary Coordination Of Benefits (COB) Claims:** must include the following fields:
  - **Institutional:** Payer Prior Payment, Medicare Total Paid Amount, Total Non-Covered Amount, Total Denied Amount.
  - **Professional:** Payer-Paid Amount, Line Level Allowed Amount, Patient Responsibility, Line Level Discount Amount (contractual discount amount of other payer), Patient-Paid Amount (Amount that the payer paid to the Customer not the provider).
  - **Dental:** Payer Paid Amount, Patient Responsibility Amount, Discount Amount (contractual discount amount of other payer), Patient Paid Amount (Amount that the payer paid to the Customer not the provider).
  - **Span Dates:** Exact dates of service are required when the claim spans a period of time. Please indicate the specific dates of service in Box 24 of the CMS-1 500, Box 45 of the UB-04, or the Remarks field. This will eliminate the need for an itemized bill and allow electronic submission.

Requirements for claims (paper or electronic) reporting revenue codes

• All claims reporting Revenue Codes require the exact dates of service if they are span dates.

• If Revenue Code 270 is submitted by itself on an institutional claim for outpatient services, we require a valid CPT or HCPCS code or description.

• If you report Revenue Code 274, you are required to provide a description of the services or a valid CPT or HCPCS code.

• Claims reported with Revenue Codes 250-259 require an itemized statement if the charges exceed $1,000.

• All claims reporting the Revenue Codes on the list below require that your report the appropriate CPT and HCPCS codes.
Revenue codes requiring CPT® and HCPCS codes

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Electronic Data Interchange (EDI)

You may use EDI to conduct business with us electronically, including submitting claims, receiving remittances, and transferring funds. To enroll, please call EDI Customer service at (866) 509-1593 or send an email to: RVITEDISolutions@uhc.com.

Claims transmission

You should inform your office software vendor that you want to begin electronic transmission of claims to the River Valley Entities, Payer ID 95378.

All claims are received through our clearinghouse, OptumInsight, OptumInsight.com/edi. The clearinghouse sets up all claims as commercial. Your EDI software vendor is responsible for establishing your connectivity to the clearinghouse.
Your vendor can advise you of the specific requirements that apply to claims transmissions to the River Valley Entities.

**Electronic Remittance Advice (ERA)**

To enroll for 835 ERA, your software vendor should go to our clearinghouse website at OptumInsight.com/edi and click on “ERA Information.” Using our Payer ID (95378), the vendor can complete the short enrollment form. ERAs will be returned through the clearinghouse.

**Electronic Funds Transfer (EFT)**

To initiate EFT, please send an email to: JDHPDemo@uhc.com, with “EFT Enrollment” as the subject line. Please include a contact name, your TIN, your telephone and fax numbers and your e-mail address. A representative will send you the EFT enrollment documents.

**EDI acknowledgment/status reports**

Your software vendor will provide you with a report that shows only that an electronic claim left your office. It does not confirm that claims have been received or accepted at the clearinghouse or by us.

Clearinghouse acknowledgment reports do show the status of your claims. They are returned after each transmission so you are able to confirm immediately whether a claim reached us for payment or was rejected because of an error, because additional information is needed or for any other reason. This allows you to correct any errors and retransmit a claim the same day so there will be no delay in processing.

You will also receive various Status Reports from the River Valley Entities that provide additional information on the status of claims including copies of Explanations of Benefits (EOBs) and denial letters that may request additional information.

It is very important that you carefully review all Vendor Reports, Clearinghouse Acknowledgment Reports and the River Valley Entities’ Status Reports as soon as you receive them. You will know the status of each claim you have submitted and you will be able to correct any errors promptly.

**Provider e-Services**

The River Valley Entities’ provider e-Services can be accessed at uhcrivervalley.com. You will find the following tools that will allow you to quickly and efficiently obtain important and up-to-date information you need when providing services to our Customers:

- **Claim status review**
  You may locate specific claims using either your provider ID or a specific Customer’s ID and obtain a claim summary or line-item detail about claims status including whether we have received the claims and whether they have been paid, pended or denied.

- **Benefits and eligibility**
  You may verify the eligibility of your patients before you see them and obtain information about their benefits including required co-payments and any deductibles, out-of-pockets maximums or co-insurance for which your patients are responsible.

- **PCP roster**
  You may find a list of all Customers who have designated you as their Primary Care Physician.

**Registration for provider e-Services**

Before you may use Provider e-Services, your office is required to designate a Security Administrator. The Security Administrator (1) will be the primary contact with the River Valley Entities and (2) is responsible for maintaining access for all users in your office. An officer of your organization who has authority for the Tax IDs seeking access to Provider

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* For River Valley Customers, Providers are not able to submit claims via the “Connectivity Director” or UnitedHealthcareOnline.com All-Payer Gateway TM. 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 → Register Now.

Within 7 to 10 days after submission, the Security Administrator will receive a User ID and Password in separate letters via US mail.

For additional information on the registration process, go to uhcrivervalley.com, and in the section entitled “e-Services” select “Register Now” or the link for providers under “Why use e-Services”.

For technical assistance or information, you may contact our e-Business department from 8:00 a.m. – 4:30 p.m. CT by telephone at (866) 509-1593.

**Payment policies**

In accordance with your agreement with us, reimbursement of claims is subject to payment policies, among other things. You may find these policies at uhcrivervalley.com → Provider → Coverage Policy Library. Change in our payment policies are generally announced in the Network Bulletin found on UnitedHealthcareOnline.com.

We also apply coding edits procedures, based primarily on the National Correct Coding Initiative (NCCI) edits developed by the Centers for Medicare and Medicaid Services (CMS) as well as the CMS’ Outpatient Code Editor (OCE). You may find the NCCI edits and the OCE at 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 (also referred to as “Coverage Policies” in the River Valley Entities’ Coverage Policy Library), to assist us in making coverage determinations which includes evaluating whether a particular treatment or service is medically necessary and appropriate in a particular case. The Coverage Policies are developed and approved by a committee that includes physicians and other medical professionals representing multiple specialties and are based on current clinical practices, current peer-reviewed medical literature, evidence-based medicine and other relevant factors. You may find and obtain copies of our current Coverage Policies at uhcrivervalley.com → Provider → Coverage Policy Library.

Coverage determinations are also based on other factors including but not limited to a Customer’s eligibility, the Customer’s benefit plan document (such as a summary plan description), applicable state or federal law benefit mandates, and evidence-based guidelines which may include MCG™ Care Guidelines, (formerly known as Milliman Care Guidelines®). Our clinical coverage criteria are generally reflected in the Coverage Policies. Our clinical coverage criteria are based on current clinical principles and processes and evidence-based practices and are generally reflected in our Coverage Policies. Coverage Policies are developed as needed and are regularly reviewed and modified as necessary to ensure that they reflect changes and advances in healthcare treatment.

We announce new policies, retired policies and amendments to existing policies in the monthly Policy Update Bulletin. This communication provides online notice of Coverage Policy updates and is published on the first calendar day of every month at uhcrivervalley.com → Providers → Coverage Policy Library → Policy Update Bulletin.
As a supplemental reminder to the detailed policy update summaries provided in the monthly Policy Update Bulletin, a list of recently approved and/or revised Coverage Policies is also provided in the bimonthly Network Bulletin available at UnitedHealthcareOnline.com.

**Preauthorization**

**Services that require preauthorization**

“Preauthorization” means a process of evaluating and authorizing coverage for services using clinical coverage review criteria. The River Valley Entities require preauthorization for certain procedures, items of durable medical equipment (DME), prescription drugs and other services. Many are indicated throughout this Supplement and are posted at uhcrivervalley.com → Coverage Policy Library → Services Requiring Preauthorization.

As of 10/1/13, preauthorization is required for the following procedures, devices and services and is also required for any other procedure, device, drug or service if indicated elsewhere in this Supplement. If you have questions about whether a procedure, DME, prescription drug or service requires preauthorization, contact a UnitedHealthcare Customer Service Representative for the most current information. We reserve the right to remove a procedure, DME, drug or other service from the preauthorization list before notice is provided to you.

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Preauthorization: Physician responsibility for submitting adequate clinical documentation

It is your responsibility to request preauthorization when it is required. It is important that you provide complete clinical information and medical documentation to support the services you are requesting at the time you submit your request so that we may promptly determine whether the services are covered and medically necessary. We make these determinations based upon the information available to us at the time we are required to make a decision. We will consider additional information provided within the time period allowed for review, but delayed submissions increase administrative time and work for you and for us.

The preauthorization request also must include the documentation needed to evaluate each particular procedure, device, drug and service for which you seek authorization. You should refer to our Coverage Policies when determining what documentation and information you should provide.

How to request preauthorization when required

Submitting a request

Please refer to the How to contact River Valley section at the beginning of this Supplement for information regarding how to submit a request for preauthorization when required.

Failure to obtain preauthorization when required may result in denial of a claim and you cannot bill the Customer for such denied services.

Preauthorization review hours

The River Valley Entities’ staff is available for review of preauthorization requests from Monday through Friday from 8:00 a.m. CT to 4:30 p.m. CT with the exception of national holidays and the day after Thanksgiving. Medical Directors are available to discuss clinical policies or decisions by calling the following numbers: Illinois/Iowa/ Wisconsin: (800) 747-1446; Tennessee/Virginia/Arkansas/Georgia: (800) 224-6602.

Clinical review of a preauthorization request

When we receive a preauthorization request, our Clinical Coverage Review Department evaluates the submitted clinical information to determine whether the procedures, devices, drugs or other services are medically necessary and appropriate in a particular case. River Valley Entities’ nursing staff may make decisions to approve care based on specific criteria. Care and/or services that do not fall within the criteria are referred to a Medical Director or other appropriate reviewer such as a Board-Certified Physician in the applicable specialty or a Registered Pharmacist, to evaluate circumstances or conditions that the criteria do not address. Only physicians and other appropriate providers may issue a medical necessity denial for coverage.

The River Valley Entities’ staff and their delegates who make these decisions are not rewarded for denying coverage. The River Valley Entities and its delegates do not offer incentives to physicians to encourage underutilization of care or services.

The treating physician has the ultimate authority for the medical care of the patient. The medical management process does not override this responsibility. If there is disagreement regarding whether care or treatment is medically necessary, the treating physician may care for the patient without any encumbrances from the utilization management process.

Timing of utilization management decisions

We make our utilization management decisions within the time periods required by state and federal law (including ERISA when applicable) for the nature of the request, and in accordance with National Committee for Quality Assurance (NCQA) standards.

We also provide notice of our decisions to providers and Customers in the form and manner required by applicable state and federal law and in accordance with NCQA standards and River Valley Entities’ policy. Among other things, all denial letters outline a Customer’s appeal rights, including, where applicable, the right to an expedited and/or external review, as well as the requirements for submitting an appeal and the requirements for our response. A Customer may designate a health care professional to appeal a decision on the Customer’s behalf. A copy of the Customer’s written consent is required and must be submitted with the appeal.
Facility Utilization Review

Notification of inpatient admission required
Facilities are required to notify us of an inpatient admission within 24 hours of the admission or on the next business day following a holiday or weekend admission. The notification should include the Customer’s name, identification number, admitting diagnosis, and the name of the attending physician.

Failure to notify
If the facility does not notify us of an inpatient admission as required, claims will be returned to the facility as not allowed (not allowed to bill the Customer for the services). The facility must contact our Utilization Management department with case information and a Medical Director will determine the appropriateness of the admission and length of stay. The facility will be responsible for all hospital charges deemed not allowed by our Medical Director. The facility will need to resubmit the claims.

Inpatient review
Inpatient review is a component of our utilization management activities. The Medical Director and other clinical staff review Customer hospitalizations to detect and better manage over- and under-utilization and to determine whether the admission and continued stay are medically appropriate and consistent with evidence-based guidelines.

Where appropriate, the River Valley Entities also use 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.

If our conclusion does not change after additional review and discussion, and you do not agree that the Customer should be discharged, the Medical Director will determine what action, if any, to take under the Provider Education - Sanction Policy section discussed below. Among other sanctions, the Medical Director may assess a monetary penalty and determine that the Health Plan will not reimburse you for the days of the hospital stay found not to be medically necessary. You have a right to appeal the sanction as described below. Non-reimbursable charges are not billable to the Customer.

The facility and the attending physician have sole authority and responsibility for the medical care of patients. Our medical management decisions do not override those obligations. We do not ever direct an attending physician to discharge a patient. We simply inform you of our determination.
Admission to other facilities

Admission to Rehabilitation Units
All rehabilitation confinements require authorization for admission and are reviewed concurrently for continued services at this level of care. Please refer to the Skilled/Extended Care row in the How to contact River Valley section at the beginning of this Supplement for information on how to submit a request for preauthorization.

Admission to skilled nursing units
A Customer may require inpatient skilled nursing care due to acute illness, injury, surgery, or exacerbation of a disease process.

• Preauthorization is required for all admissions to a Skilled Nursing Facility (or skilled level of care within an acute facility). Please refer to the How to contact River Valley section at the beginning of this Supplement for information regarding how to submit a request for preauthorization.

• The facility must submit the documented plan of care including treatment goals, summary of services to be provided, expected length of stay (LOS), and initial discharge plan.

• Initial certification for admissions will be authorized consistent with the level of care required based upon the anticipated treatment plan.

Concurrent review is conducted at least weekly, or more often if indicated

• The skilled facility provider is responsible for providing appropriate/adequate documentation, including changes in the level of care.

• Approval for additional days of authorized coverage must be obtained prior to the expiration of the authorization.

• Determinations regarding levels of care must consider not only the level of service but also the medical stability of the Customer.

• Disagreements regarding the level of care required will be addressed by our Medical Director in consultation with you (as the physician managing the Customer in the skilled facility, not the transferring attending physician). The appeal procedure can be initiated as desired by the Customer and/or authorized representative when coverage is not authorized.

We determine whether the admission and subsequent stay and care are covered and medically necessary based upon the following clinical guidelines among others:

• Services must be ordered by a physician and be reasonable and necessary for the treatment of the Customer's illness or injury, i.e., be consistent with the nature and severity of the individual's illness or injury, particular medical needs, and accepted standards of medical practice.

• The Customer must be clinically stable with clinical and lab findings improving/unchanged for the last 24 hours and diagnosis and initial treatment plan established prior to admission to the skilled nursing facility.

• The services must also be reasonable in terms of duration and quantity. The Customer must require skilled services on a daily basis (i.e., available on a 24-hour basis, 7 days/week). If skilled rehabilitation services are not available on a 7 day-a-week basis, a Customer whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the daily basis requirement when he/she needs and receives those services at least 5 days a week. Skilled services, however, are required and provided at least 3 times per day. Note that the frequency with which a service must be performed does not, by itself, make it a skilled service.

• The nature and complexity of a service and the skills required for safe and effective delivery of that service are considered in determining whether a service is skilled. Skilled care requires frequent patient assessment and review of the clinical course and treatment plan for a limited time period, until a condition is stabilized or a predetermined treatment course is completed. Skilled care is goal-oriented to progress the Customer toward functional independence, and requires the continuing attention of trained medical personnel.
**Admission for observation**
We may review observation services concurrently or post-discharge to determine whether the use of hospital services was appropriate and medically necessary. Inappropriate use of observation services may result in physician education, sanction, or payment denial or any other action permitted under your participation agreement.

Observation services are a means to evaluate and determine a Customer’s need for hospital admission. Observation may be appropriate when determining response to treatment, or monitoring/diagnosing a medical condition when such diagnostic testing or treatment exceeds usual outpatient care. Observation is generally used when 48 hours or less is needed for evaluation of a Customer’s condition. In rare and exceptional cases, observation services may span more than 48 hours. Transition to inpatient admission status from observation is generally indicated when:

- A condition is diagnosed requiring a long-term (usually greater than 48 hours) stay (e.g., acute MI).
- Long-term (usually greater than 48 hours) treatment or monitoring are needed for a condition (e.g., persistent severe asthma).

**Notice of termination of inpatient benefits**
We may determine that an admission and/or a continued stay in a Hospital, Rehabilitation Unit or Skilled Nursing Facility (SNF) are not covered benefits for a number of reasons including, but not limited to the following:

- A Medical Director determines that an admission or continued stay, which was not preapproved at an out-of-network facility, is not medically necessary at the level of care the facility provides;
- Preauthorization was not obtained for a procedure or service subject to that requirement and/or the procedure or service is not a covered benefit under the Customer's benefit plan;
- A Medical Director determines that the Customer's condition is custodial, and is a non-covered benefit;
- A Medical Director and the attending physician determine that continued acute inpatient/Acute Inpatient Rehabilitation/SNF level of care is no longer medically necessary but the patient refuses discharge;
- The Customer has exhausted all existing inpatient or skilled care benefits under his or her benefit plan. If a non-coverage determination is made, written notification will be provided to the physician, the Customer and facility on the day the determination is made.

**Referrals**
An out-of-network (OON) referral means a written authorization provided by a participating physician and approved by the River Valley Entities for services from a non-participating provider. OON referrals must be requested by the Customer’s primary care physician (PCP). If an OON referral is obtained, services received from a non-participating provider are covered at an in-network level of benefits under the Customer’s benefit plan. An OON referral is needed when services are not available from a participating provider and may be needed for various services including, but not limited to, podiatry, chiropractic and mental health/substance abuse services. To determine whether an OON referral is necessary under a Customer's benefit plan, contact Customer Care at the number on the back of the Customer’s health care ID card. Additional information regarding OON referrals is provided in a section below.

An in-network referral allows a Customer enrolled in a primary care coordinator (PCC) plan to access care from a participating provider other than a primary care physician (for instance, a specialist) at the in-network benefit level. Additional information regarding in-network referrals for PCC benefit plans is provided in the sections below.

Referrals are required when we are the primary or secondary payer. Please note that a referral does not guarantee payment of a claim.
In-network referral process for primary care coordinator (PCC) plans

An in-network referral allows a Customer to access care from a participating provider other than a primary care physician (for instance, a specialist) at the in-network benefit level. Referral requests must originate from the Customer’s network PCP. The final decision concerning a referral will be the sole responsibility of the 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 in-network specialist.

Process to facilitate in-network referrals for the Customer:

• The PCP determines the need for an in-network referral to a network specialist, communicates this to the Customer, and sends a letter of referral or phones/faxes a referral to the consulting specialist. The PCP indicates in the referral what services he/she is requesting that the specialist provide.
• Service requests must be a covered benefit under the Customer’s plan and must be made to 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 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 service approval request form and faxing it with documentation for consideration. A copy of the out-of-network referral request form can be accessed at uhcrivervalley.com → Provider → 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 on Quality Assurance (NCQA) standards.
• A letter confirming our approval or denial of a referral will be sent to the Customer and your office.
• If a Customer requests approval after the fact, please advise the Customer that this is contrary to policy and refer the Customer to call the following numbers if they have further questions: Illinois/Iowa/Wisconsin: (800) 747-1446; Tennessee/Virginia/Arkansas/Georgia: (800) 224-6602.
• Participating physicians may not refer their own family members 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 that require preauthorization or have special rules may be found at uhcrivervalley.com → Providers → Preauthorization → Drugs. There are links for the list of drugs with special rules.
- If you order and/or administer any medication that requires preauthorization or special clinical management services, you may be required to acquire those medications from a participating specialty pharmacy, unless we authorize a non-specialty pharmacy in a particular situation.
• Certain drugs are available in quantities up to 90 or 100 day supplies, depending on plan benefit design. A list of many of the drugs on the three-month supply list is available at uhcrivervalley.com. Provider → Pharmacy - 90 and 100 day supply lists. This list is subject to change at any time without notice.

• The River Valley Entities’ Prescription Drug Lists (PDLs), which identify those drugs that currently have special rules are located at uhcrivervalley.com → Pharmacy, and can be found by clicking on the links for: “2014 4-Tier PDL”, “2014 Traditional PDL”, and “2014 Advantage PDL”.

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

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

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

Home health care including home infusion services

• Preauthorization is required for Home Health Care including but not limited to Home Infusion Services.

• You must complete a specific Home Health Authorization Form which you may find at uhcrivervalley.com → Provider → 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 / interpreted by a network physician can be sent to the transplant center for interpretation. Please notify the transplant case manager if assistance is needed in making arrangements. Most of these services are covered under the transplant contract. It is cost effective to use the transplant center when appropriate. It is important that the transplant center be involved in the continuing care of the transplant patient.
Post-transplant care
• Preauthorization is required for all follow-up care. Requests should be made using the standard River Valley Entities’ preauthorization process.
• One year post transplant, Customers will be transferred back to their respective local physician for any additional care management services required.

End of life care
• Some Customers have end of life care benefits which may include hospice services. Preauthorization is required for these services. Approved care is coordinated by the River Valley Entities’ care managers. Requests for end of life care may be faxed to the Home Health Department at (800) 340-2184.

Provider Education – Sanction Policy
The Provider Education/Sanction Policy has been developed to promote your compliance with medical management processes. All network providers including all practitioners, facilities, home health agencies, ambulatory surgery centers and ancillary providers, including durable medical equipment suppliers, are subject to the education/sanction process. Providers may be subject to sanctions for non-compliance with administrative requirements and/or inappropriate utilization of services including provision of services that are determined to be medically unnecessary.

The River Valley Entities’ Medical Directors or Senior Medical Director, Health Services Central Region determine whether a sanction is warranted. They have the authority and discretion to impose monetary and non-monetary sanctions, to place a provider on focused review and/or to require appropriate education. Quality of care issues that meet established criteria are forwarded to and managed by the appropriate UnitedHealthcare department. When appropriate, certain sanctions are reported to regulatory agencies.

Sanctions for inappropriate utilization of services, including the provision of medically unnecessary services, may include denial of payment in whole or part. The provider may not bill the Customer for such services unless the Customer knows that we have determined that a service is not medically necessary, agreed in writing, before the services are provided to be responsible for payment of charges for those services.

Other measures that may be imposed with sanctions include but are not limited to:
• Notification and education regarding the occurrence(s);
• A documented plan for improvement from the provider;
• Focused review of the provider’s practice;
• Additional training and/or mandatory Category 1 Continuing Medical Education (CME). Specific CME will be determined by the Medical Director(s) or Chief Medical Officer (CMO). All expenses associated with training and CME will be the responsibility of the provider;

Providers who are determined to be noncompliant with required medical management processes and provision of services will notified in writing of the areas of noncompliance, including a description of all specific incidents that lead to the determination, the sanction to be imposed and the potential consequences of future non-compliance. A physician will also be notified in writing of any sanction issued to a mid-level professional under the physician’s supervision.

Provider appeal rights
Providers also are notified in writing of their right to appeal via the Network Provider Appeal Process for Sanctions, which includes the opportunity to discuss the determination and sanction with a physician reviewer. If you elect to appeal a sanction, you must notify the issuer of the sanction in writing within 30 calendar days of the date of notification of the sanction. If the initial reviewer does not approve the appeal request, it will be presented to another reviewer of same or similar specialty for the decision. A decision will be made within 30 calendar days of receipt of all information you submit. You will be notified in writing of the appeal decision.
If you disagree with the appeal decision, you have 60 calendar days from the date of the decision on the appeal to notify River Valley Entities of a request for arbitration. The request should be submitted to River Valley Entities in writing. Upon receipt of the request, River Valley will send you information regarding how to initiate arbitration with the American Arbitration Association (AAA).

A request for arbitration must be made to AAA within 180 calendar days of the decision on the appeal. Judgment upon the decision by the arbitrator may be entered in any court having jurisdiction. Each party will bear its own costs and attorney fees. The expenses associated with the arbitration will be shared equally by both parties. Arbitration shall be final and binding on all parties.
UnitedHealthcare West Non-Capitated Supplement

Important information regarding the use of this Supplement

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

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

Note: Please be aware that we may be making changes in 2014 to the PacifiCare name with the PacifiCare companies listed below. If these changes occur, we will communicate with you about them.

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

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<tr>
<th>Legal Entities</th>
<th>Products Offered</th>
<th>Benefits Plans</th>
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<tbody>
<tr>
<td>PacifiCare of Arizona, Inc.</td>
<td>Medicare Advantage</td>
<td>• AARP® MedicareComplete®</td>
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<td>• UnitedHealthcare Dual Complete™</td>
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<td>• UnitedHealthcare® Group Medicare Advantage</td>
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<td>PacifiCare of Colorado, Inc.</td>
<td>Medicare Advantage</td>
<td>• AARP® MedicareComplete® SecureHorizons®</td>
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<td>• UnitedHealthcare® Group Medicare Advantage</td>
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<td>PacifiCare of Nevada, Inc.</td>
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<td>• UnitedHealthcare® Group Medicare Advantage</td>
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<td>UnitedHealthcare of California</td>
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<td>• UnitedHealthcare SignatureValue Flex</td>
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<td>UnitedHealthcare of Oklahoma, Inc.</td>
<td>Commercial and Medicare Advantage</td>
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<td>• AARP MedicareComplete® SecureHorizons®</td>
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<td>• Sharp® SecureHorizons® Plan by UnitedHealthcare®</td>
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<td>• UnitedHealthcare Dual Complete ™</td>
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<td>• UnitedHealthcare Group Medicare Advantage</td>
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<th>UnitedHealthcare of Oklahoma, Inc.</th>
<th>Commercial and Medicare Advantage</th>
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| UnitedHealthcare of Oregon, Inc.        | Commercial and Medicare Advantage | **Commercial:**
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|                                        |                                   | **Medicare:**
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|                                        |                                   | • UnitedHealthcare Group Medicare Advantage                                      |
| UnitedHealthcare Benefits of Texas, Inc.| Commercial and Medicare Advantage | **Commercial:**
|                                        |                                   | • UnitedHealthcare SignatureValue                                                |
|                                        |                                   | **Medicare:**
|                                        |                                   | • AARP® MedicareComplete® SecureHorizons®                                        |
|                                        |                                   | • UnitedHealthcare® Chronic Complete                                              |
|                                        |                                   | • UnitedHealthcare Dual Complete™                                                 |
|                                        |                                   | • UnitedHealthcare® Nursing Home Plan                                             |
|                                        |                                   | • UnitedHealthcare Group Medicare Advantage                                       |
| UnitedHealthcare of Washington, Inc.    | Commercial and Medicare Advantage | **Commercial:**
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|                                        |                                   | **Medicare:**
|                                        |                                   | • AARP MedicareComplete                                                            |
|                                        |                                   | • UnitedHealthcare Group Medicare Advantage                                       |

Administrative services provided by the following affiliated companies: United HealthCare Services, Inc. OptumRx or OptumHealth CareSolutions, Inc. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC) or United Behavioral Health (UBH).
## How to contact us

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<tr>
<th>Resource</th>
<th>Where to go</th>
<th>What you can do there</th>
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<tr>
<td>UnitedHealthcare West</td>
<td>uhcwest.com</td>
<td>• Self-service available 24/7 to provide flexibility to access information you need and the time you need it.</td>
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<td>Provider Portal</td>
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<td>• Get a printable response for all posted information.</td>
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<td>• Register to gain secured access (Login) for uhcwest.com.</td>
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<td>• Create/manage individual user accounts for your team.</td>
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<td>• View the provider directory.</td>
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<td>• Check Customer eligibility Status, up to 10 Customers at a time</td>
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<td>› Primary Care Physician (PCP) assignment and history</td>
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<td>› Plan codes and coverage history.</td>
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<td>• Review Customer benefits/copay detail (including benefits).</td>
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<td>› Medical</td>
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<td>› Outpatient (surgical, rehab, maternity, lab and x-ray).</td>
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<td>› Office visit</td>
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<td>› Inpatient hospital</td>
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<td>› Riders/Supplemental (Pharmacy/Vision/Behavioral).</td>
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<td>• Check claim(s) detail and status (by Customer ID or by TIN).</td>
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<td>• Access/download Capitation/Financial Reports by provider/by state if applicable.</td>
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<td>• Access and submit Medicare Advantage Risk Adjustment data via CMS-HCC Risk Adjustment functionality.</td>
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<td>• Online Notification/Prior Authorization submission, status, and update</td>
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<td>› Submit, check the status of, and update inpatient and outpatient Notification/Prior Authorization requests for UnitedHealthcare West Customers.</td>
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<td>› Obtain a Notification/Prior Authorization reference number upon submission, which can be used to track the case.</td>
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<td>› Provide clinical notes upon submission and receive comments from the UnitedHealthcare West clinical team during the review process.</td>
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<td>› Print copies of Notification/Prior Authorization requests.</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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<tr>
<td>UnitedHealthcare West Provider Portal</td>
<td>uhcwest.com</td>
<td>• Use the Library/Resource Center (before and after authentication) to access the following information:</td>
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<td>› Grievance forms</td>
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<td>› Guidelines &amp; interpretation manuals Health Care Reform</td>
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<td>› Customer related Information (Customer Rights, Health Programs etc.)</td>
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<td>› Pharmacy related information (Formulary/Pharmacy Directory)</td>
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<td>› Plan schedules and codes</td>
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<td>› Product information</td>
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<td>› Provider Disputes Resolution for California providers ONLY</td>
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<td>› Provider Policy and Procedures Manuals</td>
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<td>› Publications (California Language Assistance Program, Communication Highlights)</td>
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<td>› Quality Index Profiles</td>
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<td>› Continuing Medical Education</td>
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<td>› Electronic Data Interchange (EDI) and Clearinghouse information</td>
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<td>› Prior authorization information</td>
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<td>› IVR system information</td>
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<td>› Medicare Physician Fee Schedule Look Up National Provider Identifier (NPI)</td>
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<td>› Contact us via secure email by clicking on “Contact Us”</td>
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<td>• Link to UnitedHealthcareOnline.com and affiliate websites</td>
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<td>• Request a claim reconsideration when attachments are needed for a UnitedHealthcare Commercial, UnitedHealthcare Medicare Solutions, Oxford, UnitedHealthcare West or UnitedHealthcare Community Plan* claim.</td>
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<td>• Check the status of a claim reconsideration request</td>
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<tr>
<td>Optum Cloud Dashboard website</td>
<td>If you aren’t registered for Optum Cloud Dashboard, please go to: UnitedHealthcareOnline.com → Health Information Technology → Optum Cloud Dashboard</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If you are registered on Optum Cloud Dashboard, please go to cloud.optum.com. Quick Reference Guides are available at UnitedHealthcareOnline.com → Help → Optum Cloud Dashboard. For assistance with registration or using Optum Cloud Dashboard contact us at (855) 819-5909 or <a href="mailto:optumcloudsupport@optum.com">optumcloudsupport@optum.com</a></td>
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</tr>
<tr>
<td>Preauthorization (Non-delegated)</td>
<td>Arizona: Medicare Advantage Phone: (800) 746-7405 California, Oregon and Washington: SignatureValue, Medicare Advantage, Direct contract network and medical group/IPA carve-out Phone: (800) 762-8456 Colorado: Medicare Advantage Phone: (800) 746-7405 For complex radiology, contact MedSolutions-medsolutionsonline.com Phone: (888) 693-3211 Nevada: Medicare Advantage Phone: (800) 337-8114 Texas and Oklahoma: Medicare Advantage, SignatureValue Inpatient Notification/Utilization Management Phone: (800) 668-8139</td>
<td>• Request urgent preauthorization approval</td>
</tr>
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<td>• Request routine preauthorization approval</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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<td><strong>Hospital Inpatient Notification</strong>&lt;br&gt;(Non-delegated)</td>
<td><strong>Colorado only</strong>&lt;br&gt;(866) 822-0591 Fax: (888) 714-3991</td>
<td>• Notify us of any admission</td>
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<td><strong>All other UnitedHealthcare West States:</strong>&lt;br&gt;&lt;i&gt;Inpatient &amp; observation&lt;/i&gt;&lt;br&gt;(800) 799-5252 Fax: (800) 274-0569</td>
<td></td>
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<td><strong>Mental health</strong>&lt;br&gt;Medicare Advantage: (800) 508-0088&lt;br&gt;&lt;i&gt;Transplant&lt;/i&gt;&lt;br&gt;(866) 300-7736 Fax: (888) 361-0502</td>
<td></td>
</tr>
<tr>
<td><strong>EDI Support</strong>&lt;br&gt;&lt;i&gt;Encounter Collection, Submission &amp; Controls**&lt;/i&gt;</td>
<td>uhcwest.com&lt;br&gt;Password and User ID are not required to review and access EDI information on uhcwest.com.&lt;br&gt;Online:&lt;br&gt;UnitedHealthcareOnline.com → Contact Us → Electronic Data Interchange (EDI) Claims → EDI Issue Submission&lt;br&gt;OR&lt;br&gt;UnitedHealthcareOnline.com → Tools &amp; Resources → EDI Education for Electronic Transactions&lt;br&gt;Phone: (800) 842-1109,&lt;br&gt;Email: <a href="mailto:supportedi@uhc.com">supportedi@uhc.com</a></td>
<td>• Obtain information on how to submit and receive transactions electronically and technical support&lt;br• Select Provider - Under “Quick Link” - Select “Service and Tools” to review services available for:&lt;br• Eligibility&lt;br• Claim Status&lt;br• CMS-HHC Risk Adjustment ASM&lt;br• Select Provider-Library-Resource Center-Electronic Data Interchange (EDI) to access EDI information.&lt;br• HIPAA Resources&lt;br• Companion Guide&lt;br• EDI Payer ID&lt;br• EDI Resources&lt;br• FAQ&lt;br• Helpful Hints</td>
</tr>
<tr>
<td><strong>Enterprise Voice Portal</strong></td>
<td><strong>Commercial &amp; Medicare Advantage HMO/MCO:</strong>&lt;br&gt;California: (800) 542-8789&lt;br&gt;Azizona/Colorado/Nevada: (888) 866-8297&lt;br&gt;Oklahoma: (877) 847-2862&lt;br&gt;Oregon: (800) 920-9202&lt;br&gt;Texas: (877) 847-2862&lt;br&gt;Washington MCO: (800) 213-7356</td>
<td>• Check eligibility&lt;br• Access Primary Care Physician assignment&lt;br• Verify Plan Code&lt;br• Verify Provider History&lt;br• Access Coverage History&lt;br• Check copay and benefits&lt;br• Check claim status (TIN required)&lt;br• Quick FAX (eligibility and claims)&lt;br• Pharmacy approval&lt;br• Prior Authorization&lt;br• Inpatient notification</td>
</tr>
<tr>
<td><strong>Standard Customer Appeals</strong>&lt;br&gt;Applies only to Commercial UnitedHealthcare Signature Value HMO/MCO</td>
<td><strong>California, Oklahoma, Oregon, Texas, Washington</strong>&lt;br&gt;Mail: Mailstop CA124-0160&lt;br&gt;P.O. Box 6107&lt;br&gt;Cypress, CA 90630&lt;br&gt;Fax: (866) 704-3420&lt;br&gt;CA Phone: (800) 624-8822&lt;br&gt;OK/TX Phone: (800) 825-9355&lt;br&gt;OR/WA Phone: (800) 932-3004</td>
<td>• Request a standard decision on an appeal.</td>
</tr>
<tr>
<td><strong>Medicare Advantage Member Appeals</strong>&lt;br&gt;Applies only to Commercial UnitedHealthcare Signature Value HMO</td>
<td>Mailstop CA124-0157&lt;br&gt;P.O. Box 6106&lt;br&gt;Cypress, CA 90630&lt;br&gt;Fax: (888) 517 7113&lt;br&gt; AARPMedicareComplete.com</td>
<td>• Request a standard decision on an appeal.</td>
</tr>
<tr>
<td><strong>Expedited Appeals</strong>&lt;br&gt;Applies only to Commercial UnitedHealthcare Signature Value HMO</td>
<td><strong>California Oklahoma, Oregon, Texas, Washington</strong>&lt;br&gt;Phone: (888) 277-4232&lt;br&gt;Fax: (800) 346-0930</td>
<td>• Request an expedited decision on an appeal.</td>
</tr>
<tr>
<td>Resource</td>
<td>Where to go</td>
<td>What you can do there</td>
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<tr>
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</table>
| Pharmacy Services | **For Commercial products:** uhcwest.com  
**For Medicare products:** UHCMedicareSolutions.com → Our Plans → Medicare Prescription Drug Plans |  
- Access formularies, preauthorization guidelines and after-hours procedures, 24 hours a day, 7 days a week.  
- View the Medicare Advantage Part D (MAPD) Formulary or request a copy.  
- Phone: (800) 711-4555  
- Fax: (800) 527-0531  
- Fax: (800) 853-3844  
- Website: OptumRx.com  
- **Medicare Advantage products:** (866) 798-8780, Option 2 |  
- Request a Prior Authorization  
- For oral medications  
- For injectable medications |
| Mental Health, Substance Abuse/Substance Use, Vision or Transplant Services | See Customer's health care ID card for carrier information and contact numbers |  
- Inquire about a Customer's behavioral health, substance abuse, substance use, vision or transplant benefits. |
| California Language Assistance Program | uhcwest.com → Provider → Spotlight → California Regulation SB 853 - Language Assistance Program Information  
Phone: (800) 752-6096 |  
- Access information regarding the California Language Assistance Program. |
| Health Management and Disease Management Programs | uhcwest.com → Login → Providers → Library → Click on the desired state → Forms  
To enroll patients:  
Phone: (877) 840-4085  
Fax 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 ID card guides: UnitedHealthcareOnline.com → Tools & Resources → Products & Services → Medicare → UnitedHealthcare Medicare Solutions Physician & Provider Information → Scroll to “Benefit Plan Name Overviews” section at the bottom right of the page.

**UnitedHealthcare West sample Commercial health care ID card:**
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:

• Our provider website at uhcwest.com
• 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
• Enterprise Voice Portal
Electronic Data Interchange (EDI) (Does not apply in Nevada)

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

EDI tools

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

EDI claims/encounters

EDI claim is the preferred method of submission for 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 ANS1 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 ANS1 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 ANS1 X1 2 270/271 format is the only acceptable format for this EDI transaction.

3. **Electronic claims status inquiry/response**

   This EDI transaction allows a provider to send and receive in “real-time” an electronic status of a previously submitted claim using a computer. Claims with missing or inaccurate information can be resubmitted, which greatly enhances the provider’s receivables and cash flow cycle. The HIPAA ANS1 X1 276/277 format is the only acceptable format for this EDI transaction. To determine the status of your submitted electronic claims, log on to uhcwest.com. (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 uhcwest.com.

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

- Before submitting your EDI claims to us, you must first refer to the front of the Customer’s health care ID card to determine the appropriate UnitedHealthcare West product type.

- Finally, refer to the EDI Payer ID Quick Reference Tool below for the correct Payer ID number and the corresponding claim address of the UnitedHealthcare West product in your market.

- Claims previously submitted that were either denied or pended for additional information should not be resubmitted as electronically or as a new paper claim. Please contact us at the phone number on the back of the Customer’s health care ID card for more information.

**EDI Payer ID quick reference tool**

<table>
<thead>
<tr>
<th>Market</th>
<th>Product type</th>
<th>EDI Payer ID</th>
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</thead>
<tbody>
<tr>
<td>California</td>
<td>Commercial/HMO</td>
<td>87726</td>
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<tr>
<td>Oregon</td>
<td>Commercial/HMO</td>
<td>87726</td>
</tr>
<tr>
<td>Washington</td>
<td>Commercial/MCO</td>
<td>87726</td>
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<tr>
<td>Oklahoma</td>
<td>Commercial/HMO</td>
<td>87726</td>
</tr>
<tr>
<td>Texas</td>
<td>Commercial/HMO</td>
<td>87726</td>
</tr>
<tr>
<td>California</td>
<td>Medicare Advantage/HMO</td>
<td>87726</td>
</tr>
<tr>
<td>Oregon</td>
<td>Medicare Advantage/HMO</td>
<td>87726</td>
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<tr>
<td>Washington</td>
<td>Medicare Advantage/MCO</td>
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<tr>
<td>Texas</td>
<td>Medicare Advantage/HMO</td>
<td>87726</td>
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<tr>
<td>Oklahoma</td>
<td>Medicare Advantage/HMO</td>
<td>87726</td>
</tr>
<tr>
<td>Colorado</td>
<td>Medicare Advantage/HMO</td>
<td>87726</td>
</tr>
<tr>
<td>Arizona</td>
<td>Medicare Advantage/HMO</td>
<td>87726</td>
</tr>
<tr>
<td>Nevada</td>
<td>Medicare Advantage/HMO</td>
<td>P.O. Box 95638, Las Vegas, NV 89193-5638, Call P5 Health Solutions (702) 318-2468</td>
</tr>
<tr>
<td>All Markets</td>
<td>UnitedHealthcare MedicareDirect (Private Fee for Service - PFFS)</td>
<td>87726</td>
</tr>
<tr>
<td>All Markets (Except Nevada) Online:</td>
<td><a href="mailto:encountercollection@optum.com">encountercollection@optum.com</a></td>
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<tr>
<td>For additional EDI information Visit us:</td>
<td>uhcwest.com</td>
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<tr>
<td>To get started with EDI or EDI technical support</td>
<td>Call: (800) 203-7729, Write to: <a href="mailto:edisupport@uhc.com">edisupport@uhc.com</a></td>
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</table>

Refer to the Customer health care ID card for the appropriate product name that corresponds to the Payer ID listed above.

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

**Medical management**

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

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

In evaluating medical appropriateness of services, we use MCG™ Care Guidelines, (formerly known as Milliman Care Guidelines). For Medicare Advantage Customers, we follow CMS coverage 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;
- 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 primary care physician (PCP) or hospitalist upon a Customer’s arrival for commercial services. These services should be requested telephonically by calling us at (800) 799-5252 between 8:00 a.m. and 5:00 p.m., Monday through Friday.

**Routine**

All other services are considered routine. To request preauthorization, (see below for services requiring preauthorization), the PCP must enter all the necessary information into uhcwest.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>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage Urgent</td>
<td>All</td>
<td>72 Hours</td>
</tr>
<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>
</tr>
<tr>
<td></td>
<td>TX</td>
<td>3 Calendar Days</td>
</tr>
<tr>
<td>Commercial Routine</td>
<td>OR, WA</td>
<td>2 Business Days Exception - a delay of decision (DOD) letter</td>
</tr>
<tr>
<td></td>
<td>CA</td>
<td>5 Business Days Exception - a delay of decision (DOD) letter</td>
</tr>
<tr>
<td></td>
<td>OK</td>
<td>15 Calendar Days</td>
</tr>
<tr>
<td></td>
<td>TX</td>
<td>3 Calendar Days</td>
</tr>
</tbody>
</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 uhcwest.com → Providers → Login → Library → Select State → Resource Center. Services that are rendered without the required preauthorization will be denied as provider liability. The Customer cannot be billed for such services.

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

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

**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 Precertification Request Form to us or to the delegated Medical Group for approval, as appropriate. The Precertification Request Form can be found at uhcwest.com → Providers → Login → Library → Select State → Resource Center.

**Primary care services**

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

1. The PCP is responsible for verifying eligibility and benefits prior to rendering services;
2. To request Prior Authorization, the PCP must enter the request into uhcwest.com or complete and submit the appropriate Precertification Request Form (unless the services are required urgently or on an emergency basis). The completed Treatment Request Form must include the following information:
› Customer’s presenting complaint,
› Physician’s clinical findings on exam,
› All diagnostic and lab results relevant to the request,
› Conservative treatment that has been tried,
› Applicable CPT and ICD 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
1. The specialist will receive via fax or an uhewest.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;

2. All specialist authorizations will expire 90 calendar days from the date of issuance;

3. Plain film radiography rendered by a designated UnitedHealthcare West Participating Provider, or in the specialist’s office in support of an authorized visit, does not require Prior Authorization;

4. Routine lab services that are performed in the specialist’s office, or are provided by a designated UnitedHealthcare West contracting/participating provider in support of an authorized visit, do not require Prior Authorization;

5. Customers may self-refer to a gynecologist who is a Participating Provider for their annual routine gynecological exams. Female Medicare Advantage Customers may self-refer to a women’s health specialist who is a Participating Provider for women’s routine and preventive health care services.

6. Female Medicare Advantage Customers over age 40 may self-refer to a UnitedHealthcare West radiology provider who is a Participating Provider for a screening mammogram.

Note: Mammograms may require 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 uhewest.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 Medicare Advantage Participating Provider or in the obstetrician’s office in support of an authorized visit, do not require Prior Authorization.

4. Routine labs that are performed in the obstetrician’s office, or are provided by a Participating Provider in support of an authorized visit, do not require Prior Authorization.
5. Office procedures and diagnostic and/or therapeutic testing performed in the obstetrician’s office that do not require prior authorization may be performed.

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

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

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

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

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

1. The Customer is discharged;
2. A Participating Provider assumes responsibility for the Customer’s care (either at the hospital or through transfer); or
3. The treating physician and UnitedHealthcare West agree to another arrangement. We are responsible for the cost of post-stabilization services that are:
   - Pre-approved by us; and
   - Medically necessary.

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

**Extension of prior authorization services**
If a Customer requires services beyond the initial consult and follow-up visits in any of the situations where we require prior authorization, the specialist must request an extension of authorization through uhcwest.com or by fax:
1. Beyond the approved visits;
2. Beyond the allotted time frame of the approval (typically 90 calendar days);
3. If a Customer requires additional procedures, and/or diagnostic or therapeutic testing, requiring prior authorization.

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

- Customer’s presenting complaint;
- Physician’s clinical findings on exam;
- All diagnostic and laboratory results relevant to the request;
- Conservative treatment that has been tried;
- Applicable CPT and ICD codes; and
- Requested services (e.g., additional visits, procedures).

We will review the existing authorization and will mail or fax it back to the physician and/or make the information available on uhcwes.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 not required for Medicare Advantage.
- Elective/scheduled medical admissions require prior authorization.
- For admissions or transfers after-hours or on weekends, the Customer should be admitted to the appropriate facility at the appropriate level of care. Authorization can then be obtained on the next business day.
- Authorization is not required for a consultation with a participating in-network provider during an inpatient stay. However, consultation with a non-participating, non-network provider requires Prior Authorization.
- Transfers/admissions to SNFs; a Customer can be admitted directly from the emergency room or home to a SNF.
- A referral to a non-network facility requires preauthorization from us. However, in the case of an emergency, a non-participating hospital may be used without Prior Authorization. After initial emergency treatment and/or post-stabilization, we may request that a Customer be transferred to a network hospital when medically appropriate. If a PCP directs a Customer to a non-network hospital for non-emergent care without preauthorization, the PCP may be held responsible.

Required authorizations can be obtained through uhcwes.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 the UnitedHealthcare West Prior Authorization Nurse is unable to authorize the admission or procedure; the request will be referred to our Medical Director. If the Customer’s recovery requires an extension of days beyond those authorized, the Concurrent Review Nurse will contact the hospital for clinical indications for extension. Please note that issuance of a tracking number does not constitute authorization for admission.

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

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

Inpatient census reports

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

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

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

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

Coordination of care

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

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

Concurrent review

We will conduct concurrent review on all admissions from the day of admission through the day of discharge. Concurrent review is performed telephonically, as well as on-site at designated facilities, by clinical staff. We have established procedures for on-site concurrent review which include: (a) guidelines for identification of our staff at the facility; (b) processes for scheduling on-site reviews in advance; and (c) staff requirements to follow facility rules. If the clinical reviewer determines that the Customer may be treated at a lower level of care or in an alternative treatment setting, the case will be discussed with the hospital case manager and the admitting physician. If a discrepancy occurs, our Medical Director or designee will discuss the case with the admitting physician.
**Variance days**
If inpatient care coordination and provision of diagnostic services are not medically necessary or are not provided in a timely manner contributing to delays in care, variance days will be assigned and reimbursement adjusted accordingly. Our concurrent review staff will attempt to minimize variance days by working with the attending physicians and hospital staff if a variance is noted in the patient’s acute care process, our concurrent review staff will discuss the variance with the hospital’s medical management/case management representative. If the variance exists after the discussion, our concurrent review staff will document the variance in our utilization records and submit to the Concurrent Review Manager for approval. If approved, the variance is entered into our database as a denial of reimbursement for the variance time period. A letter stating the variance type and time period will be mailed to the facility. The facility may appeal the variances in writing. Our Medical Director will review the appeal and render a decision to overturn or uphold the decision.

**Medical observation status**
We will authorize hospital observation status when medically appropriate. Hospital observation is generally designed to evaluate a Customer’s medical condition and determine the need for actual admission, or to stabilize a Customer’s condition and typically lasts for 23-48 hours. Typical cases, when observation status is used, include 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;
- 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 a 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 physician, health care professional, facility or ancillary provider must respond to requests for all appropriate medical records within 5-7 calendar days from receipt of the request, unless otherwise indicated in your agreement.

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

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

Minimum content of written or electronic notification

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

- The specific service(s) denied, delayed in delivery, modified or partially approved;
- The specific reference to the plan provisions to support the decision;
- The reason the service is being denied, delayed in delivery, modified, or partially approved, including:
  - Clear and concise explanation of the reasons for the decision in sufficient detail, using an easily understandable summary of the criteria, so that all parties can understand the rationale behind the decision;
  - Description of the criteria or guidelines used, and/or reference to the benefit provision, protocol or other similar criterion on which the decision was based;
  - Clinical reasons for decisions regarding medical necessity; and
  - Contractual rationale for benefit denials.
- Notification that the Customer can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request;
- Notification that the Customer’s physician can request a peer-to-peer review;
• Alternative treatment options offered, if applicable;

• Description of any additional material or information necessary from the Customer to complete the request, and why that information is necessary;

• Description of grievance rights and an explanation of the appeals and grievances processes, including:
  › Information regarding the Customer’s right to appoint a representative to file an appeal on the Customer’s behalf;
  › The Customer’s right to submit written comments, documents or other additional relevant information,
  › Information notifying the Customer and their treating provider of the right to an expedited appeal for time-sensitive situations (not applicable to retrospective review);
  › Information regarding the Customer’s right to file a grievance or appeal with the applicable state regulatory agency, including information regarding the independent medical review process, as applicable;
  › Information that the Customer may bring civil action, under Section 502(a) of the Employee Retirement Income Security Act (ERISA), if applicable (Commercial products only);
  › For the treating provider, the name and direct phone number of the health care professional responsible for the decision.

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

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

To access the formulary and changes to the formulary, go to uhcwest.com → Provider → Library → Click on the desired state → Pharmacy → Click on the desired formulary. You will then be able to search by drug name or therapeutic class. Any restriction or limitation will also be noted along with formulary alternatives, when applicable. The Commercial formulary is updated twice a year, in January and July. The Medicare formulary is updated up to 9 times during a calendar year. Physician requests for formulary review of medications or preauthorization guidelines are welcome. Prior authorization guideline change request forms and formulary change request forms can be obtained by going to OptumRx.com → HealthCare Professionals Home Page → Healthcare Provider Tools → Forms and Documents.

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

Request for prior authorization of non-formulary medications
The request for prior authorization of a non-formulary drug may only be made by the physician or his or her designee, who is located in the physician’s office or other site where the Customer is receiving medical services. The prior authorization functions may not be delegated to a third-party who is not located at the physician’s office or other site where the Customer is receiving medical services. However, clinical pharmacists who work in a medical management capacity within a medical group, and who are directly employed by or 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 any time of the day or night, any day of the week. After logging on at OptumRx.com with his or her unique National Provider Identifier (NPI) number and password, a physician or health care professional can submit patient details securely online, enter a diagnosis and medical justification for the requested medication, and, in many cases, receive authorization instantly.

Physicians can submit information that previously had to be collected by phone or fax. Also, physicians and health care professionals can use this service to check on the status of a Prior Authorization request, even if it was not submitted online. This online service applies to oral drugs as well as specialty medications.

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

Non-formulary medications and/or other medications that require prior authorization may be authorized in accordance with benefit design, provided the Customer’s benefit restrictions (applied to 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 the Centers for Medicare & Medicaid Services (CMS). Standard coverage determinations must be completed within 72 hours. Expedited coverage determinations must be completed within 24 hours.* OptumRx will communicate with the physician or his or her designee and the customer for additional information regarding the request, as well as send notification of the resulting case decision.

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

* 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).

** 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.
• 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 same tier and/or lower qualifying tiers.

**Authorizing and dispensing injectable/infusion medications**

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

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

• Complete Prior Authorization Medications Request Form (the requesting physician’s signature is required to allow the vendor to accept the document as a legal prescription);
• Recent history and physical.
• Copies of any pertinent laboratory results.
• Copies of any reports by consultant providers.

Submit requests to the OptumRx Specialty Pharmacy at (800) 711-4555, or fax requests directly to (800) 853-3844. OptumRx will verify the Customer’s eligibility, notify the physician of the determination, and if appropriate, contact the physician’s office to coordinate delivery of the medication(s). In the case of approved self-injectables, the vendor will contact the Customer to coordinate delivery of the medication(s).

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

**Claims processing**

**Claims adjudication**

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

**Complete claims requirements**

We follow the UnitedHealthcare complete claims requirements 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:

- **Website:** uhcwest.com → Provider → Electronic Data Interchange (EDI)/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, will pay the provider based on the lower level of care, which was determined by provider to be the appropriate level of care for the Customer.

**Customer financial responsibility**

Reference the applicable Commercial and Medicare Advantage Copayment Guideline Grids at uhcwest.com → Login → Library → Guidelines & Interpretation Manuals for more information about interpretation of copayments.

**Services provided to ineligible Customers**

In the event that UnitedHealthcare West provides eligibility confirmation indicating that a Customer is eligible at the time the health care services are provided and it is later determined that the patient was not in fact eligible, UnitedHealthcare West will not be responsible for payment of services provided to the Customer, except as otherwise required by state and/or federal law. In such event, you are entitled to collect the payment directly from the Customer (to the extent permitted by law) or from any other source of payment.

**Authorization guarantee procedure (California Commercial only)**

Authorization Guarantee provides for reimbursement to the Participating Provider for covered services provided to a Customer for which (1) an authorization has been provided, (2) who is determined to have been ineligible with UnitedHealthcare West on the date the authorized services were rendered and (3) where the Customer’s lack of eligibility is only determined after authorized services have been rendered. The Authorization Guarantee does not apply to self-insured or Medicare Advantage benefit plans.

**Provider’s responsibility to monitor eligibility**

UnitedHealthcare West makes available current Customer eligibility information through the Enterprise Voice Portal, UnitedHealthcare West Provider Portal, and our Customer Service Center. The Provider is responsible for checking Customer eligibility within 2 business days prior to the date of service. Provider shall be eligible for reimbursement under the Authorization Guarantee program described herein for authorized services provided that Provider has checked and confirmed eligibility within 2 business days prior to the date of service.

**Authorization guarantee and reimbursement procedure**

Currently, our systems automatically deny claims for services provided to patients who are not eligible regardless of prior authorization. We will review all fee–for-service claims denials that were based on lack of eligibility to determine whether services are eligible for reimbursement. UnitedHealthcare West will overturn denials that are payable under the Authorization Guarantee program without any action by provider. Additionally, the provider must submit the 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.

For services covered by the Authorization Guarantee program, UnitedHealthcare West will reimburse Provider in the amount that would have been due to Provider had the same services been provided to an eligible Customer.

**Note:** If, before or after UnitedHealthcare West makes a payment under the Authorization Guarantee program, the Provider receives payment for the same services from another source, the Provider shall refund the amount received from the other source to us, not to exceed the amount paid by us, within 45 business days.

**Claims status follow-up**

If, after submitting a claim within timely filing guidelines, you have not received an Explanation of Payment (EOP) within the time frames in accordance with state and federal law, the provider may follow-up on the status of a claim using one of the following methods:

- Online at uhcwest.com → Provider → Login → Check Eligibility. The website provides real-time data and is the quickest method for retrieving claim status information.
- You may also submit an Electronic Transaction (HIPAA 276/277). Please contact your EDI clearing house for additional information.
- Enterprise Voice Portal now provides access to claim status information by calling Commercial & Medicare Advantage HMO/MCO and simply following the prompt instructions over the phone:
  - California: (800) 542-8789
  - Oregon: (800) 920-9202
  - Oklahoma: (877) 847-2862
  - Texas: (877) 847-2862
  - Washington MCO: (800) 213-7356
  - Arizona/Colorado/Nevada: (888) 866-8297

This system provides a fax of the claim status detail information that is available.

**Claims submission requirements**

Claims shall be submitted to UnitedHealthcare West on industry standard forms (CMS-1500s, UB-04s) and forwarded to the address listed on the Customer’s health care ID card. Refer to the *Electronic Data Interchange* section of this Guide for more information about electronic claims submission and other Electronic Data Interchange (EDI) transactions. If your claim is the financial responsibility of a UnitedHealthcare West delegated entity (e.g., PMG, MSO, Hospital), you should bill that entity directly for reimbursement.

**Claims submission requirements for reinsurance claims for hospital providers**

If contracted covered services fall under the reinsurance provisions set forth in your agreement with us, you shall abide by the terms of the agreement in making sure that:

- The stipulated threshold has been met;
- Only covered services are included in the computation of the reinsurance threshold;
• Only those inpatient services specifically identified under the terms of the reinsurance provision(s) may be used to
calculate the stipulated threshold rate;
• Applicable eligible Customer copayments, coinsurance, and/or deductible amounts are deducted from the
reinsurance threshold computation;
• The stipulated reinsurance conversion reimbursement rate is applied to all subsequent covered services and
submitted claims;
• The reinsurance is applied to the specific, authorized acute care confinement;
• Claim submitted in accordance with the required time frame, if any, as set forth in the agreement. In addition,
when submitting hospital claims that have reached the contracted reinsurance provisions and are being billed in
accordance with the terms Agreement and/or this Supplement, you shall:
  › Indicate if a claim meets reinsurance criteria; and
  › Make medical records available upon request for all related services identified under the reinsurance
provisions (e.g., ER face sheets).

If a submitted hospital claim does not identify the claim as having met the contracted reinsurance criteria,
UnitedHealthcare West shall continue to process the claim at the appropriate LOC per diem rate in the agreement.
In order to compute specific reinsurance calculations and to properly review reinsurance claims for covered services, an
itemized bill is required.

Interim bills
We adjudicate interim bills at the per diem rate for each authorized bed day billed on the claim and reconcile the complete
charges to the interim payments based on the final bill.

The process outlined below will increase efficiencies for both us and the Hospital/SNF business offices:

• 112 Interim – First Claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of billed
or authorized level of care, unless the contract states otherwise).

• 113 Interim – Continuing Claim: Pay contracted per diem for each authorized bed day billed on the claim (lesser of
billed or authorized level of care, unless the contract states otherwise).

• 114 Interim – Last Claim: Review admits to discharge and discharge and apply appropriate contract rates, including
per diems, case rates, stop loss/outlier and/or exclusions. The previous payments will be adjusted against the final
payable amount.

Reciprocity agreements
You shall cooperate with our contracting/participating providers and other UnitedHealthcare entities and agree to provide
services to Customers enrolled in benefit plans and programs of UnitedHealthcare affiliates and to assure reciprocity of
providing health care services.

Without limiting the foregoing, if any Customer who is enrolled in a benefit plan or program of any UnitedHealthcare
West affiliate, receives services or treatment from you and your sub-contracted providers (if applicable), you and your
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 applicable copayments and/or deductibles, as payment in full for
such services or treatment.

You shall comply with the procedures established by the UnitedHealthcare affiliate and this agreement for reimbursement
of such services or treatment.
Overpayments
If you identify a claim for which you were overpaid by us, or if we inform you of an overpaid claim that you do not dispute, you must send us the overpayment within 30 calendar days (or as required by law or your participation agreement), from the date of your identification of the overpayment or our request. If refund or dispute is not made within 45 calendar days of our request, we shall recoup the amount of overpayment through other means, which may include future claim payments, to the extent permitted by your agreement with us and applicable law.

All refunds of overpayments in response to overpayment refund requests received from us, or one of our contracted recovery vendors, should be sent to the name and address of the entity outlined on the refund request letter.

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

When we determine that a claim was paid incorrectly, we may make claim reconsiderations without requesting additional information from the network physician or other contracting/participating health care professional. In the case of an overpayment, we will request a refund at least 30 calendar days prior to implementing a claim reconsideration, or as provided by applicable law. You will see the adjustment on the EOB or Provider Remittance Advice (PRA). When additional or correct information is needed, we will ask you to provide it.

If you disagree with a claim reconsideration, our request for an overpayment refund or a recovery made to recoup the overpayment, you must submit the dispute, in writing, to the recovery agent requesting the overpayment. The agent’s name and address is located on the recovery request letter.

If you dispute the refund request, the recovery of claims overpayment will not occur until after you have exhausted our appeals process. (See Provider appeals section of this Supplement.)

End-stage renal disease
If a Customer has (or develops) end stage renal disease (ESRD) while covered under an employer’s group plan, the Customer must use the benefits of the plan for the first 30 months after becoming eligible for Medicare, based on ESRD. After the 30 months elapse, Medicare is then the primary Payer. However, if the employer group plan coverage were secondary to Medicare when the Customer developed ESRD, Medicare would be the primary Payer.

Medicaid (applies only to Medicare Advantage)
Qualified Medicare Beneficiaries (QMB) are held harmless for Medicare cost-sharing under applicable CMS regulations. Medicare cost sharing includes the deductibles, coinsurance and copayments included under Medicare Advantage Plans.

Physicians and health care professionals will not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Medicare Customer who is eligible for both Medicare and Medicaid, or said Customer’s representative, or the Medicare Advantage organization for Medicare Part A and B cost sharing (e.g., copays, deductibles, coinsurance) when the State is responsible for paying such amounts. Physicians and health care professionals will either: (a) accept payment made by or on behalf of the Medicare Advantage organization as payment in full; or (b) bill the appropriate State source for such cost sharing amount.

Time limits for filing claims
All physicians and health care professionals are required to submit to clean claims for reimbursement no later than the time specified in the provider’s participation agreement or the time frame specified in the state guidelines, whichever is greater.

If a provider fails to submit clean claims within the foregoing time frames, UnitedHealthcare West reserves the right to deny payment for such claim(s). Claim(s) which are denied for untimely filing cannot be billed to a Customer.
We have established internal claims processing procedures to make sure timely claims payment to its physicians and health care professionals. UnitedHealthcare West is committed to paying claims for which it is financially responsible within the time frames required by state and federal law.

For purposes of determining the date of UnitedHealthcare West’s or its delegate receipt of a claim, the date of receipt shall be deemed to be the business day when a claim, by physical or electronic means, is first delivered to UnitedHealthcare West’s specified claims payment office, post office box, designated claims processor or to UnitedHealthcare West’s capitated provider for that claim. The following date stamps may be used to determine date of receipt:

- UnitedHealthcare West Claims Department date stamp.
- Primary Payer claim payment/denial date as shown on the EOP.
- Delegated Provider date stamp.
- TPA date stamp.
- Confirmation received date stamp that prints at the top/bottom of the page with the name of the sender.

**Note:** Date stamps from other health plans or insurance companies are not valid received dates for timely filing determination.

**Provider appeals**

**Claims research and resolution (applies 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.

We will research the issue to identify the payer who holds financial risk of the services and will abide by federal and state legislation on appropriate timelines for resolution. We will work directly with the delegated payer when claims have been misdirected and financial responsibility is in question. If appropriate, provider-driven claim payment disputes will be directed to the delegated payer Provider Dispute Resolution process.

**Claim reconsideration requests (does not apply in California)**

You may request a reconsideration of a claim determination. These rework requests typically can be resolved with the appropriate documents to support claim payment or adjustments (e.g., sending a copy of the authorization for a claim denied for no authorization or proof of timely filing for a claim denied for untimely filing). You should submit your request to us in writing by using the Claims Rework Request form (available at uhcwest.com → Providers → Login → Library → Select State Forms. All rework requests must be submitted within 365 calendar days following the date of the last action or inaction, unless your participation agreement contains other filing guidelines. When attachments are required, you can submit your request electronically using Optum Cloud Dashboard. Learn more on UnitedHealthcareOnline.com → Tools & Resources → Health Information Technology → Optum Cloud Dashboard.

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:

<table>
<thead>
<tr>
<th>UnitedHealthcare West bulk claims rework reference table</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provider’s state</strong></td>
</tr>
<tr>
<td>Arizona</td>
</tr>
<tr>
<td>California</td>
</tr>
<tr>
<td>Colorado</td>
</tr>
<tr>
<td>Nevada</td>
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<tr>
<td>Oklahoma</td>
</tr>
<tr>
<td>Oregon</td>
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<tr>
<td>Texas</td>
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<tr>
<td>Washington</td>
</tr>
</tbody>
</table>

UnitedHealthcare West’s response

We will respond to issues as quickly as possible.

- **Reworks/disputes requiring medical determination:** Individuals with clinical training/background who were not previously involved in the initial decision will review all clinical rework/dispute requests. A letter will be sent to the provider outlining the outcome of the determination and the basis for the decision.

- **Reworks/disputes requiring claim process determination:** Individuals not previously involved in the initial processing of the claim will review rework/dispute request.

- **Response details:** If claim requires an additional payment, the EOP will serve as notification of the outcome on the review. If the original claim status is upheld, the provider will be sent a letter outlining the details of the review.

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

A provider dispute is a dispute of a claim for which a determination has previously been issued by us. You must submit a provider dispute in writing and accompanied by additional documentation for review. All disputes must be submitted within 365 calendar days following the date of the last action or inaction, unless other filing guidelines contained in your participation agreement or State law dictate otherwise. This time frame applies to all disputes regarding contractual issues, claims payment issues, overpayment recoveries and medical management disputes.

The PDR process is available to provide a fair, fast and cost-effective resolution of provider disputes, in accordance with State and Federal regulations. We will not discriminate, retaliate against or charge you for submitting a provider dispute. The PDR process is not a substitution for arbitration and will not be deemed as arbitration.

What to submit

As the provider of service, you should submit the dispute with the following information:

- Customer’s name;
- Customer’s health care ID number;
- Claim number;
- Specific item in dispute;
- Clear rationale/reason for contesting the determination and an explanation why the claim should be paid or approved;
- Submitting provider’s contract information.

Note: Physicians and health care professionals who do not submit the appropriate supporting documentation when requesting review of a previously processed claim will not have the dispute reviewed.

For California physicians and health care professionals: A Provider Dispute Resolution form can be obtained online at uhcwest.com → Library → Select “Provider Disputes.” The dispute resolution form is not required; however, the minimum requirements outlined in AB1455 must be met.

Where to submit

State-specific addresses and other pertinent information regarding the PDR process may be found in the UnitedHealthcare West Provider Rework or Dispute Process Reference Table at the end of this section.

Accountability for review of a provider dispute

The entity that initially processed/denied the claim or service in question is responsible for the initial review of a PDR request. These entities may include, but are not limited to, UnitedHealthcare West, the delegated medical group/IPA/payer or the capitated hospital/provider.

Excluded from the PDR process

The following are examples of issues that are excluded from the PDR process:

- Dates of service prior to January 1, 2004.
- Instances in which a Customer has filed an appeal and you have filed a dispute regarding the same issue. In these cases, the Customer’s appeal will take precedence. You can submit a Provider Dispute after the Customer appeal decision is made. If you are appealing on behalf of the Customer, the appeal will be processed as a Customer appeal.
- An Independent Medical Review initiated by a Customer through the Customer Appeal Process.
- Any dispute filed outside of the timely filing limit applicable to you, and for which you fail to supply “good cause” for the delay.
- Any delegated claim issue that has not been reviewed through the delegated payer’s claim resolution mechanism.
- Any request for a dispute which has been reviewed by the delegated medical group/IPA/payer or capitated hospital/provider and does not involve an issue of medical necessity or medical management.
<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 in writing of any request for reconsideration within 1 year from the date the claim was processed. Second Review: Request for reconsideration of a Grievance determination is also considered a Grievance. Physicians and health care professionals are required to notify us in writing of any second level Grievance within 1 year from the date the first level Grievance resolution was communicated to the provider.</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>
<tr>
<td>Colorado</td>
<td>Medicare Advantage Claims Department Attn: Colorado Resolution Team P.O. Box 52064 Phoenix, AZ 85072-2064</td>
<td>Upon receipt of a dispute, Colorado Resolution Team will: Send the provider a written acknowledgement of receipt of the dispute within 30 calendar days of the receipt of the dispute; Conduct a thorough review of the provider’s dispute and all supporting documentation; Supply the provider with a written determination, including the specific rationale for the decision, within 60 calendar days of receipt of the dispute; Process payment, if necessary, within 5 business days of the written determination; Return the dispute to the provider of service within 30 calendar days if additional information is required; If additional information is required, we will hold the dispute request for 30 additional calendar days.</td>
</tr>
<tr>
<td>Nevada</td>
<td>For Medicare Advantage claims: UnitedHealthcare P.O. Box 95638 Las Vegas, NV 89193-5638</td>
<td>All Nevada Medicare Advantage HMO claims are processed by a delegated payer Therefore, the provider appeals are reviewed primarily by the delegated payer.</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764</td>
<td>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.</td>
</tr>
<tr>
<td>Oregon</td>
<td>UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764</td>
<td>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.</td>
</tr>
<tr>
<td>Texas</td>
<td>UnitedHealthcare West Claims Department P.O. Box 400046 San Antonio, TX 78229</td>
<td>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.</td>
</tr>
<tr>
<td>Washington</td>
<td>UnitedHealthcare West Provider Dispute Resolution P.O. Box 30764 Salt Lake City, UT 84130-0764</td>
<td>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.</td>
</tr>
</tbody>
</table>
**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><strong>Exceptions:</strong></td>
</tr>
<tr>
<td></td>
<td>• <strong>California Commercial HMO:</strong> Customers are offered appointments for non-urgent PCP within 10 business days of request, for non-urgent specialist within 15 business days of request;</td>
</tr>
<tr>
<td></td>
<td>• <strong>Texas:</strong> Within 3 weeks for medical conditions.</td>
</tr>
<tr>
<td>Preventive care</td>
<td>UnitedHealthcare Standard: 4 weeks</td>
</tr>
<tr>
<td></td>
<td><strong>Exceptions:</strong></td>
</tr>
<tr>
<td></td>
<td>• <strong>Texas:</strong> 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><strong>Exceptions:</strong></td>
</tr>
<tr>
<td></td>
<td>• <strong>California Customers:</strong> 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;
     As an “authorization representative” of the health plan, physicians are responsible to notify the Customer about the prior authorization determination, unless State regulation requires otherwise.

5. The physician will use best efforts to refer Customers to UnitedHealthcare West network providers. The physician must use only UnitedHealthcare West network laboratory and radiology providers, unless specifically authorized.

**Timely access to non-emergency health care services (applies only to Commercial in California)**

- The timeliness standards require licensed health care providers to offer Customers appointments that meet the California time frames. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has
determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Customer.

- Triage or screening services by phone must be provided by licensed staff 24 hours per day, 7 days per week. Under no circumstances shall unlicensed staff persons use the answers to those questions in an attempt to assess, evaluate, advise or make any decision regarding the condition of a Customer or determine when a Customer needs to be seen by a licensed medical professional.

- UnitedHealthcare of California HMO 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)**

Consistent with California law, UnitedHealthcare of California HMO Customers and covered persons of UnitedHealthcare Insurance Company benefit plans, who have limited English proficiency, have accessibility to translated written materials and oral interpretation services, free of charge, to assist such Customers in obtaining covered services. For more information, call (800) 752-6096.

**Customer complaints & grievances**

We acknowledge that Customer disputes may arise with the health plan or its contracting/participating providers, especially related to coverage issues. UnitedHealthcare West respects the rights of its Customers to express dissatisfaction regarding quality of care/services and to appeal any denied claim/service. All Customers receive instructions on how to file a complaint/grievance with us in their Combined Evidence of Coverage and Disclosure Form, Evidence of Coverage or Certificate of Coverage, as applicable.
UnitedHealthOne Individual Plans Supplement
(GRIC, UHCLIC and PLHIC)

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”), UnitedHealthcare Life Insurance Company, (“UHCLIC”) and PacifiCare Life and Health Insurance Company (“PLHIC”).

This Supplement applies to services provided to Insureds enrolled in GRIC, UHCLIC, and PLHIC 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><strong>GRIC– Group Number 705214</strong></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>
<tr>
<td><strong>PLHIC</strong></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.</td>
<td>To notify of hospitalizations exceeding 3 days or transplant services.</td>
</tr>
<tr>
<td>Benefits and Eligibility</td>
<td>Call the number on the back of the Insured’s health care ID card.</td>
<td>To inquire about an Insured’s plan benefits or eligibility.</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>
<tr>
<td><strong>UHCLIC– Group Number 755870</strong></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>Prior Authorization is required for certain services. Admission Notification is required for all inpatient admissions. UnitedHealthcare Standard Advanced Notification and Admission Notification requirements 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, eligibility or verify 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>
<tr>
<td><strong>UHCLIC– All Other</strong></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.</td>
<td>Notification is required for inpatient stays that exceed 3 days.</td>
</tr>
<tr>
<td>Benefits and Eligibility</td>
<td>Call the number on the back of the Insured’s health care ID card.</td>
<td>To inquire about an Insured’s plan benefits or eligibility.</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>
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, UHCLIC or PLHIC, in accordance with the notification requirements set forth in this Supplement.
2. Prepare a complete and accurate claim form.
3. 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.
4. For contracted providers who submit electronic claims for UHCLIC and PLHIC 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.

Note: The Payer ID number on the insured's 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 Claims appeals section below).

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

Grievance Administrator
PO Box 31371
Salt Lake City, UT 84131-0370

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.

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

Health care ID card
GRIC, UHCLIC and PLHIC 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.
Sample ID cards:
Golden Rule Insurance Company

UnitedHealthcare Life Insurance Company - Group Number 755870

UnitedHealthcare Life Insurance Company – All Other

PacifiCare
Notice to Texas providers

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

GRIC, UHCLIC and PLHIC 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, UHCLIC and PLHIC 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 for 2013 at care.diabetesjournals.org. To use the Quick Search in the Diabetes Care site, enter the article name in the Keyword(s) box: Standards of Medical Care in Diabetes 2013 and enter Year: 2013; Vol: 36; Pages: S11-S66.

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.