Oxford Medicare Advantage Supplement

(May apply to providers in CT, NJ, NY; refer to your agreement for applicability)

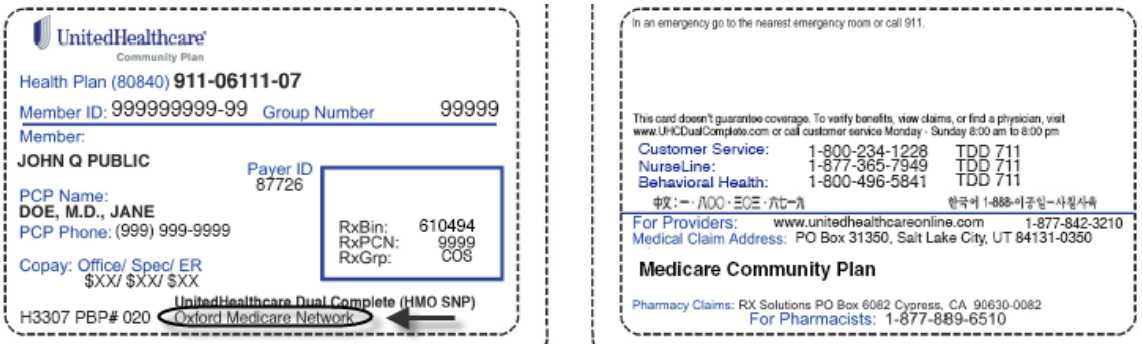
Important information regarding the use of this supplement

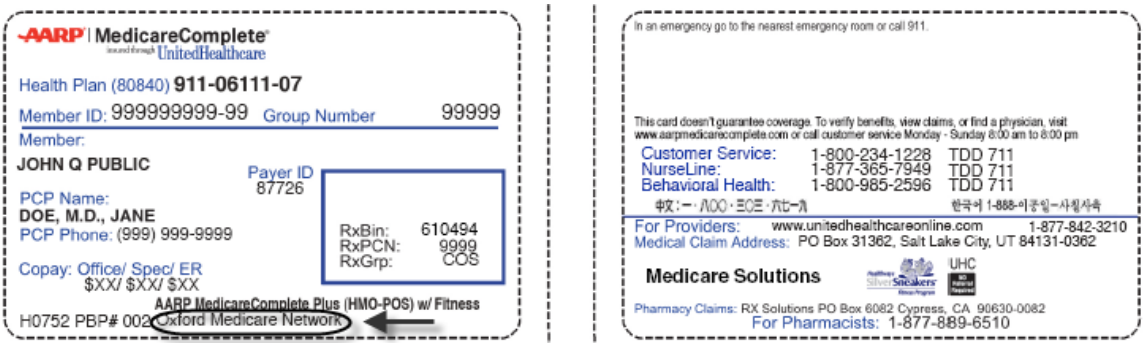
This Oxford Medicare Supplement (Supplement) applies to services provided to Customers enrolled in UnitedHealthcare Medicare Advantage plans offered under the AARP® MedicareComplete®, AARP® MedicareComplete® Mosaic*, and UnitedHealthcare® Medicare Advantage brands. This Supplement applies to Customers enrolled in the plans described above. Customers under those plans will present a health care identification (ID) card displaying the UnitedHealthcare logo in the top left corner and indicating either “Oxford Medicare network” or “Oxford Mosaic Network” in the lower right corner.

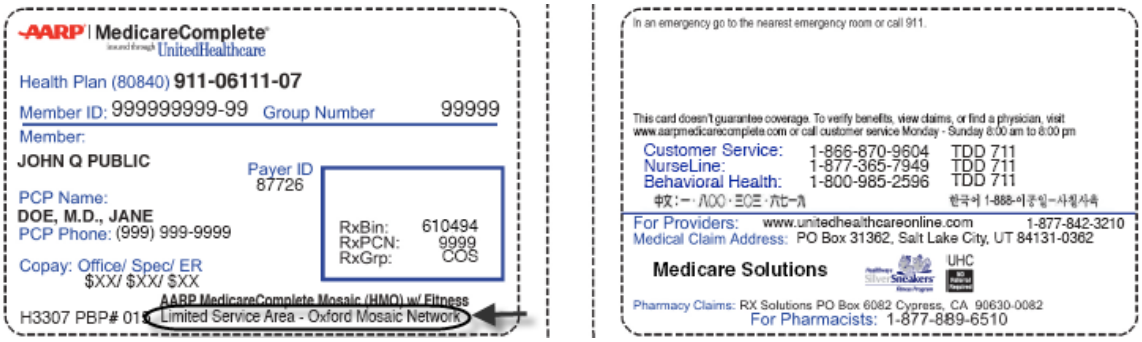
In the event of any inconsistency between the Guide and this Supplement, the Supplement and all Protocols and Payment Policies found on UnitedHealthcare Online will apply.

Health care ID cards

Customers enrolled in AARP® MedicareComplete®, AARP® MedicareComplete® Mosaic*, and UnitedHealthcare® Medicare Advantage plans on the current Oxford Health Plan benefit plans will present with a plastic health care ID card. Be sure to use the telephone numbers and addresses noted on these health care ID cards effective 1/1/2012.







* AARP® MedicareComplete® Mosaic (HMO) is a Limited Service Area and includes only the following four counties: Kings, Queens, New York and Bronx.

How To Contact Us:

Resource	Where to go	What you can do there
Online services	**Use UnitedHealthcareOnline.com**	• Register for UnitedHealthcare Online • Review a Customer's eligibility or benefits • Electronic Referral System • Submit notifications and pre-certifications • Check status of or update existing notifications and pre-certifications • View claim pre-determination and bundling logic using claim Estimator • Submit claims on-line CMS 1500 only • Check claims status • Request a claims adjustment or a reconsideration when attachments are not needed. • Submit a claim research project for 20 or more claims using the claim • Research Project online form • Update facility/practice data (except TIN) • Review the physician, health care professional, and facility directory • Look up your fee schedule, 10 codes at a time with the exception of capitated arrangements • Review/print a current copy of this Supplement • View healthplan protocols and policies • View current and past issues of our Network Bulletin • Access and review clinical program information and patient safety resources
Electronic Claim Submission (EDI Support Line)	**(800) 842-1109** To obtain information on HIPAA Transactions & code sets go to hipaa.uhc.com. Uniprise CompanionDocument Additional UnitedHealthcare and Affiliates' Payer IDs can be found on UnitedHealthcareOnline.com , Tools & resources , EDI Education for Electronic Transactions	Use our payer ID 87726

Claims process
All claims should be submitted electronically to our Payer ID **87726**. For claims appeals, please send your letter of appeal 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 under the Patient Eligibility and Benefits Section.

Health services
To notify us of the procedures and services outlined in the Preauthorization, Precertification section please fax, call or go online to:

- Non Urgent precertification requests only fax **(800) 303-9902**;
- Hospital Notification only fax **(800) 699-4712;**
- General Provider Phone Number **(877) 842-3210**;
- UnitedHealthcareOnline.com
- Submit via EDI

Services requiring precertification
The appearance of an item on this list is not a guarantee of coverage. Precertification requirements and covered services may vary depending on the Customer's plan of coverage. Precertification and payment of covered services are subject to the terms, conditions and limitations of the Customer's contract or certificate, eligibility at time of service, and approval by our Medical Management department. This list may be changed by us, and any changes will be communicated on the first business day of each month online at UnitedHealthcareonline.com.

In addition, precertification requirements may differ by individual physician or other health care professional. If additional precertification requirements apply, the physician or other health care professional will be notified in advance of the precertification rules being applied.

Inpatient and outpatient care
As a general rule, any service rendered in an inpatient facility or an outpatient facility requires precertification. These settings include, but are not limited to: acute care centers, skilled nursing facilities, freestanding ambulatory surgery centers, radiology centers, radiation therapy centers, hospice centers, and rehabilitation centers.
Exceptions to this rule include emergency room visits not resulting in an admission and urgent care delivered at a participating urgent care facility.

Emergency admissions do not require precertification. However, we must be notified within 24 to 48 hours of an emergency admission.
If an ambulatory surgery occurs as a result of an emergency room or urgent care visit, the provider must notify us within 24-48 hours of when the surgery is performed.

Elective admissions require prior authorization at least 14 days prior to the date of admission for the following: acute care, skilled nursing facility care, acute intensive rehabilitation care, and hospice care.

Transfer from one facility to another requires precertification prior to the transfer, unless the

transfer is due to a life-threatening medical emergency.

Hospital notification of admissions
Hospitals are required to notify us of inpatient admissions. We may deny part or all of an inpatient admission if the hospital fails to:

- Notify of any admission
- Obtain precertification for a non-emergency admission or an outpatient procedure for which precertification is required, including ambulatory surgery resulting from an emergency room or urgent care visit
- Notify us of any patient who changes level of care, including, but not limited to, NICU, ICU, etc.
- Obtain precertification for a non-emergency admission or an outpatient procedure for which precertification is required
- Provide records as reasonably requested by us
- Cooperate with inpatient concurrent review

If we deny part or all of an inpatient admission for one of the reasons noted above, the hospital will have 48 hours (72 hours for New Jersey hospitals) to submit a request to Medical Management for reconsideration of the denied days (excluding case rates). If during the reconsideration process, we determine the previously denied days were medically necessary and appropriate, we will pay the hospital for the covered services at the allowable rates.

Performing services at contracted hospitals

- All participating physicians and other health care professionals are responsible for obtaining precertification when hospital services (inpatient, outpatient or emergency admissions), out-of-network services and other specific services are to be delivered.
- All services require precertification 14 days prior to the scheduled date of service, with the exception of emergency room service, or unless the need is defined as a medical emergency.

Discharge planning and concurrent review
Upon admission, Medical Management will accept concurrent review information as well as the discharge plan provided by the admitting physician or other health care professional and/or the hospital's Utilization Review department. If a Customer requires an extended length of stay or additional consultations, please call our Medical Management department at (877) 842-3210 to update the precertification. For Behavioral Health, all calls related to inpatient precertification for UnitedHealthcare Community Plan Customers should be directed to (800) 496-5841 and all calls for all other Medicare Customers should be directed to (800) 985-2596.

Our concurrent review process uses approved criteria to determine the medical necessity of a Customer's continued hospitalization; it also allows for changes and updates to discharge plans.

Inpatient concurrent review – day-of-service decision-making program
We provide hospitals with day-of-service decision-making for continued and ongoing care. To achieve this goal, our processes are consistent with the Milliman Care Guidelines® for inpatient medical and surgical care, home care and recovery facility care. When issuing a precertification for an inpatient admission or concurrent review approval, the number of approved days or other types of services will be based on these guidelines. We provide concurrent and prospective certification for all services via the Hospital Communication Log (HCL). The HCL lists all our Customers currently known to be in that facility. We must be made aware of each Customer's admission, and the facility involved must provide timely necessary clinical information to

demonstrate medically appropriate covered care. Our intention is to eliminate most, if not all, retroactive denials. The following are more specifics about these processes.

Hospital responsibilities

Concurrent inpatient stays (notification prior to discharge)

The hospital will verify a patient's status, since no payment will be made for services rendered to persons who are not our Customers. The hospital is required to notify us of any patient that changes level of care, including but not limited to NICU, ICU, etc.

The Customer must be enrolled and effective with us on the date the service(s) are rendered; once the hospital verifies a Customer's eligibility with us, that determination will be final and binding; however, if the Centers for Medicare & Medicaid Services (CMS) or an employer or group retroactively disenrolls the Customer up to 90 days following the date of service, then we may deny or reverse the claim; if there is a retroactive disenrollment for these reasons, the hospital may bill and collect payment for those services from the Customer or another payer.

The hospital must provide a daily inpatient census log by 10 a.m.; the daily inpatient census log will reflect all admits and discharges through midnight the day prior; this will be considered the hospital's official record of our Customers under its care.

The hospital must provide notification of all admissions of our Customers at the time of, or prior to, admission; the hospital must notify us of all emergencies (upon admission or on the day of admission); the hospital must also notify us of "rollovers" (i.e., any patient who is admitted immediately upon receiving a precertified outpatient service); the hospital also must notify us of any transfer admissions of Customers.

The hospital must precertify any transfer admissions of Customers prior to the transfer unless the transfer is due to a life-threatening medical emergency.

The hospital must communicate necessary clinical information on a daily basis, or as requested by our Case Manager, at a specified hour that allows for timely generation of our HCL.
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).

The hospital is responsible for verifying the accuracy of the admission and discharge dates for our Customers listed on the HCL.

If we conduct on-site utilization review, the hospital will provide our on-site utilization management personnel reasonable workspace and access to the hospital, including access to Customers, their medical records, the emergency room, hospital staff, and other information reasonably necessary to:

– Conduct utilization review activities
– Make coverage decisions on a concurrent basis
– Consult in rounds and discharge planning in both inpatient and emergency room settings.

It is the responsibility of all physicians and other health care professionals to deliver letters of noncoverage to the Customer before discharge; this includes hospitals, acute rehabilitation, skilled nursing facilities, and home care.

Please 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)

A retrospective review may be initiated only within the above guidelines and when the Customer is not held financially liable. All information must be received within 10 business days of the initial request for retrospective review.

Preauthorization and precertification requirements for AARP® MedicareComplete® Mosaic

Certain services require preauthorization or precertification for AARP® MedicareComplete® Mosaic Customers.

Please remember preauthorization or precertification does not guarantee coverage or payment. All final decisions concerning coverage and payment are based upon Customer eligibility and benefits.

The following preauthorization requirements apply to AARP® MedicareComplete® Mosaic Customers. Be sure to submit your request at least 2 business days prior to the provision of services. Also, please keep in mind some procedures and services listed here may not be covered under the Customer's benefit plan. If you have any questions, please contact the Provider Services Department at the number on the back of the Customer's health care ID card.

Physical and Occupational Therapy Services

OptumHealth CareSolutions (OptumHealth), a UnitedHealth Group company, administers the physical and occupational therapy benefit for UnitedHealthcare's Oxford products.

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 by fax, mail or through the OptumHealth website at www.myoptumhealthphysicalhealth.com.

Fax: **(866) 695-6923**

Mail:

OptumHealth Care Solutions
P. O. Box 5800
Kingston, NY 12402-5800

Forms may be obtained through these channels:

Fax: **(866) 695-6923**

Mail: OptumHealth Care Solutions
P. O. Box 5800
Kingston, NY 12402-5800

www.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. Patient Summary Forms received outside of this 10-day submission requirement will reflect an adjustment to the initial payable date. This date will be calculated starting 10 days prior to the date OptumHealth received your Patient Summary Form.

Once the forms are received, OptumHealth will review the services requested for medical necessity, and will make any denial determinations. If a patient's care requires additional visits, an updated Patient Summary Form with updated clinical information must be submitted after the initially approved visits have occurred.

Laboratory services

In-office laboratory testing and procedures list

The in-office laboratory testing list provides a list of laboratory procedural/testing codes that we will reimburse its network physicians to perform in their offices. This list represents the only procedures/tests that Oxford network physicians can perform in their offices that will be reimbursed. All other lab procedures/tests must be performed by one of the participating laboratories in Oxford's network.

Certain physician contracts allow for additional tests to be reimbursed in the office. Refer to your physician contract for additional coverage guidelines.

*Note: Reimbursement for some of the procedures/ tests is limited to physician's specialties.

Primary Care Physicians and Specialists

CPT Code	Test Description
*81000	Urinalysis, non-automated, with microscopy
*81001	Urinalysis, automated, with microscopy
*81002	Urinalysis, non-automated, without microscopy
*81003	Urinalysis, automated, without microscopy
81025	Urine pregnancy test, by visual color comparison methods
*****82270	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided three cards or single triple card for consecutive collection)
*****82271	Blood, occult, by peroxidase activity (eg, guaiac), qualitative; other sources
*****82272	Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening
82948	Glucose; blood, reagent strip
82962	Glucose, blood sugar by glucometer
83014	Helicobacter pylori, breath test analysis; drug administration (Note: Dianon is providing test kit free of charge — call 800-328-2666)

83026	Hemoglobin; by copper sulfate method, non-automated
83655	Lead
***85013	Blood count; spun microhematocrit
***85018	Blood count; hemoglobin (Hgb)
85651	Sedimentation rate, erythrocyte; non-automated
****86403	Particle agglutination, screen, each antibody
86485-86580	Skin tests; various
**87070	Culture, bacterial; any other source but urine, blood or stool, with isolation and presumptive identification of isolates.
**87081	Culture, bacterial, screening only, for single organisms
87177	Ova and parasites, direct smears, concentration and identification.
87210	Smear, wet mount with simple stain, for bacteria, fungi, ova, and/or parasites
87220	Tissue examination for fungi (e.g., KOH slide)
87804	Infectious agent antigen detection by immunoassay with direct optical observation; Influenza
****87880	Infectious agent detection by immunoassay-streptococcus group A
89100	Duodenal intubation and aspiration; single specimen plus appropriate test
89105	Duodenal intubation and aspiration; collection of multiple fractional specimens with pancreatic or gallbladder stimulation, single or double lumen tube
89130-89141	Gastric intubation and aspiration; various
89350	Sputum, obtaining specimen, aerosol-induced technique
99195	Phlebotomy, therapeutic (separate procedure)
*** 85025	**For Stat Purposes Only** Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count

Those labs marked with *, **, ***, ****, ***** will be limited to one procedure (within the same family of asterisks) per visit. For example, all labs that are marked with one * will only be allowed to have one lab test performed out of all of the codes designated with the single *.

Dermatologists / Dermatopathologists

CPT Code	Test Description
88331	Pathology consultation during surgery; first tissue block, with frozen section(s), single specimen

Rheumatologists

CPT Code	Test Description
89060	Crystal Identification by light microscopy with or without polarizing lens analysis; tissue or any body fluid (except urine)

Urologists

CPT Code	Test Description
#89264	Sperm identification from testis tissue, fresh or cryopreserved
89300	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)
89310	Semen analysis; motility and count (not including Huhner test)
89320	Semen analysis; volume, count, motility and differential
89321	Semen analysis; sperm presence and motility of sperm, if performed
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)

#Customer must have the infertility benefit.

Pediatricians

CPT Code	Test Description
82247	Bilirubin, Total

Pulmonologists

CPT Code	Test Description
82803	Gases, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation)

Hematologists / Oncologists / Pediatric Hematologists

CPT Code	Test Description
***85007	Blood count; automated differential WBC count blood smear, microscopic examination with manual differential WBC count
***85025	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count) and automated differential WBC count
***85027	Blood count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)
85097	Bone marrow; smear interpretation only, with or without differential cell count
86077	Blood bank physician services; difficult cross-match and/or evaluation of irregular antibody(s), interpretation and written report
86078	Blood bank physician services; investigation of transfusion reaction, including suspicion of transmissible disease, interpretation and written report
86079	Blood bank physician services; authorization for deviation from standard blood-banking procedures, with written report
86927-86999	Transfusion medicine

Those labs marked with *, **, ***, ****, ***** will be limited to one procedure (within the same family of asterisks) per visit. For example, all labs that are marked with one * will only be allowed to have one lab test performed out of all of the codes designated with the single *.

Obstetricians / Gynecologists / Reproductive Endocrinologists / Infertility

CPT Code	Test Description
82670	Estradiol
83001	Gonadotropin; follicle stimulating hormone (FSH)
83002	Gonadotropin; luteinizing hormone (LH)
84144	Progesterone
84702	Gonadotropin, chorionic (hCG); quantitative
#89250	Culture of oocyte(s)/embryo(s), less than 4 days
#89251	Culture of oocyte(s)/embryo(s), less than 4 days, with co-culture of oocytes(s)/ embryos
#89253	Assisted Embryo hatching, microtechniques (any method)
#89254	Oocyte identification from follicular fluid
#89255	Preparation of embryo for transfer (any method)
#89257	Sperm identification from aspiration (other than seminal fluid)
#89260	Sperm isolation; simple prep (eg, sperm wash and swim-up) for insemination or diagnosis with semen analysis
#89261	Sperm isolation; complex prep (eg, Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis
#89300	Semen analysis; presence and/or motility of sperm including Huhner test (post coital)
89310	Semen analysis; motility and count (not including Huhner test)
89320	Semen analysis; volume, count, motility and differential
89321	Semen analysis; sperm presence and motility of sperm, if

	performed
#89325	Sperm antibodies
#89329	Sperm evaluation; hamster penetration test
#89330	Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test

#Customer must have the infertility benefit.

Endocrinologists / Infertility

CPT Code	Test Description
#89264	Sperm identification from testis tissue, fresh or cryopreserved
#89268	Insemination of oocytes
#89272	Extended culture of oocyte(s)/embryo(s), 4-7 days
#89280	Assisted oocyte fertilization, microtechnique; less than or equal to 10 oocytes
#89281	Assisted oocyte fertilization, microtechnique; greater than 10 oocytes
89290	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); less than or equal to 5 embryos
89291	Biopsy, oocyte polar body or embryo blastomere, microtechnique (for pre-implantation genetic diagnosis); greater than 5 embryos
89322	Semen analysis; volume, count, motility, and differential using strict morphologic criteria (eg, Kruger)
#89352	Thawing of cryopreserved; embryo(s)

#Customer must have the infertility benefit.

Specimen Handling and Venipuncture:

- If specimen handling and venipuncture codes are billed in conjunction with a lab code, only the lab and venipuncture codes will be reimbursed (and only if that lab code is on the above Lab Exception List).
- If specimen handling and venipuncture codes are billed without a lab code on Oxford's In Office Laboratory Testing and Procedures List or with other non laboratory services, the specimen handling and venipuncture codes will be paid per the Oxford fee schedule.