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

*Where information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law
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- UnitedHealthcare Hospital Quality Program – Results now Available on myHealthcare Cost Estimator
- Injectable Chemotherapy Prior Authorization Program Update
- Implementation of Additional Medical Policies on the Facility Claim Editor

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- SignatureValue Medical Management Guideline Updates
- UnitedHealthcare of the River Valley Preauthorization List and Policy Updates
- Oxford® Medical and Administrative Policy Updates
Front & Center

Laboratory Benefit Management Program Updates

The Laboratory Benefit Management Program started Oct. 1, 2014, to help improve the quality of outpatient laboratory services, support evidence-based guidelines for patient care and lower costs for UnitedHealthcare members through greater in-network utilization. As a reminder, the Laboratory Benefit Management Program only applies to laboratory services for fully insured UnitedHealthcare Commercial members in Florida, excluding Neighborhood Health Partnership members. Beacon Laboratory Benefit Solutions, Inc. (BeaconLBS®), which specializes in laboratory services management, is administering the program on our behalf.

Based on feedback we received from care providers and specialty organizations, and further assessment of Decision Support Test policies, we have made some important changes to the program:

1. We are extending the timeframe for dermatologists who perform in-office pathology services to comply with College of American Pathologists accreditation standards.

2. For cytopathology and hematopathology, we will accept either a single review from a sub-specialist or a secondary review from a board-certified anatomic pathologist.

3. For dermatopathology, we will accept a single review from a dermatopathologist or a secondary review from either a board-certified dermatopathologist or anatomic pathologist.

The updated program requirements were posted on April 15, 2015 at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Protocols > UnitedHealthcare Laboratory Benefit Management Program.

For more information, call 877.842.3210 or visit UnitedHealthcareOnline.com.
Hospital quality information is now available to members through myHealthcare Cost Estimator. The tool is an online and mobile application that gives members the transparency they need to understand health care costs and quality metrics for specific physicians and hospitals.

In February, we sent eligible hospitals their Hospital Quality Program Quality Rating Report. The mailing included the report which shows the hospital's comparative quality results as well as the methodology used for the program. The information from these reports was used to create the quality component of myHealthcare Cost Estimator.

For more information on the UnitedHealthcare Hospital Quality program, please go to UnitedHealthcareOnline.com > Clinician Resources > Performance Measurement & Reporting > Hospital Quality Program. If you have any questions, please call 866-270-5588 or email hospitalqualityprogram@uhc.com.
Effective June 1, 2015, UnitedHealthcare will implement a new online prior authorization program for injectable outpatient chemotherapy administrated in an outpatient setting for a cancer diagnosis in the following plans:

- UnitedHealthcare Commercial plans — excluding indemnity/Options PPO 1, 2, 3
- UnitedHealthcare Life Insurance Company and Golden Rule Insurance Company
- Neighborhood Health Partnership 1, 2
- UnitedHealthcare Community Plan – Florida Members Only 1

The online prior authorization program for injectable outpatient chemotherapy services will be available May 15, 2015. To complete an injectable chemotherapy prior authorization request, you will need to log into UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Oncology Authorization Submission & Status > Submit or Look up Chemotherapy Prior Authorization Request. For program questions/authorizations, please call 866-889-8054 Monday through Friday, 7 a.m. to 7 p.m.

UnitedHealthcare uses the National Comprehensive Cancer Network (NCCN) guidelines to review requests and claims for coverage for chemotherapy drugs administered in an outpatient setting. This source provides independent, evidence-based recommendations for cancer treatment and is available at nccn.org.

The expected advantages to rendering care providers include the following:

- Ability to see all eligible NCCN-recommended chemotherapy regimens during the authorization process
- Submission of clinical information during the authorization process for patients who require exceptions due to medical contraindications
- Elimination of most claim denials after the treatment has been given

Requests for pediatric chemotherapy regimens, rare cancers, or chemotherapy regimens that are not NCCN-recommended can also receive a response in a timely manner if necessary supporting documentation is provided at the time of the prior authorization request.

The UnitedHealthcare Injectable Chemotherapy Prior Authorization program includes all injectable chemotherapy drugs used to treat cancer including:

- Chemotherapy injectable drugs (J9000 - J9999), Leucovorin (J0640), Levoleucovorin (J0641)
- Chemotherapy injectable drugs that have a Q code
- Chemotherapy injectable drugs that have not yet received an assigned code and will be billed under a miscellaneous healthcare common procedure coding system (HCPCS) code will require a prior authorization.
Failure to complete the prior authorization process prior to administering chemotherapy will result in claims denial based on the absence of a prior authorization. Providers cannot bill members for services that are denied due to lack of prior authorization.

1 In Florida, the injectable chemotherapy prior authorizations for Neighborhood Health Partnership, UnitedHealthcare Community Plan in Florida and UnitedHealthcare Commercial members started May 17, 2014.

2 Some member coverage documents require a primary care physician to initiate a referral to a specialist. Member may also have a specific network service area and network configuration that reflects the needs of targeted population.

3 UnitedHealthcare will determine coverage decisions for select benefit plans for which it provides Administrative Services Only, also known as ASO plans, for prior authorizations requests that do not follow the NCCN Guidelines.
Effective for claims with dates of service on or after June 1, 2015, the following medical policies will be added to the Facility Claim Editor:

- Breast imaging
- Bronchial thermoplasty
- Cardiovascular disease risk test
- Collagen crosslinks/biochemical markers
- Computerized dynamic posturography
- Discogenic pain treatment
- Epiduroscopy, epidural lysis of adhesions and functional anesthetic discography
- Fecal calprotectin testing
- Gait analysis
- Magnetic resonance spectroscopy
- Manipulation under anesthesia
- Surgical treatment for spine pain
- Warming therapy and ultrasound therapy for wounds

The outpatient facility claims will be edited in accordance with the clinical criteria set forth in these medical policies. Charges for the experimental, investigational, or unproven services will be denied. Charges for covered services will be paid. Facilities will not be able to seek or collect payment from a UnitedHealthcare member for those services not covered by the member’s benefit plan, unless the facility obtained the member’s written consent (i.e., treatment specific waiver) prior to rendering the specific services.

For more information on Medical Policies, visit UnitedHealthcareOnline.com > Tools and Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines.
UnitedHealthcare Commercial
UnitedHealthcare Medical Policy, Drug Policy, Coverage Determination Guideline and Utilization Review Guideline Updates

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UnitedHealthcare Commercial Reimbursement Policy

Unless otherwise noted, these reimbursement policies apply to services reported using the 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent or its successor form. UnitedHealthcare reimbursement policies do not address all factors that affect reimbursement for services rendered to UnitedHealthcare members, including legislative mandates, enrollee benefit coverage documents, UnitedHealthcare medical or drug policies, and the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide. Meeting the terms of a particular reimbursement policy is not a guarantee of payment. Once implemented the policies may be viewed in their entirety at UnitedHealthcareOnline.com > Tools & Resources > Policies and Protocols > Reimbursement Policies-Commercial. In the event of an inconsistency or conflict between the information provided in the Network Bulletin and the posted policy, the provisions of the posted policy prevail.
Effective for claims with dates of service on or after Sept. 1, 2015, UnitedHealthcare will implement the Procedure and Place of Service Policy which is supported by the Centers for Medicare and Medicaid Services (CMS) and the American Medical Association (AMA) guidelines. UnitedHealthcare will deny reimbursement of codes that are reported in places of service considered inappropriate, based on the code’s description or available coding guidelines, which are not addressed in other reimbursement policies when reported by a physician or other health care professional.

For more information on the CMS Place of Service Code Set, please go to http://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.
UnitedHealthcare Medicare Solutions

Facility Claim Processing Edit Enhancements to UnitedHealthcare Medicare Advantage Benefit Plans

UnitedHealthcare will be enhancing our Medicare claim editing guidelines to be more consistent with the Center for Medicare and Medicaid Services (CMS) and Medicare Administrative Contractors (MACs) Local and National Coverage Documentation Policies.

Continued >
These editing guidelines will be applied to facility claims processed after the second quarter of 2015, regardless of date of service.

The following enhancements will bring greater consistency and clarity to provider reimbursement:

- Automation of the Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs) policies and edits will align our claims processing functions more closely with Medicare's claim editing guidelines and industry coding standards. These edits will be updated as changes are made by these entities.

- LCD and NCD guidelines that were previously applied retrospectively to paid claims will now be applied prospectively resulting in a decrease of recovery reviews and take-back requests.

- Automation of claims editing will also allow for more consistent application of edits to review claim history for duplicate and improperly split claims.

While these system enhancements will not affect the claim submission process, a facility may be required to submit additional documentation for review to support the claim. Facilities should continue to submit claims the same way they currently do. If additional documentation is needed, we will provide details regarding the requested items.

To see Local and National Coverage Determination policies, go to cms.hhs.gov/mcd/search.asp.
UnitedHealthcare Medicare Solutions
Advance Notification Protocol Reminder

We wanted to take this opportunity to remind you of the following regarding important protocol related to Standard Advance Notification requirements:

**Notification requirements at a glance:**
- Physicians, health care professionals and ancillary providers are responsible for providing Advance Notification for services referenced in the Advance Notification List. To view the most current and complete Advance Notification List, including procedure codes and associated services, go to UnitedHealthcareOnline.com > Clinician Resources > Advance and Admission Notification Requirements.
- Physicians, health care professionals and ancillary providers are responsible for directing Customers to care within the Customer’s UnitedHealthcare network.
- Customers may be required to obtain Prior Authorization of out-of-network services.
- Facilities are responsible, prior to the date of services, for confirming the coverage approval is on file.
- Facilities are responsible for Admission Notification for inpatient services even if the coverage approval is on file.
- Failure to comply with the requirements described in greater detail below may result in claims being denied in whole or in part and, as required under your agreement with us, the Customer being held harmless.

**When is Advance Notification Required?**
- Advance Notification should be submitted as far in advance as possible, but is required to be submitted at least 5 business days prior to the planned service date (unless otherwise specified with the Advance Notification List) with supporting clinical documentation, to allow enough time for coverage review. Advance Notification for home health services and durable medical equipment is required within 48 hours after the start of service. Submitting Advance Notification as early as possible is best.
- It may take up to 15 calendar days to render a decision (14 calendar days for Medicare Advantage). Prioritization of case review is based on the specifics of the case, the completeness of the information received, CMS requirements, or other state or federal requirements. Time may be extended if additional information is needed.
- For services requiring expedited review, please call the telephone number on the Customer’s health care ID card. Expedited review for benefits that require Advance Notification or a benefit determination prior to receiving medical care is available where a delay in treatment could seriously jeopardize the Customer’s life or health, or the ability to regain maximum function, or in the opinion of a Physician with knowledge of the Customer’s medical condition, could cause severe pain. You must explain the clinical urgency when requesting an expedited review.

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

- 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 (Commercial Customers: 866-756-9733; Medicare Advantage Customers: 800-676-4798; Medicare Special Needs Plan Customers: 800-538-1339).
- If you do not have electronic access, please call us at the number on the Customer’s health care ID card.

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UnitedHealthcare Community Plan
Medical Policy & Coverage Determination
Guideline Updates

For complete details on the medical policy updates listed in the following table, please refer to the monthly Medical Policy Update Bulletin at UHCCommunityPlan.com > Provider Information > Medical Policies and Coverage Determination Guidelines for Community Plan.
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UnitedHealthcare Pharmacy

New Medical Necessity Requirement for Eloctate

Our National Pharmacy and Therapeutics Committee, comprised of physicians and pharmacists representing multiple subspecialty expertise, has determined that Eloctate, a medication used to treat Hemophilia A, may be medically necessary (as defined in our benefit plans) for some patients in specific scenarios.

Please note all coverage requests for Eloctate are currently subject to prior authorization review. For some UnitedHealthcare members, coverage of Eloctate may be subject to medical necessity review for pharmacy benefit and medical benefit coverage. This new requirement will apply to new and existing UnitedHealthcare Commercial members.

If you do not receive prior authorization before administering Eloctate, claims may be denied. Physicians cannot bill members for services that are denied due to lack of prior authorization.

For more information about the prior authorization requirement for specialty medications, please refer to the 2015 Administrative Guide under Specialty Drug Prior Authorization process (for Commercial members only) at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides.
Fully insured UnitedHealthcare and UnitedHealthcare Oxford members who have Commercial pharmacy coverage will have additional programs added to their benefits, effective July 1, 2015. Members who are impacted by these new programs will receive letters the first week of June 2015.

Coverage reviews and the appeals process are available for members impacted by these programs.

To see Prescription Drug Lists and medication criteria, go to UnitedHealthcareOnline.com > Tools & resources > Pharmacy Resources > UnitedHealthcare Prescription Drug List.

Pharmacy PDL and Benefit Updates

The July 1, 2015 pharmacy prescription drug list (PDL) and benefit updates will be available by May 15 and can be viewed online at UnitedHealthcareOnline.com > Tools & resources > Pharmacy Resources > UnitedHealthcare Prescription Drug List.
In an effort to streamline the process for requesting clinical information, UnitedHealthcare has created the Medical Records Requirement for Pre-service Guide and the Medical Records Requirement for Post-Service Guide. The Medical Records Requirement for Pre-service Guide will help identify specific clinical information required for prior authorization submission. The Medical Records Requirement for Post-Service Guide will help identify specific clinical information required for Medical Necessity Facility reconsiderations and appeals.

These guides include information for the most frequently requested service categories. These documents will assist your staff to prepare the suggested materials in advance, improving the turnaround time. It will also eliminate the need for multiple phone calls to obtain clinical information.

Medical record requirements may vary by plan. You will be contacted if additional information is needed.

For the most recent version of the Medical Records Requirement Guides, please go to UnitedHealthcareOnline.com > Tools & Resources > Policies Protocols and Guides > Protocols.
Doing Business Better

Health Insurance Exchanges: Three-Month Grace Period

The Patient Protection and Affordable Care Act (PPACA) requires health insurance plans to provide a three-month grace period before terminating coverage for certain individuals enrolled in a health plan purchased through the Individual Health Insurance Marketplace (also known as Individual Exchange).

The grace period applies to those who receive federal subsidy assistance in the form of an advanced premium tax credit and who have paid at least one full month's premium within the benefit year. The three-month grace period is a required rolling feature of Individual Exchange health plans. It is only triggered when a member that receives federal subsidies does not pay their portion of the monthly premium. Unless state regulations indicate otherwise, the three-month grace period is administered as follows:

- **Month One** – UnitedHealthcare will process or pay claims even if the member has not paid their premium.
- **Months Two and Three** – UnitedHealthcare will send a letter to the care provider advising them that the member is delinquent in paying their premium and their claims cannot be processed until the member’s full premium payment is received by the end of the three-month grace period. A copy of the letter is also sent to the member. During this time, the member may not be balanced billed since they still have coverage through the health plan.
- **After Three-Month Grace Period** – If premiums are paid in full within the three-month grace period, claims will be released for processing. If the premium is not paid in full by the end of the grace period, the member’s health plan will be retroactively terminated to the end of the first month. Any claims for services received during the second and third months of the grace period will be denied. This means care providers may not be paid, or may be required to refund any payments made by UnitedHealthcare, for services the member received in the last two months of the grace period. Care providers would have to seek payment for their services directly from the member. Any claims payments made for services may be recovered as overpayments under the process described in the care provider’s participation agreement.

For more information, please go to UnitedHealthcareOnline.com > Tools & Resources > Products & Services > UnitedHealthcare Compass.

Confirming Eligibility, Benefits and Participation Status

We’re building new networks and offering additional benefit plans. That means it's more important than ever for you to verify your participation status while checking eligibility and benefits at the point of service. If you are not participating in the patient's benefit plan, or are outside the benefit plan network service area, the patient may have no coverage or be responsible for a higher cost share.

Confirm your network participation using Optum Cloud Eligibility and Benefits application by registering at UnitedHealthcareOnline.com > Quick Links > Optum Cloud Dashboard.
Register your 10-Digit NPI number or your ‘Atypical’ status with UnitedHealthcare

The Health Insurance Portability and Accountability Act (HIPAA) requires the use of National Provider Identifiers (NPI) in administrative and financial transactions by care providers, health plans and health care clearinghouses. The Centers for Medicare & Medicaid Services (CMS) requires that health care providers have a 10-digit NPI number.

Providers with ‘Atypical’ status are not required to have a 10-digit NPI. ‘Atypical’ providers are individuals and organizations that furnish atypical or nontraditional services that are indirectly healthcare-related, such as taxi services, home and vehicle modifications, habilitation, and respite services. For more information about ‘Atypical’ providers, go to the CMS website and search for NPI Final Rule.

Register your NPI in one of three ways:
- UnitedHealthcareOnline.com: After logging in, select Practice/Facility Profile from the top menu; then View/Update NPI information.
- Provider Demographic Change Form: Complete and return as indicated on the form.
- Call the United Voice Portal at 877-842-3210 and follow the prompts.

Register your ‘Atypical’ status in one of two ways:
- Provider Demographic Change Form: Complete and return as indicated on the form.
- Call the United Voice Portal at 877-842-3210 and follow the prompts.

Additional information regarding NPI is available at UnitedHealthcareOnline National Provider Identifier webpage. If you have not obtained an NPI, apply on the National Plan and Provider Enumeration System (NPPES) website.

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 this act, physicians and other health care professionals, including hospitals, skilled nursing facilities, hospices, home health agencies and others must provide written information to patients about state law, advance treatment directives, the patients’ right to accept or refuse treatment and your own policies regarding advance directives. Whenever possible, please encourage your patients to execute an advance directive and a limited durable power of attorney. UnitedHealthcare also informs our members about advance directives through our member handbooks and other communications.
UnitedHealthcare Compass is an Individual Exchange benefit plan offered in 19 states as of January 2015. Since the Compass network was built to support targeted populations, it is featured only in select states and certain counties.

Members with a Compass benefit plan are covered for non-emergency services only when they see a network care provider within the Compass network service area. Therefore, care providers located outside the network service area are not considered an in-network provider for Compass benefit plans. To confirm your participation status, use the Cloud Dashboard eligibility application found at UnitedHealthcareOnline.com > Quick Links > Optum Cloud Dashboard > Eligibility & Benefits Center or by going to UnitedHealthcareOnline.com > Patient Eligibility & Benefits > Patient Eligibility.

For more Compass Network Service Area information, go to UnitedHealthcareOnline.com > Tools & Resources > Products & Services > UnitedHealthcare Compass > Compass Service Area Maps.

Referral Status – Charter, Compass, Navigate and Medicare Advantage Referral-Required Plans

Referrals are particularly important for Charter, Compass, Navigate and Medicare Advantage Referral-Required members since many receive significantly reduced benefits, or no benefits, for care provided without an existing referral on file.

Before seeing a UnitedHealthcare member, specialists should confirm the existence of a referral that identifies the specialist's tax ID number. Facilities are also encouraged to confirm the existence of a referral to the admitting physician for planned services, unless the admitting doctor is the patient's primary care physician.

The referral status detail screen includes referred network specialist information, the number of visits authorized and the number of visits remaining. Existing referrals can be viewed at UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Referral Status.
Since we introduced myHealthcare Cost Estimator (myHCE), we’ve made a number of enhancements to respond to member needs. Approximately 99.5 percent of our commercial members are able to create cost estimates through our member website and our mobile Health4Me application, available on Apple and Android operating systems.

In the April Network Bulletin, we highlighted the new UnitedHealthcare Hospital Quality Program. In February, we sent eligible hospitals their Hospital Quality Program Quality Rating Report, which shows their comparative quality results and the methodology used for the program. The hospital quality information will be available to members this spring through the myHCE. The new UnitedHealthcare Hospital Quality Program provides comparative quality information to help UnitedHealthcare members make informed health care choices about hospitals. The program results are based on measures for acute care hospitals that include common inpatient conditions and procedures. myHCE also includes expanded Leapfrog Hospital Survey data and Hospital Consumer Assessment of Healthcare Providers and Systems data.

Member cost estimates are specific to the care provider. According to your contract, please remember to notify your local network management team promptly of any care provider terminations, demographic updates or changes in ownership for your organization.

Consistent with CA SB 751 and SB 1340, California care providers have the opportunity to receive cost and quality data and a description of the UnitedHealthcare methodology for myHCE. Please contact your UnitedHealthcare Network Management Representative or Hospital or Physician Advocate to request the cost information, or to notify us that you would like to provide a response that links to the myHCE member display.
Each year, UnitedHealthcare reviews our Quality Improvement Programs with an eye toward improving the range of services provided to members. We measure these programs based on:

- Accessibility and availability of care
- Member and physician satisfaction
- Effectiveness of clinical care using the Healthcare Effectiveness Data and Information Set (HEDIS) and other evidence-based measures
- Continuity and coordination of care
- Initiatives to address racial and ethnic disparities in health care

The following are some of our accomplishments in 2014:

**UnitedHealthcare Commercial Plans:**

- 94.85 percent of surveyed members said that their personal doctors were good listeners, explained things well, respected them and spent adequate time with them.
- Continued year-over-year improvement in documentation of evidence-based treatment following accepted clinical and preventive practice guidelines, including but not limited to:
  - Diabetes care
  - Cardiovascular disease
  - Depression (medication management)
  - Improvement in HEDIS rates for the following measures:
    - Documentation of body-mass index (BMI) for adults and adolescents
    - Counseling on nutrition and physical activity for children and adolescents
    - Nationally, we met our goal of 75 percent of transplant patients treated at Centers of Excellence
    - Improved Consumer Assessment of Healthcare Providers and Systems (CAHPS) member survey results for composite rating for getting needed care and customer service
    - Closed gaps in the Diabetes Care program that focused on African American and Hispanic members exhibiting the most instances of diabetes care gaps
    - Addressing colorectal cancer screening disparities in ethnic (African American and Hispanic/Latino) populations.
UnitedHealthcare Medicare Solutions Plans:

- 47 plans are NCQA-accredited at the commendable or excellent level.
- Several HEDIS measures have shown ongoing improvement over the last 3 years, including:
  - Colorectal cancer screening
  - LDL screening for members with diabetes
  - Glaucoma screening
  - Diagnosis of chronic obstructive pulmonary disease (COPD) and spirometry testing
- Medicare CAHPS measures continued to show for the improvement in 2013. More than 80 percent of our Medicare contracts either increased or stayed the same in 2013 for the following CAHPS measures:
  - Rating of Health Plan
  - Annual flu vaccine
  - Getting appointments/care quickly
  - Rating of drug plan
  - Getting needed Rx drugs
- Member engagement initiatives continue to be deployed into 2014 to improve many HEDIS/CAHPS measures.

UnitedHealthcare Community Plans: UnitedHealthcare Community Plan’s Quality Improvement Program works to give our members better care and services.

Each year, UnitedHealthcare Community Plans report how well we are providing health care services to our members. Many of the things we report on are major public health issues. In 2013, one our goals was to see an increase in the number of well visits for babies, children, and teenagers. Other goals were to increase the number of members who had breast cancer screenings, pap smears, and cholesterol screens.

In 2014, we found that more babies were going for their well visits and more women were getting their mammograms.

We also found a large increase in the number of members who were having their BMI measured as an important step in screening for obesity. We found that many teenagers were not going for their annual well visits.

In 2015, we will continue to encourage and try to obtain higher rates of well visits for teenagers. Another goal is for our diabetic members to go for annual eye exams and HbA1c testing. We encourage all of our diabetic members to see their physician and have these important tests performed.

UnitedHealthcare Community Plan conducts member surveys each year to see how well we are meeting our member’s needs. Our 2014 surveys showed improvement from the previous year in how our members rated their specialists, their health care, and their health plan. We are seeking to improve our customer service experience and now have staff who works with members. We are looking at new ways that customer service can better address all of our member needs.
UnitedHealthcare Affiliates

New Condition Management Programs for UnitedHealthcare Oxford Members with Kidney Disease or Morbid Obesity

UnitedHealthcare Oxford members with a clinical diagnosis of kidney disease or morbid obesity are now eligible for three new condition management programs: Kidney Resource Services, Chronic Kidney Disease Services and Bariatric Resource Services. The programs will be available to all existing and new fully insured and self-funded UnitedHealthcare Oxford members, including Individual and non-Exchange Individual plan members, and will be provided on our behalf by Optum, a leading information and technology-enabled health services business of UnitedHealth Group, which also provides condition management services to members.
UnitedHealthcare Affiliates
New Condition Management Programs for UnitedHealthcare Oxford Members with Kidney Disease or Morbid Obesity

< Continued

Chronic Kidney Disease
The Chronic Kidney Disease (CKD) program helps reduce hospital emergency room visits, admissions and re-admissions. It targets members with stage 4 and 5 CKD, and uses interventions that may help to improve a member’s clinical condition, such:

- Identification and promotion of accurate diagnosis in pre-dialysis, late-stage CKD
- Timely referral of members to a nephrologist (and care coordination, if necessary)
- Help with management of the member’s co-morbid conditions (e.g., diabetes, hypertension, cardiovascular disease)
- Advanced preparation for transition to renal replacement therapy (dialysis), including promotion of preferred (non-catheter) access, home therapy, and outpatient initiation

UnitedHealthcare Oxford members became eligible for CKD condition management clinical support services as of March 16, 2015.

Kidney Resource Services/End-Stage Renal Disease Program
The Kidney Resource Services/End-Stage Renal Disease program (KRS/ESRD) delivers an integrated, evidence-based condition management program that focuses on members with ESRD. The program helps improve these members’ outcomes and reduce medical costs. KRS has two key components: utilization management and condition management.

KRS program nurses work to help:

- Reduce avoidable hospitalizations and emergency room visits, by proactively managing associated health risks
- Reduce admissions and re-admissions by comprehensive post-discharge outreach and follow-up
- Eliminate ongoing dialysis costs through early transplantation, where medically necessary
- Reduce cost through referrals to participating dialysis facilities

UnitedHealthcare Oxford plan members became eligible for KRS condition management clinical support services as of Feb. 16, 2015.

Continued >
UnitedHealthcare Affiliates
New Condition Management Programs for UnitedHealthcare Oxford Members with Kidney Disease or Morbid Obesity

< Continued

Bariatric Resource Services
The Bariatric Resource Services (BRS) program is designed to help reduce the clinical and economic variability associated with surgery for morbid obesity. BRS has the following components:

1. Access to a Centers of Excellence (COE)/designated provider network, which provides in-network education about quality bariatric centers to help improve clinical and economic outcomes.

2. Clinical case management, which consists of pre- and post-surgical telephone outreach by dedicated BRS nursing staff, who provide:
   - Education about the benefits of choosing a participating COE (i.e., fewer complications, and greater cost savings)
   - Intervention to help reduce the number of unnecessary surgeries
   - Post-surgical follow-up to help identify potential complications and discuss lifestyle modification

UnitedHealthcare Oxford members became eligible for BRS condition management clinical support services as of March 1, 2015.

Please contact Provider Services with any questions.

1 Oxford HMO products are underwritten by Oxford Health Plans (CT), Inc., Oxford Health Plans (NJ), Inc. and Oxford Health Plans (NY), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc. Administrative services provided by Oxford Health Plans LLC.
Members of UnitedHealthcare fully insured plans who have a clinical diagnosis of kidney disease are now eligible for the Chronic Kidney Disease (CKD) program, which became effective March 2015. This program, along with the already-available Kidney Resource Services, enables UnitedHealthcare to offer members a continuum of care for advanced CKD through end-stage renal disease. In doing so, we can better provide members with the tools they need to live healthier lives.

The objectives of this comprehensive approach are to use evidence-based approaches and nurse-led interventions to help slow the progression of kidney disease; help members better manage their disease and common co-morbidities; and prepare members for renal replacement therapy, if that becomes medically necessary. In addition to helping improve health outcomes and delaying progression to renal failure, this initiative targets the largest cost drivers associated with the disease: emergency room visits, inpatient utilization, and ongoing dialysis.

CKD is being introduced because kidney disease is a serious and costly health condition. The new program will address this concern by assisting affected members early in their diagnosis stage and at critical phases across the disease continuum. CKD will be provided by Optum, a leading information and technology-enabled health services business of UnitedHealth Group, which is already providing condition management services to members.

The CKD program will be available to UnitedHealthcare's fully insured business as well as UnitedHealthcare West, Oxford, MAHP, Harvard Pilgrim and public exchanges.
UnitedHealthcare regularly evaluates its medical policies, clinical programs and health benefits based upon the latest scientific evidence and specialty society guidance. Based upon this review for hysterectomy procedures performed for benign indications, we are instituting a prior authorization process for hysterectomy for benign disease that will evaluate medical necessity and appropriate site of service.

The American Congress of Obstetricians and Gynecologists (ACOG) has identified the preferred method for hysterectomies to be vaginal. Per ACOG, “Evidence demonstrates that, in general, vaginal hysterectomy is associated with better outcomes and fewer complications than laparoscopic or abdominal hysterectomies.” UnitedHealthcare encourages the most appropriate surgical approach based upon well-documented advantages and lower complication rates. However, coverage decisions will not be made on the basis of the route of hysterectomy ultimately selected by a patient and her physician.

To support ACOG’s recommendation and provide better outcomes for UnitedHealthcare members, the following plans will begin authorizing certain hysterectomy procedures on the following dates:

- UnitedHealthcare Life Insurance Company and Golden Rule Insurance Company for select group numbers, effective April 6, 2015
- UnitedHealthcare Oxford, effective April 1, 2015
- UnitedHealthcare Commercial, MD IPA and Optimum Choice, effective April 6, 2015
- UnitedHealthcare and UnitedHealthcare West Medicare Advantage, effective April 6, 2015
- UnitedHealthcare Commercial for Colorado, effective Aug. 3, 2015
- UnitedHealthcare of the River Valley and Neighborhood Health Partnership (NHP), effective Aug. 1, 2015
- UnitedHealthcare West/Signature Value, effective Aug. 3, 2015

Continued >
Prior authorization is required for the following services for the plans listed on the above page:

<table>
<thead>
<tr>
<th>Abdominal hysterectomy (Inpatient and Outpatient)</th>
<th>Laparoscopic hysterectomy (Inpatient and Outpatient)</th>
<th>Laparoscopic assisted vaginal hysterectomy (Inpatient and Outpatient)</th>
<th>*Inpatient vaginal hysterectomy (Inpatient only)</th>
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</thead>
<tbody>
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<td>58150</td>
<td>58541</td>
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</tbody>
</table>

*Note: Vaginal hysterectomies done on an outpatient basis do not need prior authorization.

Failure to complete the prior authorization process for the above codes with the place of service requirement will result in a reimbursement reduction. Members cannot be billed for claims that are administratively denied.

If it is determined during the clinical coverage review process that the service does not meet medical necessity criteria, an adverse determination will be issued. The member and provider will receive a notice of adverse determination with the appeal process outlined. Appeals for clinical denials will be conducted by UnitedHealthcare.

The member cannot be billed for services we determined to be medically unnecessary unless the member, with the knowledge of our determination, agrees in writing to be responsible for the cost of the services.

In addition, the following codes will be removed from the MD IPA and Optimum Choice prior authorization list on June 1, 2015: 58200, 58210, 58240, 58951, 58952, 58954, 58548, 58525.

If you have questions regarding these requirements, please contact your UnitedHealthcare market medical director or Physician Advocate.
UnitedHealthcare Affiliates
Prior Authorization Change for Balloon Sinus Ostial Dilation Endoscopy Procedures, including select UnitedHealthcare Community Plans

The requirements for prior authorization will change for Balloon Sinus Ostial Dilation endoscopy procedures for members who have failed select medical treatments. The procedure is not proven for patients younger than 12.

The specific procedures and corresponding codes are:

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31295</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of maxillary sinus ostium (e.g., balloon dilation), transnasal or via canine</td>
</tr>
<tr>
<td>31296</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of frontal sinus ostium (e.g., balloon dilation)</td>
</tr>
<tr>
<td>31297</td>
<td>Nasal/sinus endoscopy, surgical; with dilation of sphenoid sinus ostium (e.g., balloon dilation)</td>
</tr>
</tbody>
</table>

The effective dates of this change are:

- UnitedHealthcare Life Insurance Company and Golden Rule Insurance Company for select group numbers, effective April 6, 2015
- UnitedHealthcare Oxford, effective April 1, 2015
- UnitedHealthcare Commercial, MD IPA and Optimum Choice, effective April 6, 2015
- UnitedHealthcare and UnitedHealthcare West Medicare Advantage, effective April 6, 2015
- UnitedHealthcare West/Signature Value, effective Aug. 3, 2015
- UnitedHealthcare of the River Valley and Neighborhood Health Partnership (NHP), effective Aug. 1, 2015
- UnitedHealthcare Community Plan in the following states: Iowa, Kansas, Louisiana, Maryland, Michigan, Mississippi, New Jersey, New Mexico, Ohio, Rhode Island and Wisconsin, effective June 1, 2015
- UnitedHealthcare Community Plan in the following states: Arizona (including long-term care), Delaware, Hawaii, Nevada, New York, Pennsylvania, Tennessee (including long-term care) and Texas, effective Aug. 3, 2015

Failure to complete the prior authorization process will result in a reimbursement reduction. Members cannot be billed for claims that are administratively denied.

If it is determined during the clinical coverage review process that the service does not meet medical necessity criteria, an adverse determination will be issued. The member will receive a notice of adverse determination with the appeal process outlined. Appeals for clinical denials will be conducted by UnitedHealthcare.

The member cannot be billed for services we determined to be medically unnecessary unless the member, with the knowledge of our determination, agrees in writing to be responsible for the cost of the services.

If you have questions regarding these requirements, please contact your UnitedHealthcare market medical director or Physician Advocate.
UnitedHealthcare’s new Virtual Visits model is available as an opt-in to select National Accounts self-funded (ASO) customers in 2015. The Virtual Visits model lets members choose a virtual visit provider group, see and speak to a doctor using their mobile phone, tablet or computer. During the virtual visit, members can obtain a diagnosis and a prescription, if appropriate, can be sent to their pharmacy (subject to availability).

The Virtual Visits model is available to eligible ASO customers in 2015 that choose to opt-in to the service. Beginning in 2016 the Virtual Visits model will be available to all UNET-based members, including fully insured and ASO customers as an included offering. ASO customers will have an opt-out option.

- Virtual visits are fully integrated with benefit plans administered by UnitedHealthcare and are provided at no additional administrative cost.
- The virtual visit model includes a benefit design combined with a network of contracted virtual visit provider groups. It is a national network of virtual visit provider groups.
- Cost of the patient visit will be subject to benefit plan design, including deductibles, copays and out-of-pocket (OOP) maximums.
- Claims will be processed using standard claim processing procedures and the employee cost share will be covered like other medical claims.
UnitedHealthcare Affiliates
Updated Medical Policy on In-Network Exceptions for Breast Reconstruction Surgery Following Mastectomy – Effective May 1, 2015

We have updated our medical policy on in-network exceptions for breast reconstruction following mastectomy for UnitedHealthcare Oxford members in New York State, effective May 1, 2015.

All breast reconstruction surgeries for UnitedHealthcare Oxford members in New York performed in New York in the same or different operative session as the mastectomy must be performed by an in-network UnitedHealthcare Oxford breast reconstruction surgeon, including but not limited to plastic surgeons, assistant surgeons, etc., unless the member agrees to receive services from an out-of-network breast reconstruction surgeon by signing the Member Advance Notice Form before the procedure. The form must be kept on file by the participating mastectomy surgeon to provide to UnitedHealthcare Oxford upon request.

For members with out-of-network benefits, all out-of-network breast reconstruction claims will be paid at the out-of-network benefit level and out-of-network cost shares and deductibles will apply. Members who do not have out-of-network benefits are responsible for the entire cost of the service. If there is not an in-network surgeon available to perform the requested service, the participating mastectomy surgeon must request an In-Network Exception.

After May 1, 2015, no action is required when you use in-network breast reconstruction surgeons for breast reconstruction following mastectomy performed in the same or different surgical setting.
**UnitedHealthcare Affiliates**

**SignatureValue Benefit Interpretation Policy Updates**

For complete details on the policy updates listed in the following table, please refer to the monthly SignatureValue Benefit Interpretation Policy Update Bulletin at UHCWest.com

* > Provider Log In > Library > Resource Center > Guidelines & Interpretation Manuals.

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**Note:** The inclusion of a service or procedure on this list does not imply that UnitedHealthcare provides coverage for the service or procedure. In the event of an inconsistency between the information in this Network Bulletin and the posted policy, the posted policy prevails.
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### SignatureValue Medical Management Guideline Updates

For complete details on the policy updates listed in the table below, refer to the monthly SignatureValue™ Medical Management Guidelines Update Bulletin at UHCWest.com > Provider Log In > Library > Resource Center > Guidelines & Interpretation Manuals.

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<tr>
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UnitedHealthcare Affiliates
UnitedHealthcare of the River Valley
Preauthorization List and Policy Updates

For complete details on the new and/or revised policies and guidelines listed in the following table, please refer to the monthly Policy Update Bulletin at UHCRiverValley.com > Providers > Coverage Policy Library > Policy Update Bulletin.

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<td>Reimbursement Policies that Apply to Commercial Claims that are Subject to the River Valley Entities Supplement</td>
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## UNITEDHEALTHCARE AFFILIATES
### Oxford® Medical and Administrative Policy Updates

For complete details on the new and/or revised policies listed in the table below, refer to the monthly Policy Update Bulletin at [OxfordHealth.com > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > Policy Update Bulletin.](#)

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

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