



**Oxford Provider Reference Manual**  
for physicians, health care professionals,  
facilities and ancillary providers  
**2012**



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# Important information regarding the use of this Manual

This Manual applies to all covered services which you provide to members under a commercial benefit plan insured by or receiving administrative services from Oxford, except where noted below for Oxford Medicare members. In the event your agreement indicates additional protocols or guides are applicable to members covered under certain benefit plans, those other protocols and guides will control with respect to such members.

Unless otherwise specified herein, this Manual is effective on **January 1, 2012** for physicians, health care professionals, facilities and ancillary providers currently participating in the Oxford network.

In the event of a conflict or inconsistency between a Regulatory Requirements Appendix attached to your agreement and this Manual, the provisions of the Regulatory Requirements Appendix will control with regard to benefit plans within the scope of that Regulatory Requirements Appendix. Additionally, in the event of a conflict or inconsistency between your agreement and this Manual, the provisions of your agreement with us will control. This entire Manual is subject to change.

All items within this Manual that describe how you must do business with us are Protocols under the terms of your agreement.

This Manual refers to a “member” as a person eligible and enrolled to receive coverage from a payer for covered services as defined in your agreement with us. “You” or “your” refers to any provider subject to this Manual, including physicians, health care professionals, facilities and ancillary providers; unless otherwise specified in the specific item, all items are applicable to all types of providers subject to this Guide. “Us,” “we” or “our” refers to Oxford or those Products and services subject to this Manual.

## Oxford Medicare Exceptions

**Effective January 1, 2012**, 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 current Oxford Health Plan platform, please refer to the 2012 UnitedHealthcare Administrative Guide located at **UnitedHealthcareOnline.com**.

The 2012 UnitedHealthcare Administrative Guide will include policies and procedures for your Medicare members with the exception of the following list of services.

Details relating to these exceptions can be found in the **Oxford Medicare Advantage Supplement** also included with the 2012 UnitedHealthcare Administrative Guide.

### List of exceptions:\*

- Contracted hospital notification of admissions
- Inpatient concurrent review – day-of-service decision-making program
- Preauthorization and precertification requirements for AARP® MedicareComplete® Mosaic for Physical and Occupational therapy
- In-office laboratory testing and procedures list

This applies to members enrolled in the plans described above and will present an identification card that will display the UnitedHealthcare logo at the top left-hand corner and will indicate “Oxford Medicare Network” and “Oxford Mosaic Network” in the lower right corner of the card.

\* Additional details pertaining to these policy exceptions which are part of the 2012 UnitedHealthcare Administrative Guide and effective on 1/1/12, can also be found on **Oxfordhealth.com > Providers or Facilities > Tools & Resources > Practical Resources > Medicare Information**.

# Network Bulletin

UnitedHealthcare publishes 6 editions annually of a user-friendly online notice of updates to policies, protocols, programs and other interesting items. The Network Bulletin helps our network physicians and facilities know about changes throughout UnitedHealthcare lines of business, including, but not limited to, commercial, Medicaid and Medicare. The Network Bulletin is posted online at **UnitedHealthcareOnline.com > Most Visited > Network Bulletin**. Here, you also can sign-up to receive the Network Bulletin via email. The email distribution is not limited to only one person in your office - have everyone sign up! Postcard announcements are mailed to all contracted providers in January and where required by law to send written notice the remainder of the year.

In 2012, Network Bulletin will be available on UnitedHealthcareOnline.com and through email on the following dates:

- January 3
- March 1
- May 1
- July 2
- September 4
- November 1

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



# Section 1: Contact Overview

## Contact information and resources

Commercial Products		
RESOURCE	WHERE TO GO	WHAT YOU CAN DO THERE
<b>Website</b>	<p><b>OxfordHealth.com</b></p> <p><b>Please note:</b> Many pages of information on the website are accessible without logging in. To use transactions, a username and password are required.</p> <p><b>Registration for physicians:</b> Go to <b>OxfordHealth.com</b> and click on Providers on the left navigation bar. Click “Need to Register?” and fill in the requested information (including SSN/TIN and date of birth).</p> <p><b>Registration for facilities:</b> You can start the process online or call our Web Help Desk at <b>(800) 811-0881</b>.</p>	<ul style="list-style-type: none"> <li>• Determine whether a CPT code requires precertification (up to 12 codes at one time)</li> <li>• Submit and check referrals and precertification</li> <li>• Check claim status and print an Explanation of Benefits (EOB)</li> <li>• Submit notifications of inpatient admissions (facilities only)</li> <li>• Check patient benefits and eligibility</li> <li>• Change your address (physicians only), e-mail, username, password, and referral fax number</li> <li>• Keep apprised of news in the Messages section</li> <li>• Request materials</li> <li>• Search for a physician, laboratory or hospital</li> <li>• Learn about new business arrangements</li> <li>• View radiology and laboratory program information</li> <li>• View our prescription drug information</li> <li>• View our medical and administrative policies</li> <li>• Review/print a current copy of this Manual</li> <li>• View our clinical and preventive practice guidelines</li> <li>• View our disease management initiatives</li> </ul> <p><b>Need Help?</b> For step-by-step instructions to using our website transactions, go to <b>OxfordHealth.com &gt; Providers or Facilities &gt; Tools &amp; Resources &gt; Manage Your Practice &gt; Administrative Ease &gt;</b></p> <ul style="list-style-type: none"> <li>• Provider Quick Reference, or</li> <li>• Facility Quick Reference</li> </ul> <p>We also offer instructor-led webcast training sessions. View the schedule at <b>OxfordHealth.com &gt; Tools &amp; Resources &gt; Manage Your Practice &gt; Administrative Ease &gt; Electronic Solutions Training Schedule.</b></p>
<p><b>Oxford Express®</b></p> <p><b>Automated telephone system</b></p>	<p>Phone: <b>(800) 666-1353</b> option 2 (for provider), Option 1 (participating), then Option 1 (Oxford Express)</p> <p>To obtain an access code: Facilities call <b>(800) 811-0881</b>.</p> <p>Physicians call <b>(800) 666-1353</b> and follow the prompts to Oxford Express, then: Enter the physician's Oxford Provider ID number, When asked for your access code, press pound (#), Press 1, enter the physician's SSN and date of birth, Enter a 4-6 digit code of your choice. You are immediately able to use Oxford Express.</p>	<ul style="list-style-type: none"> <li>• Check patient eligibility and primary care physician</li> <li>• Check the status of referrals and precertification requests</li> <li>• Submit referrals</li> <li>• Check the status of claims and request copies of remittance advices</li> </ul> <p>For a Quick Reference guide, go to <b>OxfordHealth.com &gt; Providers or Facilities &gt; Tools &amp; Resources &gt; Manage Your Practice &gt; Administrative Ease &gt; Using Oxford Express</b></p>
<p><b>Behavioral Health Department</b></p>	<p>Phone: <b>(800) 201-6991</b> Fax: <b>(800) 760-4041</b></p>	<p>Precertification only</p>
<p><b>Centers for Disease Control (CDC) National AIDS hotline</b></p>	<p>Phone: <b>(800) 232-4636</b></p>	<p>Anonymous counseling and HIV testing program information</p>

Commercial Products		
RESOURCE	WHERE TO GO	WHAT YOU CAN DO THERE
<b>Crisis Intervention Hotline- Connecticut</b>	Phone: <b>(800) 203-1234</b>	Provides referrals to all Connecticut local hotlines and resources.
<b>Crisis Intervention Hotline – New Jersey</b>	Phone: <b>(800) 624-2377</b> New Jersey phone: <b>(973) 926-7443</b>	Available 24 hours a day, 7 days a week, this number is only accessible when calling from New Jersey.
<b>Crisis Intervention Hotline – New York</b>	<ul style="list-style-type: none"> <li>• State of New York and New York City information: <b>(800) 541-2437</b></li> <li>• Spanish/bilingual information: <b>(800) 233-7432</b></li> <li>• TTY/TDD (for the hearing-impaired): <b>(800) 369-2437</b></li> <li>• Department of Health Testing Hotline: <b>(800) 825-5448</b></li> </ul>	<p>Pretesting counseling is conducted over the phone, and appointments are made for callers at testing centers throughout the 5 boroughs.</p> <p>This service is linked to a crisis intervention hotline.</p>
<b>Claim submission</b>	For claims submitted electronically: Payer ID 06111	For paper claims, please mail to: Oxford Claims P.O. Box 7082 Bridgeport, CT 06601-7082
<b>Clinical Appeals</b>	Fax: <b>(203) 459-7351</b>	Submit appeal requests
<b>Complementary &amp; Alternative Medicine For Chiropractic Services -- OptumHealth</b>	Fax: <b>(800) 201-7025</b>  <b>Provider Services/Claims</b> Phone: <b>(800) 985-3293</b> <b>Precertification by Fax</b> Fax: <b>(845) 382-6294</b>	Fax treatment care plans <ul style="list-style-type: none"> <li>• Physician claim/authorization questions</li> <li>• Inquiry about claims status, claims payment, authorization status, first level appeals</li> <li>• Submit precertification requests</li> </ul>
<b>Electronic Solutions Support)</b>	Phone: <b>(800) 599-4EDI (4334)</b>  Assistance with electronic solutions for your administrative needs, and helpful information regarding Electronic Data Interchange (EDI)	<ul style="list-style-type: none"> <li>• Understanding the benefits of electronic claims</li> <li>• Resolving problems with your practice management vendor</li> <li>• Addressing issues with your clearinghouse</li> <li>• Reading your electronic claims tracking reports</li> <li>• Setting up electronic claim payments and remittances</li> <li>• Submitting electronic referrals</li> </ul>
<b>Fraud Hotline</b>	Phone: <b>(866) 242-7727</b>	Report fraudulent activity
<b>Inpatient admission</b>	Web: <b>OxfordHealth.com &gt; Transactions &gt; Precert Requests</b> Phone: <b>(800) 666-1353</b> Fax: <b>(800) 303-9902</b>	Precertification of inpatient admission
<b>Laboratory information:  Laboratory Corporation of America (LabCorp) Client services:</b>	<b>(888) LabCorp [(888) 522-2677]</b>  Or visit <b>OxfordHealth.com</b> for a complete list of participating laboratories.	Patient service center locator number for members Visit <b>OxfordHealth.com</b> for the following: <ul style="list-style-type: none"> <li>• Inventory of patient service centers</li> <li>• List of available laboratories</li> <li>• Answers to frequently asked questions</li> </ul>
<b>Medical management Inpatient and Outpatient</b>	Phone: <b>(800) 666-1353</b>	<ul style="list-style-type: none"> <li>• Inpatient admissions</li> <li>• Outpatient procedures</li> </ul>
<b>Montefiore-CMO, the Management Company</b> (Contact and claim information)	Medical management/physician services, claim information: <b>(800) 876-7455</b>  Referral fax number: <b>(914) 467-4362</b>	Montefiore-CMO claims: Contract Management Organization, LLC Attn: Claims Department 200 Corporate Drive Yonkers, NY 10701

Commercial Products		
RESOURCE	WHERE TO GO	WHAT YOU CAN DO THERE
<b>Network Bulletin</b>	Online: <b>UnitedHealthcareOnline.com &gt; Most Visited &gt; Network Bulletin</b> Email: Sign up to receive the Network Bulletin via email in the News section of the <b>UnitedHealthcareOnline.com</b> home page.	<ul style="list-style-type: none"> <li>• Oxford medical and administrative information is included in the Affiliates section of this bi-monthly online publication.</li> </ul>
<b>Oxford On-Call®</b>	Phone: <b>(800) 201-4911</b>	<ul style="list-style-type: none"> <li>• Available 24 hours a day, 365 days a year</li> <li>• Staffed by registered nurses</li> <li>• Assistance for urgent and non-urgent medical problems</li> </ul>
<b>Pharmacy customer service</b>	Phone: <b>(800) 905-0201</b> TTY/TDD: <b>(800) 759-1089</b> Available 24 hours per day, 7 days per week, including holidays	Obtain information pertaining to prescription benefits
<b>Pharmacy notification</b>	Phone: <b>(800) 753-2851</b> Available 24 hours per day, 7 days per week, including holidays	Obtain medication notification/precertification for members
<b>Physical and occupational therapy - OptumHealth</b>	Provider services/claims: <b>(877) 369-7564</b> Precertification by fax: <b>(866) 695-6923</b> Claims inquiry: <b>(800) 666-1353</b>	<ul style="list-style-type: none"> <li>• Physician authorization questions</li> <li>• Submit precertification requests</li> <li>• Inquiry about authorizations, In-Network Exceptions, First Level UM Appeals</li> </ul>
<b>Outpatient Diagnostic Radiology CareCore National LLC</b> (radiology)	Phone: <b>(877) PREAUTH</b> Online: <b>www.CareCoreNational.com</b>	Outpatient Radiology precertification
<b>Radiation Therapy CareCore National LLC</b>	Phone: <b>(877) 773-2884</b> Online: <b>www.CareCoreNational.com</b>	Radiation Therapy precertification
<b>Website Help Desk</b>	Phone: <b>(800) 811-0881</b>	<ul style="list-style-type: none"> <li>• Learn about submitting electronic referrals</li> <li>• Topics Assistance with related to OxfordHealth.com</li> <li>• Help obtaining an <i>Oxford Express</i> access code</li> </ul>

# Section 2: Member Responsibilities and Management Information

## Member rights and responsibilities

### Members have the right to:

- Be treated with respect and dignity by our personnel, participating doctors and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures they receive.
- Voice concerns about the service and care they receive.
- Register complaints and appeals concerning their health plan or the care provided to them.
- Receive timely responses to their concerns.
- Participate in a candid discussion with their doctor about appropriate and medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Be provided with access to doctors, health care professionals and other health care facilities.
- Participate with their doctor or other health care professional in care decisions.
- Receive and make recommendations regarding the organization's members' rights and responsibilities policies.
- Receive information about us, our services, participating doctor and other health care professionals.
- Be informed of, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an Advance Directive to designate the kind of care they wish to receive should they be unable to express their wishes - Obtain current information concerning a diagnosis, treatment, and prognosis from any participating doctor in terms that a member can understand. If appropriate, this information will be made available to another person acting on the member's behalf.
- Make recommendations regarding the organization's member rights and responsibilities.

### Members have the responsibility to:

- Know and confirm their benefits before receiving treatment.
- Contact an appropriate health care professional when they have a medical need or concern.
- Show their member ID card before receiving health care services.
- Pay any necessary copayment at the time they receive treatment.
- Use emergency room services only for injury or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for their care.
- Follow agreed-upon instructions and guidelines of doctors and other health care professionals.
- Participate in understanding their health problems and developing mutually agreed-upon treatment goals.
- Notify their employer's human resource department of changes in their address or family status.
- Visit our website, **OxfordHealth.com**, or call Customer Service when they have a question about their eligibility, benefits, claims and more.
- Visit our website, **OxfordHealth.com**, or call Customer Service to verify that their physician or health care

professional is participating in our network before receiving services.

- In addition to the above noted information, members are entitled to rights and responsibilities, subject to applicable state law. These rights and responsibilities are outlined in their member health benefit plan.

## Management information

### Confidentiality – HIPAA privacy practices

We are committed to maintaining the confidentiality of our members' Protected Health Information (PHI). PHI is individually identifiable information about members that is used or disclosed by us to administer insurance coverage and to pay for the medical treatment members receive. It includes demographic information, such as names, addresses, telephone numbers, Social Security Numbers, and any medical information pertaining to members.

As required by HIPAA, we have provided members with a copy of our Notice of Privacy Practices.

### Selecting a primary care physician (PCP)

- Members enrolled in a gated HMO or HMO-based plan must select a PCP who provides primary care services and coordinates other services. Non-gated HMO and HMO-based products require the selection of a PCP; however, a member does not need to receive primary care from their selected PCP or obtain referrals to other network PCPs.
- In accordance with New York Department of Health Regulations, information about services received from physicians and other health care professionals may be sent to the PCP. Some insurance products require the selection of a PCP, however, members of our Freedom Plan<sup>®</sup> Select, Access and Direct, and Liberty Plan<sup>SM</sup> Select, Access and Direct Plan members do not need referrals and may receive primary care from any network physician or other health care professional.
- Members can only select a PCP within their network (e.g., a Liberty Plan<sup>SM</sup> member must select a Liberty Network participating PCP).
- Adult female members may also select an obstetrician/gynecologist (OB/GYN) whom the member may see without a referral from her PCP.
- Family members do not have to select the same PCP (see list of exceptions in Section 4 *Precertification and Referrals*).
- For gated plans, all services performed by physicians and other health care professionals other than the member's PCP or OB/GYN require a referral or precertification in order to be covered on an in-network basis; the exceptions to this procedure are medical emergencies and urgent care received from a network physician or other health care professional; members of plans that do require a referral will have "In-network Referral Required" printed on the back of the member's ID card.
- Members who are enrolled in a non-gated plan may self-refer to specialists on an in-network basis; these members have "No Referral Required" printed on the back of the member ID card; if the member's plan also includes out-of-network coverage, the member is required to pay deductibles and coinsurance as provided by the out-of-network benefit.
- If there is no referral indicator on the member's card, referrals are required for in-network specialty care.

### Primary care or specialist physician change

There are times when a member may need to change their primary care or specialist physician. Members can change their PCP through one of the following methods:

- Members may call Customer Service at **(800) 444-6222** or visit **OxfordHealth.com**

Members should consult with their PCP in order to change a specialist physician or other health care professional in order to remain under the supervised care of the PCP, and obtain any necessary referrals.

## 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**.

## Member 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.

Our goal is to make all administrative processes involving physicians and other health care professionals as efficient as possible. To perform an electronic eligibility inquiry, use any of the following methods:

- *Oxford Express*® **(800) 666-1353**, option 2 (provider), then option 1 (Oxford Express), option 1 (check eligibility and PCP).
- **OxfordHealth.com > Providers or Facilities > Transactions > Check Eligibility & Benefits**
- OptumInsight(formerly Ingenix)
- Post-n-Track
- Your clearinghouse of choice
- NAVINET – New Jersey physicians and health care professionals only

The HIPAA 270/271 Eligibility Inquiry and Response EDI transactions provide increased flexibility, accuracy and detailed information on individual patients.

### Search options

- Member ID number and last name
- Member first name and Social Security Number
- Member last name, first name and date of birth
- Ability to search one year in the past and 7 days in the future

### Information available on an inquiry

- Whether a referral required
- PCP in-network and out-of-network copayment, deductible and coinsurance information
- Specialist in-network and out-of-network copayment, deductible and coinsurance information
- Hospital Room and Board in-network and out-of-network copayment, deductible and coinsurance information
- Emergency room (ER) copayment and deductible information

**Please note:** Active Coverage means only that the individual is listed in our records as a member as of the confirmation date. Member eligibility is subject to change.

For additional information regarding electronic inquiry methods available, visit **OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > Electronic Eligibility & Benefits**,

contact Provider Services at **(800) 666-1353** or the Physician Electronic eSolutions Support Team at **(800) 599-4EDI (4334)**.

## **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. Out-of-pocket cost may include a copayment (i.e., fixed fee), a deductible (in-network or out-of-network) and/or coinsurance (in-network or out-of-network).

You should collect out-of-pocket costs for illness visits, allergy visits, all in-office procedures, and all office consultations. Generally, do not collect out-of-pocket costs\* for the following services:

- Annual preventive care visits
- Well-woman exams
- Well-baby care
- Prenatal care (after first visit)
- Radiological diagnostic testing
- Laboratory tests
- Immunizations and vaccines
- Follow-up services included in the Global Surgical Package

Please be aware that repeated waiver of out-of-pocket costs or other member financial responsibility is a violation of our policies and procedures and possibly applicable law.

\* Refer to the applicable member's plan for specific out-of-pocket cost guidelines, as some plans have different out-of-pocket costs for preventive care, laboratory testing, diagnostic testing, etc.

## **Member health care identification (ID) cards**

Each member is given a health care ID card. The member should present his/her card when requesting any type of covered health care service.

This card is for health care ID only and does not establish eligibility for coverage. 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.

# Section 3: Participating physician and other health care professional responsibilities

## Primary care physicians

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.

As a participating PCP, you agree to provide the following when applicable:

- Treatment of routine illness
- Child care from birth
- Pediatric and adult immunizations, according to the recommendations of the American Academy of Pediatrics and *The Guide to Clinical Preventive Services: Report of the United States Preventive Services Task Force*  
See the *Clinical Guidelines* section.
- Vision and hearing screenings for members up to age 18 (except for refraction for prescription vision correction)
- Treatment that follows current published clinical practice guidelines
- Laboratory procedures that may be performed in your office that are on our laboratory exception list
- Pap smears and pelvic exams. While you are required to offer Pap smears and pelvic exams, adult female members may also choose an obstetrician/gynecologist (OB/GYN), whom they may see without a referral; however, members are not required to choose an OB/GYN for gynecological exams
- Personal attendance to, or appropriate coverage for, your patients who may be in a facility or skilled nursing facility
- Educational services, including:
  - › Information to assist members in using health care services appropriately
  - › Information on personal health behavior
  - › Information on achieving and maintaining physical and mental health
- Maintenance of appropriate standards for your office, service and medical records
- Access to your records relating to services rendered to our members; if you believe consent is required from the specific member prior to granting us access to the records, you must obtain their consent; if you cannot obtain such consent, we shall not be responsible for payment of services rendered to such member
- Coordination of referrals to participating specialists and precertification within the member's network of participating physicians and other health care professionals, unless the member specifically elects, after full disclosure, to utilize any out-of-network benefits available
- If a member receives services from a facility, physician or other health care professional who does not participate in our network, we may make the claim payment directly to the member instead of to the non-participating physician or other health care professional; in such cases, the non-participating physician or other health care professional provider 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. For complete details, refer to **OxfordHealth.com > Tools & Resources > Practical Resources > Medical and Administrative Policies > Administrative Policies > Assignment of Benefits to Non-Network Providers.**

- Arrangement of coverage for the provision of medical services, 24 hours a day, 7 days a week, including:
  - › Telephone coverage after hours: You must have either a constantly operating answering service or a telephone recording that directs members to call a special telephone number to reach a covering medical professional. Your message must direct the member to go to the emergency room or call 911 in the event of an emergent situation; the message should be in English and any other relevant languages if your panel consists of patients with special language needs
  - › Covering physicians and other health care professionals: You must provide coverage of your practice 24 hours a day, 7 days a week; your covering physician or other health care professional must be a participating physician or health care professional; in the event that there is no participating physician or other health care professional available, a non-participating physician or other health care professional may deliver service; in this case, you must obtain precertification from us to ensure that the covering physician or other health care professional receives the correct payment of the claim; we will consider the covering, non-participating physician or other health care professional an agent of the participating physician; it is your obligation to inform the non-participating, covering physician or other health care professional that reimbursement will be their fee region rates, and that he or she may not balance bill the member; the participating physician or other health care professional will be held liable for any failure by the covering physician or other health care professional to follow our policies (i.e., the covering physician cannot attempt to balance bill).

## **Specialist services provided by PCPs**

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.

## **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.

## **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. These include, but are not limited to:

- Office staff shall receive initial and annual in-service education regarding the legal prohibition of unauthorized disclosure.
- Office staff shall maintain a list containing job titles and specified functions for which employees are authorized to access such information. This list shall describe the limits of such access to information and must be provided to the employees during employee education sessions.
- Only employees, contractors and medical, nursing or health-related students who have received such education on HIV confidentiality, or can document that they have received such education or training, shall have access to confidential HIV-related information while performing the authorized functions.
- Office staff shall maintain and secure records, including records which are stored electronically, and ensure records are used for the purpose intended.

- Office staff shall maintain procedures for handling requests by other parties for confidential HIV-related information.
- Office staff shall maintain protocols prohibiting employees, agents and contractors from discriminating against persons having or suspected of having HIV infection.
- Office staff shall perform an annual review of the 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.

## **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 if a member under specialist care using one of our electronic solutions or by calling our Medical Management Department at **(800) 666-1353**, and by notifying the member's PCP
- 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; if you cannot obtain such consent, we shall not be responsible for payment for services rendered to such member
- Follow our authorization guidelines for those services requiring precertification

You will only be reimbursed for services provided to our members if the member has a referral from his/her PCP, our medical director or Oxford On-Call®, unless the member is using out-of-network benefits or is in a non-gatekeeper plan. When a member schedules services, please confirm whether we have a referral on file for the service.

- If we have a referral on file or the member has a non-gatekeeper plan and the service is covered and medically necessary, we will be responsible for reimbursing the entire contracted fee and the member will be responsible for any applicable out-of-pocket cost.
- If 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.
- If 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. 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.

If such an election appears to be appropriate, our Medical Management Department will fax the specialist a form to complete. The completed form must be returned to us by fax before we can process the request. 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.

## Standing referrals

Standing referrals are granted to specialists or ancillary facilities for members who may require ongoing specialist treatment, including any member with a life-threatening or degenerative and disabling condition. These 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 a standing referral is appropriate, we will fax a form to the requesting physician or other health care professional. The physician or other health care professional must complete the form and fax it back to us for processing.

## 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 precertification, in accordance with the member's benefits

### Participating hospitals agree to:

- Verify a patient's status, since no payment will be made for services rendered to persons who are not our members
- Obtain precertification/authorization from us or a delegated vendor for all hospital services that require precertification; precertification/authorization must be obtained prior to rendering services
- Generally, all hospital services require our precertification/authorization (See Section 4 *Services Requiring Precertification and Referrals* for additional information on what services require precertification).
- Notify us of all elective/scheduled admissions of members at least 14 days prior to the admit date\*
- Notify us of any patient who changes level of care, including, but not limited to, NICU, ICU, etc.
- Notify us of all emergency/urgent admissions of members upon admission or on the day of admission\*
- Notify of an ambulatory surgery that occurs as a result of an emergency room or urgent care visit within 24-48 hours; provide care to any member who is admitted by a physician or other health care professional with appropriate privileges
- 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

\* 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.

## **Ancillary facilities and physicians (including facilities providing ancillary services)**

Participating ancillary facility/physicians agree to:

- Obtain authorization from us or our delegated vendor for all services that require precertification, and obtain referrals for those services that require referrals
- Work with PCPs to ensure coordination of care for our members, including advising PCPs, in writing, of treatments and services performed
- Maintain appropriate standards for your facility
- Receive compensation only from us, and adhere to our balance billing policies
- Cooperate with us in any audit, including providing access to all records relating to services provided to our members
- Complete the appeals process in a timely manner prior to proceeding to arbitration

## **New York physicians and other health care professionals and the 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.state.ny.us/nysdoh/hcra/hcrahome.htm](http://www.health.state.ny.us/nysdoh/hcra/hcrahome.htm).

Additional information on HCRA includes:

- Designated physicians of services under HCRA
- Net patient service revenues subject to the NYBDC surcharge
- Their obligations under HCRA

## **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.

# Basic administrative procedures

## Appropriate site of service

The usual sites of service are the physician's office, a freestanding outpatient or ambulatory center, a facility-associated outpatient or ambulatory surgery center, or an inpatient facility. We approve all services for the appropriate site and give consideration to a member's clinical needs for a higher level of care.

## Alternative level of care

Alternative level of care refers to the use of a subacute level bed for a skilled nursing facility (SNF) level of care, as well as an inpatient physical rehabilitation level of care.

We maintain a large network of physicians and other health care professionals and facilities capable of delivering appropriate care at various levels. For the purposes of reimbursement, we reserve the right to determine the appropriate level of care for inpatient stays based on the services the member receives, and to pay for such care at levels specified in the physician agreement or in accordance with our payment policy.

## Notification

Referrals and precertification are examples of how physicians and other health care professionals give us notice of services performed. Please be advised that notification must be timely and concurrent with care delivery to permit effective case management and coordinated care across the continuum.

Significant penalties apply for failure to provide proper notification.

Physicians and other health care professionals are required to notify us of any patient who changes level of care, including, but not limited to, NICU, ICU, etc.

## 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

## Insurance

All physicians and other health care professionals must maintain general liability and professional malpractice insurance. This is to insure physicians and other health care professionals and their employees against any claims arising from personal injury or death that may occur or be alleged to occur because of services performed by a physician or other health care professional or his/her staff. Unless we agree in writing, physicians and other health care professionals must maintain a minimum of \$1 million in malpractice insurance per occurrence and \$3 million as an annual aggregate.

## Access and availability standards

We determine the standards of physician and other health care professional access and availability based on the needs of the membership. A participating physician or other health care professional appointment system must adhere to the following guidelines on access:

Type of service (General)	Standard
Preventive care	Within 4 weeks
Customer Service telephone access average speed to answer (ASA)	30 seconds
Abandonment rate	2 percent
Emergency care	Immediate
Urgent care appointment	Same day
Routine symptomatic	Within 72 hours
Regular and routine care appointment	Within 14 days
Gynecology – well-woman physical	Within 6 weeks
Newborn first PCP visit	Within 2 weeks
Access to after-hours care	24-hour access, 7 days per week for primary physicians
Minimum number of days and hours per week	Minimum 4 days/20 hours per week
Maximum number of appointments per hour PCP	Less than or equal to 5 appointments per hour
In-office wait time, all physicians and other health care professionals	Less than or equal to 30 minutes
Type of service (Mental health/substance abuse)	Standard
Emergency	Immediate
Non-life-threatening emergency	Within 6 hours
Urgent care	Within 48 hours
Routine care	Within 10 business days

Acceptable after-hours access and systems include:

- Answering service
- Answering machine that informs patients how to access emergency care and directs patients needing urgent care to call an answering service pager, covering physician or other health care professional
- Phone forwarded to physician's or other health care professional's home
- Phone forwarded to covering physician or other health care professional
- Response time to an urgent after-hours call – within 30 minutes

## Availability standards

We establish standards for practitioner, physician and other health care professional availability in our service areas. For the purpose of measuring practitioner availability, a PCP is defined as a practitioner with one of the following specialties: family medicine, general medicine, internal medicine, or pediatric medicine. We also have standards for high-volume specialties. We determine which specialties are high-volume based on utilization and claims data. We do not contract with foreign physicians to satisfy local network requirements.

# Practice guidelines

## Basic standards of practice

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.

All physicians and other health care professionals shall immediately notify us if any medical license, board certification, facility admitting privileges, or other government certification to furnish health care services applicable to the physician or other health care professional is ever revoked, restricted or surrendered in any manner.

All our physicians and other health care professionals agree to cooperate with peer-review programs, including utilization review and quality assurance programs, precertification, external audit systems, administrative and grievance procedures, and all other policies as they are established by us. All our physicians and other health care professionals agree to comply with all final determinations rendered by our quality assurance programs, peer-review programs, audit programs, or grievance procedures.

In addition, all our participating physicians and other health care professionals agree to comply with our credentialing and recertification, administrative policies and procedures, patient referral, utilization review, quality assurance, and reimbursement procedures that we have established or will establish.

## Member cost of services

Physicians and other health care professionals are responsible for advising a member, prior to initiating services, when a particular service is not covered through his/her health plan. Please also advise the member of the amount required to pay for the service.

## Americans with Disabilities Act 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.

We are expected to promote the fact that our facilities and those of a sufficient number of affiliated physicians and other health care professionals are readily accessible to the physically and mentally disabled, that translator services are available as needed for non-English speaking members, and that interpreter services and other accommodations (such as a teletypewriter or TTY/TDD connections for member services) are made available to the hearing-impaired. Title III of the ADA also requires that covered entities make currently inaccessible facilities physically accessible to people with disabilities to the extent it is readily achievable for them to do so.

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 <http://www.ada.gov/cguide.htm#anchor62335>**

## 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 or of a reasonable alternative means to access your services for members using wheelchairs (or other mobility aids)
- A description of the methods that you or your staff will use to communicate with members who have visual or

hearing impairments, including any necessary auxiliary aid/services for members who are deaf or hard of hearing, and TTY/TDD technology available through a toll-free telephone number

- A description of the training your staff receives to learn and implement these guidelines and to become sensitive to the needs of persons with disabilities

### **Suggested accessibility standards**

Standard methods for making your office locations and services accessible to, and usable by, people with disabilities include the following:

- If parking is provided, nearby spaces reserved for people with disabilities, curb cuts at driveways and drop-offs
- Exterior walks, at least 36 inches wide, leading from parking areas or public transportation stops into the office building and/or facility
- Stable, slip-resistant routes of travel into the office/facilities, with all steps greater than 1/2 inch high ramped, and doorways with a minimum 32-inch opening
- Waiting rooms, restrooms and other rooms used by members accessible to people with disabilities
- Interior halls and passageways to bathrooms and other rooms commonly used by members with a clear and unobstructed path of travel at least 36 inches wide
- New member orientation, if any, available in audio or by interpreter services
- Staff trained in the use of telecommunication devices for members who are deaf or hard of hearing (TTY/TDD), as well as in the use of state-provided relay for phone communication
- Policy that when member services staff receives calls through the state relay, they will offer to return the call utilizing a direct TTY/TDD connection
- Staff training that includes sensitivity training related to disability issues

**Please 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).

### **Identifying members with disabilities**

We are expected to have satisfactory methods/guidelines in place for identifying persons having, or at risk for, chronic diseases and disabilities and for determining their specific needs in terms of specialist/physician referrals, durable medical equipment, medical supplies, home health services, etc. We expect your cooperation to achieve this goal and to implement the compliance methods listed below. Affiliated physicians and other health care professionals may not discriminate against a potential member based on his/her current health status or anticipated need for future health care, and may not discriminate on the basis of disability or perceived disability against a current member or his/her family member(s).

### **Suggested methods for compliance**

- Appropriate post-enrollment health screening for each member, using health-screening tools approved by the state or the Centers for Medicare & Medicaid Services (CMS), as applicable
- Patient profiles by condition/disease for comparative analysis to national norms, with appropriate outreach and education
- Process for follow-up of needs identified by initial screening (e.g., referrals, assignment of case management, and assistance with scheduling/keeping appointments)
- Enrollment population disability assessment survey
- Process for members who acquire a disability subsequent to enrollment to access appropriate services



## **Additional suggestions**

You should identify special health care, physical access or communication needs of members on a timely basis, including but not limited to, the health care needs of members who:

- Are blind or have visual impairments (also identify the type of auxiliary aids and services\* the member requires)
- Are deaf or hard of hearing (also identify the type of auxiliary aids and services\* the member requires)
- Are mobility-impaired (also explain the extent, if any, to which the member can ambulate)
- Have other physical or mental impairments or disabilities, including cognitive impairments
- Have conditions that may require more intensive case management

## **Patient education for members with disabilities**

Just as a managed care organization's materials may be made available to persons with disabilities in alternative formats (such as Braille, large print and audiotapes), you should develop or have available pertinent materials in similar formats and offer them to your disabled patients.

### **Suggested methods for compliance**

- Provide physically accessible office location(s)
- Make materials available in alternative formats such as Braille, large print, audiotapes
- Institute staff instruction, including sensitivity training related to disability issues
- Include sign-language interpreters upon request
- Offer health promotion materials targeted specifically to persons with disabilities (e.g., secondary infection prevention, decubitus prevention, special exercise programs, etc.)
- Communicate to individuals who are blind or vision-impaired that office staff will read or summarize any written materials that are typically distributed to all patients
- Provide staff and resources to assist individuals with cognitive impairments in understanding office procedures and materials

## **Clinical care and effective communication**

Effective communication is a critical part of rendering appropriate clinical care. Physicians and other health care professionals should provide members with the information they need to:

- Make informed choices about treatment options
- Effectively utilize health care resources
- Assist them in making appointments
- Field questions and process complaints when applicable

## **Care for members who are hearing-impaired**

There are federal requirements pertaining to physicians and other health care professionals who render services to members who are deaf or hard of hearing:

- Title III of the Americans with Disabilities Act, 42 U.S.C. Sect. 12182, 12183, provides people with disabilities with the rights to equal access to public accommodations.
- The U.S. Department of Justice regulation to Title III of the ADA requires that public accommodations provide auxiliary aids when such are necessary to enable a person with disabilities to benefit from their services: "A

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\* Auxiliary aids and services may include qualified interpreters, note-takers, computer-aided transcription services, written materials, telephone handset amplifiers, assisted listening systems, telephone compatible with hearing aids, closed-caption decoders, opened and closed captioning, telecommunications devices for members who are deaf or hard of hearing (TTY/TDD), video text displays, and other effective methods of making aurally delivered materials available to individuals with hearing impairments. Also included are qualified readers, taped texts, audio recordings, Braille materials, large print materials, or other effective methods of making visually delivered materials available to individuals with visual impairments.

public accommodation shall furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities.”\*

- Auxiliary aids and services required by the ADA include “qualified licensed and insured interpreters” to ensure that effective communication is provided at critical points during the provision of health care services as follows\*\*:
- When critical medical information is communicated
- When explaining a medical procedure
- When informed consent is required for treatment

**Please 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.

## Locating qualified interpreters for members who are hearing-impaired

An interpreter is necessary during a medical appointment with a member who is hearing-impaired. These agencies serve as a resource to connect interested parties with qualified interpreters.

<b>Connecticut</b>	
State of Connecticut Commission on Deaf and Hearing-Impaired. . . . .	(860) 708-6796 (TTY/Voice) (860) 231-8756 (TTY/Voice) (860) 8231-7623 (Interpreting)
Emergencies)	
<b>New Jersey</b>	
New Jersey Department of Human Services Division of the Deaf and Hard of Hearing . . . .	(609) 984-7281
<b>New York</b>	
New York Society for the Deaf . . . . .	(212) 777-3900
New York City Metro Registry of Interpreters for the Deaf . . . . .	(212) 821-9588
Deaf and Hard of Hearing Interpreting Services, Inc. . . . .	(718) 433-1092

To access our telecommunications device for the deaf (TTY/TDD), please call **(800) 201-4875** to assist members.

## Translator assistance for non-English speaking members

According to CMS and NCQA guidelines, we are required to ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds. Our physicians and other health care professionals play a key role in fulfilling these requirements by:

- Being responsive to the needs of a diverse patient population
- Demonstrating knowledge and sensitivity to the unique, culturally-based health care beliefs of patients
- Incorporating educational programs for office staff to improve their knowledge, attitudes and skills to be as culturally appropriate as possible

Our service associates are available to assist members in Chinese, Mandarin, Cantonese, and Korean. To speak with a service associate:

- In Chinese, Mandarin or Cantonese, call **(800) 303-6719**
- In Korean, call **(888) 201-4746**
- In English and other languages, call **(800) 444-6222** regarding members.

\* 28 CFR Sect. 36.303(c)

\*\* 28 CFR Sect. 36.303(b)(1)

**Please note:** We utilize a special translating service to communicate with members in the language they are most comfortable speaking.

## Patient education and treatment

It is your responsibility to share with your patients the findings of their history, examinations and tests, and to discuss potential treatment options without regard to plan coverage limitations. You should also inform patients about any side effects associated with treatment, as well as how to manage symptoms.

You should explain clearly and objectively to your patients the benefits, drawbacks and likelihood of success of any proposed treatment, and discuss the consequences of refusal or non-compliance with the recommended treatment plan. Ultimately, it is the patient who must choose the final course of action among clinically acceptable choices.

## Advance medical directives

We support a patient's right to participate in health care decision-making. The Patient Self Determination Act of 1991 guarantees an individual the right to accept or refuse any medical treatment or procedure.

In order to comply with the CMS regulations regarding advance directives, we ask you to document in a prominent place in the medical record whether or not your patients have advance directives. If a patient has created such a document, a copy should be included in a prominent place in his/her medical record.

You are responsible for providing your patients with comprehensive, clear information about therapeutic and diagnostic options. We encourage collaboration and open communication. Please make yourself available to discuss advance directives, life-prolonging measures and "do not resuscitate" orders with patients and/or families who have questions.

## Disease and intensive case management

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.

<b>Active Care Engagement<sup>SM</sup> (ACE)</b>	<b>(877) 759-3059</b>
The ACE program is a comprehensive health management program for high-risk members with heart failure, coronary artery disease and diabetes. The program is designed to help members manage their chronic condition to improve health status and quality of life. We are contracted with Healthways, Inc. to manage the ACE program. Additionally, the ACE program assists physicians in the successful management of the chronically ill member. Physicians with members participating in the program will receive disease specific guidelines for care, patient specific data reports and a variety of educational and support materials geared toward improving adherence to nationally recognized care guidelines for cardiac and diabetic conditions.	
<b>Better Breathing<sup>®</sup> Asthma Intervention Program</b>	<b>(800) 665-4686</b>
The asthma program is designed to emphasize patient education and promote compliance with the guidelines established through the National Institutes of Health. Its purpose is to complement the care a member receives from his/her doctor by providing educational mailings on topics such as the proper technique for administering medications and avoiding the triggers of asthma.	
<b>Living with Diabetes<sup>SM</sup></b>	<b>(800) 665-4686</b>
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. In addition, the program is designed to educate physicians about current treatment guidelines set by the American Diabetes Association (ADA) and to promote the use of these guidelines in diabetic treatment. The overall goal of the program is to improve the glycemic and lipid control of members with diabetes, thereby reducing morbidity and mortality associated with the disease.	
<b>Heart Smart<sup>SM</sup> Programs:</b>	
<b>Cardiovascular Disease</b>	<b>(800) 665-4686</b>
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 those who have experienced a CVD-related event (secondary). The program also provides up-to-date treatment and prevention information to physicians through the distribution of clinical practice guidelines, practice feedback and member-specific information.	
<b>Heart Failure</b>	<b>(800) 665-4686</b>
The Heart Smart heart failure (HF) population health management program is a comprehensive, population-based health management program for people with heart failure. The program also provides up-to-date treatment and prevention information to physicians through the distribution of clinical practice guidelines, practice feedback and member-specific information.	

<b>Oxford Cancer Support Program<sup>SM</sup></b>	<b>(800) 835-8021</b>
The cancer support program focuses primarily on members who have the potential to experience complications associated with their cancer treatment and who would benefit from case management interventions. As a physician, you can refer members over the age of 18 with an Oxford product, who are diagnosed with cancer (excluding acute leukemia) and are in active treatment or end-stage management.	
<b>Preventive Health Program</b>	<b>(800) 665-4686</b>
The preventive health program is designed to empower members to make informed, educated decisions about their personal health care. The program focuses on childhood and adolescent well care and immunizations, women's health, (mammography, pap smears), colorectal screening, and adult immunizations. The overall goal is to improve health outcomes and quality of care of our members by educating physicians and other health care professionals and members about general health and wellness and condition-specific preventive care.	
<b>Rare Chronic Care Program</b>	<b>(866) 217-2921</b>
We have contracted with Accordant Health Services to deliver an integrated, comprehensive case management program to empower members to successfully manage their chronic illness through education and symptom management, while encouraging compliance with the physician's care plan. Conditions addressed include myasthenia gravis, lupus, hemophilia, cystic fibrosis, and multiple sclerosis.	
<b>Transplant Program</b>	<b>(888) 936-7246</b>
OptumHealth is contracted to manage all aspects of every transplant to ensure medically appropriate care, including precertification and coordination of services.	
<b>Standard Care Coordination Program</b>	<b>(800) 444-6222</b>
(if no 5 digit extension is entered, hold for routing to next available representative).	
OptumHealth is contracted to manage Transitional Case Management and Complex Case Management (CCM) Programs.	
<b>Transitional Case Management</b>	
The Transitional Case Management program supports members in transition from an inpatient setting to a home setting. In our effort to prevent avoidable readmissions of recently discharged individuals, we help ensure that a discharge plan is in place and that the member is compliant with his/her medications and follows up with his/her physician.	
<b>Complex Case Management</b>	
Focused on the highest need consumers of a population, Complex Case Management serves as a means for achieving client wellness and autonomy through advocacy, communication, education, identification of service resources and service facilitation. The focus of the programs is to coordinate care and reduce health care costs by supporting our value pillars of right care, right provider, right medications and right lifestyle. The process helps identify appropriate providers and facilities throughout the continuum of services, while ensuring that available resources are being used in a timely and cost-effective manner in order to obtain optimum value.	
<b>NICU Program</b>	<b>(888) 936-7246</b>
We have contracted with OptumHealth Neonatal Resource Services (NRS) to provide Neonatal Intensive Care Unit (NICU) on-site and telephonic case management services for members. The objectives of the NRS program are to promote continuity of service and care, encourage family involvement, and assist with the neonate's successful transfer home by coordinating discharge planning needs. NRS clinical staff will help support the facility's NICU staff and neonatologists in their role as clinical decision-makers, optimizing family involvement in the baby's care.	

## Examples of fraud, waste and abuse behaviors

The following provides information regarding possible schemes, activities and behaviors of potential fraud, waste, and abuse that may affect or may be encountered by physicians and other health care professionals. This list is not exhaustive and is for information purposes.

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 in the beginning this manual for contact information. We expressly prohibit retaliation if a report is made in good faith.

**Illegal remuneration schemes** – Prescriber is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the prescriber to write prescriptions for drugs or products.

**Prescription drug switching** – Drug switching involves offers of cash payments or other benefits to a prescriber to induce the prescriber to prescribe certain medications rather than others.

**Script mills** – Physician or other health care professional writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients who are not theirs.

**Theft of prescriber's DEA number or prescription pad** – Prescription pads and/or DEA numbers can be stolen from prescribers. In the context of e-prescribing, this includes the theft of the physician's or other health care professional's authentication (login) information.

**Inappropriate relationships with physicians** – Potentially inappropriate relationships between pharmaceutical manufacturers and physicians or other health care professionals, such as “switching” arrangements to induce a physician or other health care professional to switch the prescribed drug from a competing product; incentives offered to physicians or other health care professionals to prescribe medically unnecessary drugs; consulting and advisory payments, payments for detailing, business courtesies and other gratuities, educational and research funding; improper entertainment or incentives offered by sales agents.

**Illegal usage of free samples** – Providing free samples to physicians or other health care professionals knowing and expecting those physicians or other health care professionals to bill the federal health care programs for the samples.

Physicians and other health care professionals should be aware that there are schemes perpetrated by beneficiaries. The following are a list of types of fraud, waste and abuse that could be perpetrated by beneficiaries in Part D:

**Prescription forging or altering** – Prescriptions are altered, by someone other than the prescriber or pharmacist, without prescriber approval, to increase quantity or number of refills.

**Prescription diversion and inappropriate use** – Beneficiary obtains prescription drugs from a physician or other health care professional, possibly for a condition from which they do not suffer, and gives or sells this medication to someone else. This can also include the inappropriate consumption or distribution of a beneficiary’s medications by a caregiver or anyone else.

**Resale of drugs on black market** – Beneficiary falsely reports loss or theft of drugs or feigns illness to obtain drugs for resale on the black market.

**Doctor shopping** – Beneficiary or other individual consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs.

## **Utilization management**

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

## **Appropriate service and coverage**

Our Medical Management 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.

We may compile information regarding procedures that, based on a review of our members’ claims experience, are performed more frequently or with unclear or controversial indications. We may also conduct reviews regarding overutilization, including but not limited to, working with physicians and other health care professionals to improve performance, and disciplining repeat offenders.

## **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, precertification procedures, referral processes or protocols and reporting of clinical accounting data
- Member and physician and other health care professional grievances
- 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, by phone and in writing, within 3 business days of receipt of necessary information.\*

**Concurrent review** – UR decisions will be made and notice will be provided to the member or the member's designee by phone and writing within 1 business day of receipt of necessary information. Please note that this requirement may be satisfied by giving notice to you, the physician or other health care professional, by telephone and in writing, within 1 business day of receipt of necessary information.

**Retrospective** – UR decisions will be made within 30 days of receipt of necessary information. We will notify you of the determination in a Remittance Advice statement or a separate notice.

A written notice of an initial adverse determination will include:

- The reasons for the determination including the clinical rationale, if any;
- Instructions on how to initiate standard and expedited internal and external appeals;
- Notice of the availability, upon request of the member or the member's designee, of the clinical review criteria relied upon to make such determination;
- The notice will also specify what, if any, additional necessary information must be provided to, or obtained, to render a decision on the appeal.

A preauthorized treatment, service or procedure may be reversed on retrospective review under the following circumstances:

- Relevant medical information presented to us or utilization review agent upon retrospective review is materially different from the information that was presented during the preauthorization review; and
- The information existed at the time of the preauthorization review but was withheld or not made available; and
- Health plan or the UR agent was not aware of the existence of the information at the time of the preauthorization review; and
- Had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

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

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\* Per Section 4 of this manual, the telephonic notification to members has been delegated to you. Please remember to call the member.

a reconsideration of the adverse determination. Except in cases of retrospective reviews, such reconsideration shall occur within 1 business day of receipt of the request and shall be conducted by the member's physician or other health care professional and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer cannot be available. In the event that the adverse determination is upheld after reconsideration, a written adverse determination notice containing the items specified above will be sent to you. Nothing in this section shall preclude the member from initiating an appeal from an 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.

## **Criteria for determining coverage**

Our medical directors are available to discuss their decisions with you. Contact our Medical Management department directly at **(800) 666-1353** (Mon. - Fri., 8 a.m. - 6 p.m. ET) and ask to speak to one of our medical directors. Medical policies are also available online at **OxfordHealth.com > Providers or Facilities > Tools & Resources > Medical and Administrative Policies.**

## **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. A written request will give us a clear understanding of the issues being appealed, and must include any documentation/information already requested by us (if not previously submitted) and any additional information the member or the member's designee would like to submit in support of the appeal. Additional information about member appeals is contained in this manual and will be sent with each initial adverse UR determination.

An expedited UR appeal may be filed for denials of:

- Continued or extended health care services, procedures or treatments;
- Additional services for member undergoing a course of continued treatment; and
- Health care services for which the physician or other health care professional believes an immediate appeal is warranted.

Determinations concerning services that have already been provided are not eligible to be appealed on an expedited basis.

The process for handling expedited appeals includes mechanisms which facilitate resolution of the appeal including but not limited to:

- The sharing of information by telephone or fax;
- Reasonable access to the clinical peer reviewer within 1 business day of our receipt of notice of the taking of an expedited appeal; and
- A mechanism for immediately requesting necessary information from the member and the member's physician or other health care professional by telephone and/or fax.

Expedited UR appeals will be determined within 2 business days of receipt of necessary information to conduct such appeal. Written notice of final adverse determination concerning an expedited UR appeal will be transmitted to the member within 24 hours of rendering the determination. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process.

Standard (non-expedited) UR appeals may be filed by telephone or in writing by the member or member's designee.

Written acknowledgment of the filing of the appeal will be provided to the appealing party within 15 days of the filing of a standard appeal if a determination is not made within fifteen days of the filing of the appeal. The process for standard appeals also includes a mechanism for requesting necessary information from the member and the member's physician or other health care professional in writing within 15 days of receipt of the appeal and a follow-up as appropriate, if information is not received.

A determination will be made within 60 days of the receipt of necessary information to conduct the appeal. The member, the member's designee and, where appropriate, the member's physician or other health care professional, will be notified of the appeal determination in writing within 2 business days of the rendering of such determination. The notice will include reasons for determination. If an adverse UR determination is upheld on appeal, the notice will include the clinical rationale for such determination and a notice of the member's right to an external appeal together with a description of the external appeal process.

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.

## **Members' rights to external appeal**

The member has a right to an external appeal of a final adverse determination (FAD). An external appeal may also be filed if the member and the plan jointly agree to waive the internal UR appeal process and the issue would otherwise be the type eligible for external appeal if the first-level internal appeal had been processed.

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 or the experimental/investigational exclusion. Determinations concerning clinical trials and experimental or investigational procedures may be appealed through the external appeal process only if the member's physician is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's condition or disease, and has certified that:

- The member's condition meets the statutory definition of a "life threatening" or "disabling" condition or disease for which standard health services or procedures have been ineffective or would be 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 clinical trial for which the member is eligible; and
  - › The specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for our determination that the health service or procedure is experimental or investigational.

Furthermore, the physician's certification must include a statement of the evidence relied upon by the physician in certifying his/her recommendation, and an external appeal must be submitted within 45 days upon receipt of the FAD, regardless of whether or not a second level appeal is requested. If a member chooses to request a second level internal appeal, the time may expire for the member to request an external appeal.



# 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 the basis and clinical rationale for the denial as applicable to the member;
- a clear statement that the notice constitutes the final adverse determination;
- the health care plan's contact person and his/her telephone number;
- the member's coverage type;
- the name and full address of the health care plan's utilization review agent;
- the utilization review agent's contact person and his/her telephone number;
- a description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service;
- a statement that the member may be eligible for an external appeal and the timeframes for requesting an appeal; and
- for health care plans that offer two levels of internal appeals, a clear statement written in bolded text that the 45 day timeframe for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the enrollee to request an external appeal.

## Criteria and guidelines

We have adopted the Milliman Care Guidelines® and criteria for inpatient care where an optimal recovery guideline 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

## Clinical guidelines

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 log in as a physician or facility at **OxfordHealth.com > Tools & Resources > Clinical & Preventive Guidelines > Clinical Practice Guidelines.**

## 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 serves to provide 30 days advance notice of medical policy updates. By accessing the monthly Policy Update Bulletin, you may view 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 > Tools & Resources > Practical Resources > Medical and Administrative Policies > Policy Update Bulletin**.

You can request a hard copy of a medical policy by writing to:

Oxford Policy Requests and Information  
48 Monroe Turnpike  
Trumbull, CT 06611

# Section 4: Precertification and Referrals

## Precertification or notification

- Our participating facilities, physicians and other health care professionals must notify us at least 14 days prior to a patient's scheduled procedure. Obstetrical admissions for normal delivery should be precertified as early as possible in the course of prenatal care, based on the expected date of delivery.
- Participating physicians and other health care professionals and facilities are responsible for contacting us for all procedures requiring precertification; however, an active referral\* must also be on file for services to be covered in-network, depending on the member's benefits.
- Neither precertification 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.
- If a participating PCP 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 precertification 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, then it is the member's responsibility to obtain all required precertifications by calling **(800) 444-6222**. Please remember to tell the member that you may not refer the member to a non-participating provider, and the member must contact us to obtain the required precertification.
- Participating physicians and other health care professionals are responsible for notifying us when there has been a change of treating physician or other health care professional, CPT codes or dates of service for the precertified service.
- Members are responsible for notifying us of emergency facility admissions to a non-participating facility. Participating physicians, other health care professionals and contracted facilities must notify us of 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 physician or other health care professional receives notification to inform the member of our determination.
- We may require that your patient 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.

\* Not required when a member is seeing their designated participating OB/GYN.

## Using non-participating 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., Freedom 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 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.

**Please 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.

## Services requiring precertification

Precertification requirements and covered services may vary depending on the member's plan of coverage. The appearance of an item on this precertification list is not a guarantee of coverage. Precertification and payment of covered services are subject to the terms, conditions and limitations of the member's contract or certificate of coverage, eligibility at time of service, and approval by our Medical Management Department.

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.

A list of services requiring precertification is available for your reference at **OxfordHealth.com > Providers or Facilities > Tools & Resources > Practical Resources > Medical and Administrative Policies**. 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** via the monthly Policy Update Bulletin.

Additionally, you can log on to **OxfordHealth.com** and check up to 12 CPT codes at one time, using the **Precert Required Inquiry tool** on the **Transactions** tab.

## 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. In addition, a list of outpatient services not requiring precertification is available in our

policy *Precertification Exemptions for Outpatient Services*.

Emergency admissions do not require precertification. However, we must be notified within 24 to 48 hours of an 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, sub-acute 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.

## **Assistant surgeons and co-surgeons**

Participating physicians are required to use a participating physician's assistant surgeon when an assistant surgeon is warranted. Precertification is required; you must use one of our electronic solutions, or call our Medical Management Department at **(800) 666-1353**.

## **Home health care**

Home health care includes, but is not limited to, physical therapy, nursing visits and occupational therapy.

## **Office-based procedures**

Any surgical procedure, major diagnostic test and endoscopic procedure

## **Potentially cosmetic procedures (including but not limited to)**

- Repair of ptosis, blepharoplasty and repair of ectropion/ectropion
- Ablative procedures for venous insufficiency and varicose veins
- Breast reduction (both male and female)
- Refractive eye surgery
- Rhinoplasty and nasal surgical procedures
- Destruction of cutaneous vascular proliferative lesions less than 10 sq. cm. for hemangiomas and port wine stains, birthmarks, strawberry nevis
- Destruction of cutaneous vascular proliferative lesions (e.g., laser technique) over 10 sq. cm.
- Panniculectomy and body contouring procedures
- Gynecomastia
- Breast reconstruction for non-cancer diagnosis

## **All other services requiring precertification (all settings including in-office unless otherwise noted)**

### **Complementary and alternative medicine**

Chiropractic services for members\* require precertification\*\*

OptumHealth Care Solutions

P.O. Box 5800

Kingston, NY 12402-5800

\* Coverage is based on member's benefit.

\*\* Precertification is not required for certain groups.

**Behavioral health/substance abuse**

- Outpatient mental health; members of gated plans need a referral from their PCP or through our Behavioral Health department **(800) 201-6991**
- Cognitive and neuropsychological testing
- Inpatient care

**Dental procedures**

- Procedures to treat injury to sound natural teeth
- Procedures requiring inpatient/outpatient general anesthesia

**DME/prosthetics/supplies/implantables**

- DME and orthotics over \$500
- All prosthetics, custom orthotics and custom DME (regardless of cost)
- All rentals, repairs and replacements, and implantables
- Beds, cribs and pressure-reducing mattresses/pads/overlays
- Bone growth (osteogenesis) stimulators
- Cochlear implants and osseointegrated (boneanchored) hearing aids
- Continuous passive motion devices
- Cryotherapy devices
- Electrical stimulation devices (e.g., wound care, muscle rehabilitation, pain management)
- High-frequency chest wall compression devices
- Mechanical stretching devices (dynamic and static)
- Nutritional therapy (including formula and specialized foods)
- Speech generating devices
- Standing systems
- Wheelchairs (manual and power), power-operated vehicles (scooters), specialized strollers
- Wigs (replacement)

**Experimental and investigational therapies (including off-label therapies)**

- Clinical trials
- All other experimental and investigational therapies

**Genetic Testing for Hereditary Breast and/or Ovarian Cancer Syndrome (HBOC)****Radiology procedures (through CareCore National)**

- CT scans
- MRI
- MRA
- PET scan
- Nuclear medicine studies
- Endoscopic/obstetrical ultrasounds

## **Polysomnography and Portable Monitoring**

### **Radiation Therapy Procedures (through CareCore National)**

- 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),

### **Rehabilitation services**

- Occupational and physical therapy for members\* through OptumHealth Care Services\*\* (authorization is required for the initial evaluation)
- Speech therapy in the home for members

### **Surgical procedures**

- All outpatient and inpatient procedures

### **Transplantation**

- Solid organ transplants
- Bone marrow/stem cell transplant

### **Transportation (land, air and water)**

- Excluding emergency

### **Unlisted codes**

Refer to our policy Unlisted CPT Codes Requiring Medical Director Review on [OxfordHealth.com](https://www.oxfordhealth.com)

### **Unproven or ineffective treatment**

Refer to our policy on Experimental/Investigational Treatment on [OxfordHealth.com](https://www.oxfordhealth.com)

Additionally, you can log on to [OxfordHealth.com](https://www.oxfordhealth.com) and check up to 12 CPT codes at one time, using the Precert Required Inquiry tool on the Transactions tab.

## **Prescription medications requiring advance precertification/notification**

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 precertification or prior authorization and requires that you submit a formal request and receive advance approval for coverage of certain prescription medications. 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. 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 advance notification/precertification is available for your reference at [OxfordHealth.com](https://www.oxfordhealth.com) > **Tools & Resources** > **Practical Resources** > **Prescription Drug Information** > **Drugs Requiring Precertification**. A copy of the most current list can also be obtained by sending a written request to:

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\* Coverage is based on member's benefit.

\*\* Precertification is not required for certain groups.

Oxford Policy Requests and Information  
48 Monroe Turnpike  
Trumbull, CT 06611

Changes to the advance notification/precertification requirements for prescription medications are announced at **OxfordHealth.com** via the monthly Policy Update Bulletin.

**Please note:** Advance notification/precertification requirements may vary depending on the member's benefit plan.

See Section 6 *Ancillary Services* for additional information on prescription drug coverage.

## How to submit precertification and requests

Physicians and other health care professionals can submit electronic precertification requests through an EDI vendor, via fax or on our website at **OxfordHealth.com > Providers or Facilities > Transactions > Submit Precert Requests**.

Submitting precertification requests through our website provides convenience and flexibility, as the services are available 24 hours a day.\* Many procedures are approved on a real-time basis. More complex procedures are captured and held over for follow-up within 1 business day.

### Required information

The following data is required when submitting a precertification request:

- Patient's member ID number and date of birth
- Primary procedure code
- Quantity/visits requested
- Service date
- Principal diagnosis code
- Facility ID (required if services are not performed in the office or home care setting)
- Contact name and phone number

**(Please note:** You are required to provide additional information if needed for us to review and process your precertification request.)

### Electronic precertification exclusions

The following requests must be made directly to our Medical Management Department at **(800) 666-1353** or the appropriate delegated vendor for precertification:

- Any service for which review is delegated in whole or in part to a vendor, including CareCore National, Medco, Montefiore/CMO, Prescription Solutions and OptumHealth Care Solutions
- Services performed on an urgent basis (within the next 24 hours) or precertification requested on a retroactive basis
- Requests relating to a clinical trial, experimental treatment, new technology, or a therapeutic abortion

### Precertification-by-fax program

We have implemented a precertification-by-fax program to alleviate the need for telephone transactions to obtain precertification or provide notification of admission.

In order for this program to be successful, we need you to use the forms (located on **OxfordHealth.com > Tools & Resources > Manage Your Practice > Forms**) when submitting precertification requests and notification of admissions. These forms will allow us to quickly review all requests and provide you with timely service. We will only accept those faxes received on the appropriate forms.

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\* With the exception of Scheduled System Maintenance that occurs daily from 2am to 3am EDT and Saturday 1pm to Monday 6am EDT



## **Hospital Notification-by-Fax form**

Please use this form to:

- Report an emergency admission
- Report an inpatient admission
- Report an emergency maternity admission

## **Precertification-by-Fax form**

### **Physicians**

Please use this form to:

- Precertify services being performed in the future
- Update an existing precertification request

### **Facilities**

Please use this form to:

- Precertify services being performed in the future when a precertification request is not already on file

**Please note:** We recommend that physicians and other health care professionals perform a precertification status first to determine if there is already a precertification on file.

## **Precertification-by-Fax form - non-emergency maternity admissions**

Physicians – Please use this form to:

- Precertify maternity services being performed in the future
- Update an existing maternity precertification request

## **Precertification Status online**

You can also use our website to view the status of current and previous precertification requests. This feature, available to all physicians and other health care professionals, allows for better tracking of requests, as well as confirmation of approved services. You can check your precertification requests via **OxfordHealth.com > Transactions > Check Precert Status, Oxford Express** (our automated phone system) or through an EDI vendor.

### **To check the status of a precertification request, you will need the following:**

- Member's ID or Social Security Number; or
- Reference number associated with the precertification request
- You can view requests by:
  - Last five requests on file
  - Date of service (data retrieved will reflect plus or minus 7 days)

## **Referrals (gated plans only)**

Our physician contracts require referrals be issued to participating physicians and other health care professionals within the member's network, 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 want to direct a member to non-participating physicians and other health care professionals, our Medical Management department must approve an in-network exception request prior to the services being rendered (please refer to previous comments for your obligations to seek precertification). 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.

Electronic referrals to participating physicians and other health care professionals can be submitted online at **OxfordHealth.com**, through Oxford Express (our automated telephone system) or through an EDI vendor.

## **Locating a participating specialist**

To locate a participating specialist, consult our Roster of Participating Physicians and Other Health Care Professionals for the relevant state or Oxford product on **OxfordHealth.com > Providers or Facilities > Search >** and click on **Doctor Search**.

Call toll-free **(800) 666-1353** to request a copy of the roster or to locate a specialist. PCPs who have contracted with us as specialists may provide specialty care services to their patients on an in-network basis, according to our policies. Other PCPs may also refer their patients to a PCP/specialist.

For further instructions, please contact Provider Services at **(800) 666-1353**.

## **Services obtained out-of-network**

Participating physicians and other health care professionals cannot generate an electronic referral to a physician or other health care professional who does not participate in the member's selected network. The member's network can be found by checking the member's eligibility online at **OxfordHealth.com > Transactions > Check Eligibility & Benefits**. It is also noted on the member's ID card. However, if a member prefers not to use a physician or other health care professional affiliated with his/her applicable network, the member may utilize his/her out-of-network coverage (if applicable) without a referral. Claims for non-emergent and non-urgent care from non-participating physicians and other health care professionals received by members without out-of-network coverage will be denied.

## **Referral policies and guidelines**

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 > Administrative Policies > Referrals**.

## **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 Medical Management and request a standing referral.

## **Submitting referrals**

A PCP or OB/GYN can issue a referral to participating physicians and other health care professionals online at **OxfordHealth.com**, through *Oxford Express*® (our automated telephone system) or through an EDI vendor. Once the referral is entered, the referring physician or other health care professional will receive a reference number that should be given to the member. The reference number indicates that the member is eligible and the referral has been completed correctly. If the referral is submitted through an Emdeon™ point-of-service terminal, it will print out a receipt (similar to a credit card receipt). The receipt can be given to the patient to bring with him or her to the appointment.

## Submitting referrals online

To submit referrals, go to [OxfordHealth.com](#) > [Providers or Facilities](#) > [Transactions](#) > [Submit Referrals](#).

Please enter the following:

- Patient identification information
- Servicing physicians and other health care professionals information
- Number of visits
- Effective date of the referral

## Submitting referrals via *Oxford Express*

Call **(800) 666-1353**, option 1, then select option 1 for automated service and option 4 to submit a referral. A referral can be generated simply by following the prompts and entering the member's ID number, the referred-to-physician's or other health care professional's ID number, the number of visits, and the effective date of the referral.

### How to obtain an access code or password

If your office does not have an access code, you can easily request one through Oxford Express. After you finish entering and verifying your physician ID number, press the pound sign (#) when asked for your access code. Press 1 if you are representing a physician or press 2 if you are representing a facility or ancillary facility. Physicians, please enter your Social Security Number and your date of birth (MM/DD/YYYY). You will then be asked to enter a four- to 6-digit access code of your choice and to confirm the code by re-entering it a second time. Your access code will be generated immediately if the information that you entered matches our system. Please record your access code for future use.

Hospitals and ancillary facilities will be transferred to a representative who will ask for contact information, including facility name, facility ID, contact name, and phone number. We will call back within 5 business days to set up your access number. If you need instructions on how to submit your referrals to us electronically, please contact the Physician eSolutions team at **(800) 599-4334**.

### Referral verification

- **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.

**Please 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 or via Oxford Express during a referral inquiry or submission transaction.

- **Referral inquiries**

All submitted referrals are also available immediately for inquiry by facilities and physicians; this includes those submitted electronically and those initiated by Oxford On-Call®. A physician or other health care professional can confirm the electronic referral online at [OxfordHealth.com](#) > [Providers or Facilities](#) > [Transactions](#) > [Check Referrals](#), or through Oxford Express at **(800) 666-1353** (option 2 then option 1), or use an EDI vendor.

# Section 5: Hospitalization, Urgent Care and Behavioral Health Care Services

## Emergency hospitalization

### Definition of a medical emergency

#### New York and Connecticut

An “emergency condition” is defined as medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect 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 such that a prudent layperson, who possess an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: there is inadequate time to effect a safe transfer to another hospital before delivery; or the transfer may pose a threat to the health or safety of the woman or the unborn child.

### 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 facsimile number and contact person designated by the hospital) within 24 hours of making the decision. We may also communicate our precertification decision to the hospital by telephone.

### 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 primary care physician (PCP) and are subject to the standard referral process.

### In-area emergency services

You do not need to provide notification or obtain authorization for in-area emergency room treatment and subsequent release. Claims are subject to the prudent layperson standard. 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). In the case of ambulatory surgery occurring 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.

## **Out-of-area emergency services**

Out-of-area coverage for emergency room (ER) services is 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 precertification and is subject to medical necessity review. Participating physicians and other health care professionals are required to request precertification by contacting us, even if the member was directed to a hospital by the PCP without a referral.

## **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 precertified. Newborn coverage varies from plan to plan and state to state.

## **Hospital services, admissions and procedures**

You must precertify all elective and nonelective inpatient hospital admissions, as well as admissions to skilled nursing facilities, subacute and rehabilitation facilities. Please precertify online at **OxfordHealth.com > Transactions > Submit Precert Requests**, use your EDI vendor, or call the Medical Management Department at **(800) 666-1353**.

Outpatient precertification is also required for surgical and major diagnostic testing performed in an outpatient clinic or any ambulatory or freestanding surgical or diagnostic facility. Precertification is the responsibility of the hospital or ancillary facility and the physician or other health care professional.

## **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. This assumes that the member's benefit structure has inpatient copayments. According to state laws, inpatient hospital copayments must be based on a "per continuous confinement" basis.

## **Discharge planning and concurrent review**

Upon admission, Medical Management 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 Medical Management Department at **(800) 666-1353** to update the precertification. For Behavioral Health, all calls related to inpatient precertification should be directed to **(800) 201-6991**.

Our concurrent review process uses approved criteria to determine the medical necessity of a member'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, we have refined some of our processes as part of a consistent application of 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 end-of-day report (EDR). The EDR lists all our

members currently known to be in that facility. We must, however, be made aware of each member'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 members.
- The hospital is required to notify us of any patient that changes level of care, including but not limited to NICU, ICU, etc.
- The member must be enrolled and effective with us on the date the service(s) are rendered; once the hospital verifies a member's eligibility with us, that determination will be final and binding; however, if the 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; if there is a retroactive disenrollment for these reasons, the hospital may bill and collect payment for those services from the member 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 members under its care.
- The hospital must provide 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 precertified outpatient service); the hospital must also notify us of any transfer admissions of members.
- The hospital must precertify any transfer admissions of members 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 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).
- The hospital is responsible for verifying the accuracy of the admission and discharge dates for our members listed on the EDR.
- 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, 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 member 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)**

**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).

## **Enhancing care management through electronic medical records (EMR)**

EMR is any type of electronic concurrent medical information management system. This process improves efficiency and quality in patient 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.

Having access to a hospital's EMR system allows for a more timely and accurate understanding of our member's clinical status, thereby facilitating evidence-based dialogue and timely care coordination and management.

There are several direct advantages in allowing us to access your EMR system:

- Reduction in Utilization Management staff time, which allows for reallocation to other utilization review activities or potential full-time employee (FTE) savings
- Fewer interruptions with telephone calls
- Reduction of administrative resources to manage documentation and review activities
- More timely coverage determination decisions
- Real-time clinical information exchange produces faster turnaround times when scheduling aftercare modalities, which results in fewer discharge delays and improved patient satisfaction
- Go Green: EMR access drastically reduces the amount of paperwork required to perform utilization review activities and brand your hospital as eco-friendly

## **HIPAA compliance and security**

We are committed to strict compliance with all security and privacy regulations. Patients' Protected Health Information (PHI) will remain restricted to cases where there is a "need to know" in order to conduct "Treatment, Payment, or Healthcare Operations" (TPO) as outlined in the HIPAA Privacy Rule.

For additional information on granting remote access to your EMR system, please submit your questions, along with your contact information including facility name, city and state and a phone number to: [emrcdsa@uhc.com](mailto:emrcdsa@uhc.com).

## **Our responsibilities**

- We will maintain a system for verifying member eligibility/status.
- We will use reasonable efforts to transmit a decision regarding an emergency/urgent admission to the hospital (to the fax number and contact person designated by the hospital) within 24 hours of making the initial decision; we may also communicate our decision by telephone.
- We will request any necessary clinical information; failure by us to seek such information will result in our liability for that day service.
- We agree to provide concurrent and prospective certification for all services via a daily EDR when the hospital provides timely necessary clinical information to demonstrate medically appropriate covered care; the EDR will communicate our intention to pay for specific services or a specific plan of care for the member.
- 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 verbally or by written communication (that is consistent with NCQA requirements and applicable law) of all denied days; our daily EDR

will include a report on the decisions for the current day, as well as a preliminary decision for the next day when review is performed on that day; failure by us to communicate a decision to deny precertification will result in our liability for that day's service; if we deny inpatient days due to benefit or medical necessity reasons, the hospital may seek to appeal the adverse determination in accordance with applicable law and our appeal procedures.

- We will perform clinical review of days that fall on the weekend (Saturday and Sunday), 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.

**Please note:** We will not deny services retrospectively or reduce the level of payment for services that have been precertified or received concurrent review approval unless:

- The member is retroactively disenrolled as explained in the section titled **Hospital responsibilities – concurrent inpatient stays (notification prior to discharge)** (see Section 5)
- 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.

## **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.

## **Clinical process definitions**

### **Acute hospital day**

An acute hospital day (AHD) is any day when the severity of illness (clinical instability) and/or the intensity of service are sufficiently high and care cannot reasonably be provided safely in another setting.

### **Alternative level of care (ALC)\***

We will determine that an inpatient ALC applies in any of the following scenarios:

- An acute clinical situation has stabilized.
- The intensity of services required can be provided at less than an acute level of care.
- An identified skilled nursing and/or skilled rehabilitative service is medically indicated.
- ALC is prescribed by the 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. This does not apply to a service, product or device that is new to a hospital but not new to the 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.

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\* ALC only applies if the facility has a contracted rate.

\*\* Inpatient ALC must meet clinical criteria per clinical guidelines. Failure to satisfy these criteria can result in denial of coverage.



## 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 noncertification 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.

## 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.

At our discretion, the day-of-service (DOS) process may or may not be applied for DRG hospitals. Therefore, if we choose not to apply the DOS process, end-of-day reports are not generated. Decisions are communicated to DRG hospitals either telephonically and via letters or through an end-of-week report, depending on the agreement established between us and the hospital.

If a member is readmitted into the same hospital/hospital system within 30 days of discharge, then the second readmission will not be reimbursed.

If a member is transferred to a hospital within the same hospital system as the first hospital during one continuous admission, payment will be made only to the hospital the member was transferred to as the final discharge DRG.

### **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 Section 9 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 with the codes that are validated only.

## **Technical definitions**

### **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.

## **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 previously defined. Members are encouraged to call their PCP if they think they need urgent care. Members may also contact Oxford On-Call® for assistance with clinical issues. Oxford On-Call registered nurses may triage the member and recommend an appropriate site of care based on information provided. Our members may also seek urgent care at a contracted urgent care center facility, in which case precertification is not required.

## **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.

The BEH department offers a toll-free, dedicated line, **(800) 201-6991**, that is available to members, Employee Assistance Programs and physicians and other health care professionals, Mon. – Fri., 8 a.m. – 6 p.m. ET. This line can be used to certify care and to obtain referrals for mental health or substance abuse treatments.

The BEH department recognizes the importance and the sensitivity surrounding mental health and substance abuse diagnosis and treatment. 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. This form may be downloaded from our website, [OxfordHealth.com](http://OxfordHealth.com) > **Tools & Resources** > **Manage Your Practice** > **Forms** > **Behavioral Health Release Form**.

### **Clinical definitions and guidelines**

The BEH department uses United Behavioral Health (UBH) Level of Care criteria in determining medical necessity of inpatient psychiatric, partial hospitalization substance abuse treatment and rehabilitation, and outpatient mental health treatment.

#### **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.

Examples include:

- The patient has been unresponsive to an appropriate course of treatment at a lower level of care and is at significant risk.
- The patient is considered a serious risk to self or others and requires 24-hour supervision.
- The patient is unable to maintain a safe environment for self or others.

#### **Partial hospitalization – mental health**

Partial hospitalization (only available for members with this benefit) for mental health treatment is defined as day treatment of a psychiatric disorder at a hospital or ancillary facility with the following criteria:

- 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 precertification and ongoing medical necessity reviews. Each state has different requirements and benefits should be reviewed.

#### **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. Examples include:

- The primary diagnosis/focus of treatment is for a psychiatric condition and is not related to substance abuse or dependence.
- The diagnosis or service is not a benefit exclusion (e.g., sexual disorders, marital counseling, etc.).
- The primary diagnosis is not identified as a V-code (any diagnosis beginning with a V indicates wellness and is not considered a psychiatric diagnosis.)
- Treatment is focused on restoring or maintaining function that has been compromised due to mental illness.
- Treatment is goal-oriented and directed to achieve specific outcomes.

**Please note:** Under NCQA guidelines and requirements, we strongly support coordination of care between behavioral health physicians and PCP. With input from the BEH Quality Improvement Committee, we have developed a Release of Information (ROI) form to facilitate the sharing of treatment information between BEH physicians and PCPs. This form is designed to elicit member consent to such sharing of information in the presence of his/her behavioral health physician. This form may be downloaded from our website, [OxfordHealth.com](http://OxfordHealth.com) > **Tools & Resources** > **Manage Your Practice** > **Forms** > **Behavioral Health Release Form**.

### **Inpatient detoxification**

Inpatient detoxification is defined as the treatment of substance dependence to prevent a life-threatening withdrawal syndrome, provided on an inpatient basis. Conditions under which inpatient detoxification is medically indicated include:

- The patient is a risk to self and others.
- The patient's medical status is altered by withdrawal syndrome that requires 24-hour monitoring.
- A licensed physician (MD or DO) is available on-site 24 hours per day.
- The DSM-V diagnosis indicates psychoactive substance dependence.

The facility is a licensed, accredited detoxification facility.

### **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. Conditions under which outpatient substance abuse rehabilitation is medically indicated include:

- The primary diagnosis and focus of substance abuse treatment is within the DSM-IV range of 303-305.
- An evaluation by a licensed substance abuse physician has resulted in certification by our BEH department.

## **Certification for mental health, substance abuse and detoxification treatment**

### **Inpatient care**

All inpatient behavioral health treatment requires precertification.

### **Partial hospitalization**

Partial hospitalization is not a standard benefit for all members and always requires certification through the BEH department. If clinical criteria are met and the member has the benefit, 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. This will not be done unless the member has a benefit that covers partial hospitalization.

## **Mental Health Parity and Addiction Equity Act of 2008** (MHPAEA)

As of July 1, 2010, for certain new and renewing groups, benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are covered services must be treated in the same manner and be provided at the same level as covered services for the treatment of any other illness or injury.

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits.

Changes that result from MHPAEA also affect both prior authorization requirements and excluded services. Prior authorization requirements no longer apply for outpatient mental health and substance abuse services. Exclusions for mental health conditions and substance use disorders that were specific to these conditions, but that were not applicable to

other sickness or medical conditions, no longer apply.

**Please note:** MHPAEA applies to fully insured and self-funded plans that have 50 or more total employees. Groups that are not subject to MHPAEA may be subject to state parity legislation, which is summarized on the following pages.

### **New Jersey mental health parity**

The State of New Jersey has enacted Biologically Based Mental Health Parity legislation (P. L. 1999, c. 106) that states that biologically based mental illness must be covered under the same terms and conditions as all other medical illnesses and diseases.

The law defines biologically based mental illness as a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness including, but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

This law does not affect coverage for substance abuse or for mental illness that is not biologically based. These latter conditions include mental retardation, learning disorders, motor skills disorder, communication disorders, caffeine-related disorders, relational problems, and additional conditions that may be a focus of clinical attention, but which are not otherwise defined as mental disorders in the most recent edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM)* referenced in this section.

The New Jersey law does not affect medical necessity, certification or referral requirements. New Jersey members should check their *Certificate of Coverage* for certification and referral requirements.

### **Connecticut mental health parity**

Connecticut has also enacted Mental Health Parity legislation (Managed Care Act – Public Act No. 99-284). The law states that all Connecticut commercial group products will be required to provide benefits for the diagnosis and treatment of mental or nervous conditions under the same terms and conditions as all other illnesses and diseases.

For purposes of this legislative requirement, mental or nervous conditions means mental disorders, as defined in the most recent edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM)*. The definition does not include mental retardation, learning disorders, motor skills disorder, communication disorders, caffeine-related disorders, relational problems, and additional conditions that may be a focus of clinical attention that are not otherwise defined as mental disorders in the DSM referenced above.

**Please note:** Parity is also required for disorders related to the complications of alcohol and substance abuse, as defined in the DSM. The Connecticut law does not affect self-funded plans. In addition, it does not affect medical necessity, precertification or referral requirements.

### **New York mental health parity**

As of January 1, 2007, for new and renewing groups, legislation was enacted in New York mandating broad-based coverage for the diagnosis and treatment of mental, nervous, or emotional disorders and ailments. Previously, coverage of mental illness was only a “mandated offer.”

Additionally, treatment for biologically based illness and treatment for Children with Serious Emotional Disturbances is mandated for large groups on a parity basis. “Parity” means the benefit must be equal to the coverage provided for other health conditions (i.e., mental health benefits cannot have a higher cost share than is required for other medical services or contain day or visit limits that are lower than medical services). Small groups may elect to purchase this additional level of coverage.

The coverage varies depending on the size of the group and the type of policy. This does not apply to the self-funded, Healthy NY and individual plans.

### **For purposes of the New York mandate**

Mental, nervous or emotional disorders or ailments means medically necessary care rendered by an eligible practitioner or approved facility which, in our opinion, is directed predominantly at treatable behavioral manifestations of a condition that we determine:

- is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and
- substantially or materially impairs a person's ability to function in one or more major life activities; and
- has been classified as a mental disorder in the current American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

### **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.

**Please note:** Visits for biologically based services will count toward this limit.

### **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 precertified, 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.

**Please 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.

# Section 6: Ancillary Services

## Laboratory

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). Since January 1, 2007, Quest Diagnostics no longer participates in the network and is a non-participating laboratory.

### Outpatient laboratory policies and procedures

It is important that you refer your patients and their samples to participating patient service centers and laboratories, as it helps patients avoid unnecessary cost. Given the broad scope of our laboratory network, we believe there is a participating lab that will meet the needs of your practice.

A referral is not required for lab specimens sent to participating laboratories (only a physician's prescription or lab order form is required).

We review laboratory ordering information on a periodic basis in an effort to support full use of our contracted laboratory network; 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.

A list of available laboratories, an inventory of patient service centers and other helpful information can be found at **OxfordHealth.com** by signing in as a provider or facility and selecting **Tools & Resources > Practical Resources > Laboratory Services**.

### 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. Lab procedures/tests not appearing on this must be performed by one of the participating laboratories in our network. For the most up-to-date list, log into our website at **OxfordHealth.com** as a provider or a facility and select **Tools & Resources > Practical Resources > Laboratory Services > In-Office Laboratory Testing List**.

### 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 appears on the In-office Laboratory Testing List).

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.

## Radiology

Participating primary care physicians and specialists will be reimbursed for radiology services rendered in the office or in an outpatient setting. The 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. For the most up-to-date list of services that are payable to participating physicians based on their specialty, log into our website at **OxfordHealth.com** as a provider or a facility and select **Tools & Resources > Practical Resources > Radiology Information**.

The radiology privileging list is applicable to commercial plans (excluding Oxford USA/Choice Plus Network).

All X-rays performed at an urgent care facility are payable.

These procedures require precertification. To precertify a radiology procedure, please contact CareCore National via one of the two options listed below:

- Physicians can call CareCore National at **(877) PreAuth (877) 773-2884**
- Physicians can log onto **www.CareCoreNational.com**

## **Imaging requiring precertification**

It is the responsibility of the referring physician to contact CareCore National Management Services, LLC to request precertification and to provide sufficient history to demonstrate the appropriateness of the requested services. Our radiology policy does not permit precertification requests from persons or entities other than referring physicians.

The following radiology procedures require precertification through CareCore national for Oxford products:

- CT scans
- MRI
- MRA
- PET scans
- Nuclear medicine studies
- Endoscopic procedures
- Obstetrical ultrasounds\*

\* For specific guidelines, refer to **OxfordHealth.com > Tools & Resources > Practical Resources > Medical and Administrative Policies > Reimbursement Policies > Obstetrical Ultrasonography.**

## **Radiology precertification 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, in which there is no time to obtain an authorization number and in cases in which, in the opinion of the attending physician or other health care professional, a change is required from the precertified examination, and the CareCore 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 in the usual manner by calling or faxing your request. If the CareCore 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. CareCore National precertification lines are open Monday through Friday, 7 a.m. to 7 p.m. (ET) and precertification request, both routine and urgent, can be initiated 24 hours a day 7 days a week on **www.CareCoreNational.com**.

## **Radiology precertification online**

CareCoreNational provides a secure, interactive web-based program where precertification 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. Log into **www.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 and allows you to enter multiple clinical certification requests at your convenience.

## **Radiology 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. 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 notification of review determinations for non-urgent care by fax/telephone within 2 business days of receiving all the necessary information.



Notification 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, if the services are performed outside CareCore's hours of operation. 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.

For the most current list of imaging CPT codes that require authorization, please log into our website at **OxfordHealth.com** as a provider or a facility and select **Tools & Resources > Practical Resources > Radiology Information > Procedures Requiring Precertification**. You will be informed of any new procedures or other changes to this list at **OxfordHealth.com** via the Policy Update Bulletin.

When you call or fax a request to the Radiology Precertification unit, please provide the following information:

**Patient identifiers:**

- Health plan name
- The member ID number
- Patient date of birth
- 10-digit patient phone number
- Patient name

**Medical identifiers:**

- The ordering physician's or other health care professional's ID
- The ordering physician's or other health care professional's full last name
- Ordering physician's or other health care professional's office number
- Ordering physician's or other health care professional's fax number

**Clinical information:**

- Examination(s) being requested, with CPT codes if available
- Presumptive diagnosis or "rule out," with ICD-9 codes, if available
- Patient's signs and symptoms, listed in some 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 you believe will help in evaluating the request, including prior diagnostic tests, consultation reports, etc.

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 that indicate:

- Patient symptoms, with duration and severity
- Patient medical history
- Previous imaging studies and findings
- Prior treatment and/or therapy, including surgery, with history
- Drug dosage prescribed and duration

**Please 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.

For full clinical criteria please log into CareCore National at [carecorenational.com](http://carecorenational.com) and select **Criteria > Radiology Management > Oxford**

## **Radiation therapy**

Outpatient radiation therapy services require precertification and medical necessity review.

For Oxford products, a precertification and medical necessity review program for all outpatient radiation therapy services. Radiation therapy precertification is managed through CareCore National, LLC. The Oxford product program details are available online at [OxfordHealth.com](http://OxfordHealth.com).

The following radiation therapy treatments require precertification 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),

For Oxford products, the rendering radiation therapists office is required to request precertification 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.

We have partnered with CareCore National, LLC for clinical review of cases based upon their expertise in administering similar programs and their record of working effectively with the physician community. To ensure that the radiation therapy criteria utilized in our program and cases reviewed by CareCore radiation oncologists are consistent with specialty society guidance and current clinical evidence, we have solicited comments from our external oncology expert advisory board, CareCore's radiation oncology board and relevant medical specialty societies. The policies and coverage criteria are available on the websites noted above and at [www.CareCoreNational.com](http://www.CareCoreNational.com) > **Criteria > Radiation Therapy Criteria**.

## **Review process for Oxford products**

We have developed the following utilization review process for the administration of outpatient radiation therapy services to Oxford product members. Corresponding CPT Codes that require a Radiation Therapy authorization for payment may be found [OxfordHealth.com](http://OxfordHealth.com) by logging in as a provider or a facility and selecting **Tools & Resources > Practical Resources > Radiology Information > Procedures Requiring Precertification > Radiation Therapy Procedures Requiring Precertification**.

1. Medical necessity review online or by phone will require the treating physician's office to submit information about their patient's treatment plan as specified in the Radiation Therapy Physician Worksheets.\*
2. Physicians and other health care professionals should submit an authorization request either online at [CareCoreNational.com](http://CareCoreNational.com), or by calling toll-free at **(877) 773-2884**, Monday through Friday, 7 a.m. to 7 p.m. (ET), and precertification request can be initiated 24 hours a day 7 days a week on [www.CareCoreNational.com](http://www.CareCoreNational.com).
3. CareCore National will provide a medical necessity determination response after receipt of all necessary clinical information about the patient's treatment plan as specified in the worksheets.

\* Radiation Therapy Physician Worksheets to guide offices in gathering the information that will be required for the review are available on CareCore National's website, [www.CareCoreNational.com](http://www.CareCoreNational.com), under **Physician Resources > Physician Tools > Oncology > Radiation Therapy Physician Worksheets**.

Clinical criteria consistent with Oxford product policies are available at [www.CareCoreNational.com](http://www.CareCoreNational.com), and updated medical policies are available at [OxfordHealth.com](http://OxfordHealth.com) > [Physicians](#) > [Tools & Resources](#) > [Practical Resources](#) > [Medical and Administrative Policies](#).

## 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. You can verify your patient's benefit information and whether such a referral is required at: [OxfordHealth.com](http://OxfordHealth.com) > [Providers](#) > [Transactions](#) > [Check Eligibility & Benefits](#).

## 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. Please continue to submit claims electronically, directly to our Payer ID #06111, or by mail to the following address:

Oxford Claims Department  
P.O. Box 7082  
Bridgeport, CT 06601-7082

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. If you have questions about this program, please call Provider Services toll-free at **(800) 666-1353**, and choose option 2.

## Physical and Occupational therapy services

OptumHealth Care Services, a UnitedHealth Group company, administers the physical and occupational therapy benefit for UnitedHealthcare's Oxford products. OptumHealth is a leading physical medicine care management company with significant experience in promoting best practices and evidence-based health care while working with physical and occupational therapists as well as physicians. OptumHealth is our benefit manager for 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 by fax, mail or through the OptumHealth website at [www.myoptumhealthphysicalhealth.com](http://www.myoptumhealthphysicalhealth.com). Forms may also be obtained through these channels.

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

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

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.

Please note: Coverage is based on member's benefit. Precertification is not required for certain groups.

## Referrals

As a reminder, certain Oxford products require referrals from the member's primary care physician. If your patient has such a plan, the patient will be required to obtain a referral before seeing you for an initial visit. Member benefit information can be found on [OxfordHealth.com > Providers > Transactions > Check Eligibility & Benefits](#).

## Claim processing

The claim submission process has not changed. Please continue to submit your claims electronically, directly to EDI Payer ID #06111, or via mail to:

Oxford Claims Department  
P. O. Box 7082  
Bridgeport, CT 06601-7082

We will continue to process claims from participating physicians for physical therapy and occupational therapy services delivered to members with an Oxford product. Under this arrangement, OptumHealth will be responsible for the utilization management of therapy services (when performed on an outpatient basis, including in the home) for fully insured members.

**Please note:** The list of CPT codes requiring OptumHealth utilization review may be found on [www.myoptumhealthphysicalhealth.com](http://www.myoptumhealthphysicalhealth.com).

## Acupuncture guidelines

Acupuncture is covered as a benefit only for those members who have the alternative medicine rider, and we will deny all requests for acupuncture if the rider is not part of the member's benefit package, even if a letter of medical necessity has been submitted. Acupuncture is covered for 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

## Chiropractic guidelines

To receive the standard chiropractic benefit coverage, members must obtain an electronic referral from their PCP. Under our Complementary & Alternative Medicine (CAM) program, choosing a chiropractor is easy, as we have an extensive network of credentialed chiropractors throughout your service area.

To help facilitate referrals for chiropractic care, we have developed the following guidelines, which are based on current medical literature.\* PCPs should perform the customary initial comprehensive differential diagnosis with the necessary and appropriate work-up.

For patients with conditions that may respond well to chiropractic care, such as acute low-back pain, neck pain or other neuromusculoskeletal problems, you should discuss conventional and chiropractic treatment options with your patient, describing the risks and benefits of each. If a patient requests a referral to a chiropractor and there is no compelling medical contraindication, you can make the referral for an initial evaluation.

One visit within 180 days (6 months) is the maximum number of visits for which a chiropractic referral can be generated. OptumHealth Care Solutions currently manages our chiropractic benefit, therefore we require all participating chiropractors to complete and submit Patient Summary Forms to OptumHealth Care Solutions (formerly ACN Group) for services performed. You will need to obtain approval of the services as a condition of reimbursement. Form submissions

\* Meeker, W.C.; Haldeman, S. Chiropractic: a profession at the crossroads of mainstream and alternative medicine. [Review] [164 refs] [Historical Article. Journal Article. Review, Academic] *Annals of Internal Medicine*. 136(3): 216-27, 2002 Feb 5.

for chiropractic services must be faxed directly to OptumHealth Care Solutions at **(845) 382-6923**.

Patient Summary Forms should be submitted to OptumHealth Care Solutions 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.

**Please 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.

As of the initial visit, the chiropractor will fax a Patient Summary Form to OptumHealth Solutions at **(866) 695-6923**.

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 or more time than was requested, you must submit an updated Patient Summary Form with updated clinical information after the initially approved visits have occurred.

### **Absolute contraindications to manipulation**

- Vertebral malignancy
- Infection or inflammation
- Cauda equina syndrome
- Myelopathy or severe spondylosis
- Multiple adjacent radiculopathies
- Vertebral bone diseases
- Vertebral bony joint instability (e.g., fractures, dislocations)
- Rheumatoid disease in the cervical region

### **Relative contraindications to manipulation**

- Presence of spinal deformity and most skeletal anomalies
- Systemic anticoagulation, either disease-related or pharmacologic severe diabetes
- Atherosclerosis
- Severe degenerative joint disease
- Vertigo or symptoms and signs of vertebral-basilar artery disease or insufficiency
- Spondyloarthropathies (e.g., psoriatic, ankylosing spondylitis, Reiter syndrome)
- Inactive rheumatoid disease
- Ligamentous joint instability or congenital joint laxity
- Syndromes such as Marfan and Ehlers-Danlos
- Aseptic necrosis
- Local aneurysm
- Osteomalacia
- Osteoporosis

## Musculoskeletal Services

OrthoNet, a musculoskeletal disease management company is our network manager for most musculoskeletal services. OrthoNet is located in White Plains, New York. OrthoNet currently manages the following specialties:

- Orthopedic Surgery
- Pediatric Orthopedic Surgery
- Podiatry
- Neurosurgery
- Hand Surgery
- Physical Medicine Rehabilitation

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

There is no change to the current referral and precertification policy, medical and payment policy or claims submission process. Information regarding these policies can be found at our website **OxfordHealth.com > Tools & Resources > Practical Resources > Medical and Administrative Policies**. Authorization requests may be made by calling **(800) 666-1353** (follow the prompts for precertification). The Provider Service Department will also handle claims inquiries, physician or other health care professional relations issues and physician or other health care professional claims appeals. OrthoNet's provider service line can be reached by calling **(800) 303-9904**.

## 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. This management strategy encourages cost-effective, quality care.

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 complete PDL is available online at **OxfordHealth.com > Tools and & Resources > Practical Resources > Prescription Drug Information > Oxford's Prescription Drug List**.

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 precertification are noted with an "N" and supply limits with "SL."

**Please note:** The PDL is subject to change. When a medication changes tiers, the member may be required to pay more or less for that medication. In addition, the amount allowed for purchase per dispensing or per month may increase or decrease. Visit our website at **OxfordHealth.com > Tools & Resources > Practical Resources > Prescription Drug Information > Oxford's Prescription Drug List** for the most up-to-date tier placement for a particular medication.

The listing of a medication product on a PDL does not guarantee coverage, as certain products are excluded due to benefit plan design limitations that are specific to the member's individual or group benefits. In addition, diabetic supplies that are available through the member's base medical benefit are subject to the applicable office visit copayment (out-of-pocket cost) noted on the member's Summary of Benefits.

### **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 pharmacoeconomic evidence. The Pharmacy and Therapeutics (P&T) Committee 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 precertification/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 DUR**

The Concurrent Drug Utilization Review (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.

Upon receiving the claim information from the pharmacy, the system performs a number of checks against safety and utilization criteria. When 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. In many cases, the pharmacist will quickly address the potential issue and the program impact will be minimal or unknown to the member. The benefits of this program include timely reviews for medication interactions, improvement in the quality of health care and reduction in the number of inappropriately prescribed medications.

#### **Retrospective DUR**

The Retrospective Drug Utilization Review (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. This mailing includes:

- Cover letter providing an explanation of the purpose of the mailing
- Patient-specific summary including the clinical guidelines that address the patient's utilization issue
- Prescription claims history that provides a comprehensive list of prescriptions that the patient has received for up to one year.

This combination of clinical guidelines and personalized patient claim history will allow the physician or other prescriber to make an informed decision.

Because this is a retrospective program, there is no immediate effect on whether the member is able to obtain a prescription. The intent is to notify physicians and other prescribers of potential issues and allow the physician or other prescriber to make changes if necessary. The program provides information that the physician or prescriber can use to alter therapy and review medication issues.

### **FDA alerts and product recalls**

A formal process is in place to address FDA and manufacturer medication recalls. Members affected by FDA-required or voluntary medication withdrawals are identified and notified by mail. Where possible, physicians or prescribers who have recently prescribed a medication are also notified.

### **High utilization narcotic program**

The high utilization narcotic program identifies members who may be overutilizing narcotic analgesics or potentially seeking narcotics inappropriately from multiple physicians/prescribers.

### **Member identification and physician outreach**

The criteria utilized to identify members includes 9 or more narcotic prescriptions filled during a quarter and written by 3 or more physicians/prescribers and filled at 3 or more pharmacies. Patient-specific prescription information is provided to each physician/prescriber identified in the review of the pharmacy utilization.

### **Pharmacy limitation**

Members who appear on more than two consecutive quarterly reports may be limited to a single retail pharmacy. The member will receive a registered letter notifying him or her of the limitation. Within 30 days the member is required to select from one of his/her last 3 pharmacies utilized. If the member does not select a pharmacy, the last retail pharmacy of record will be assigned.

## **Clinical programs**

### **Medications requiring precertification/notification (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. This process is also known as precertification or prior authorization and requires that you submit a formal request and receive advance approval for coverage of certain prescription medications. 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. For those requests that do not meet the criteria for coverage, 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 advance notification/precertification is available for your reference at [OxfordHealth.com](http://OxfordHealth.com) > **Tools & Resources** > **Practical Resources** > **Prescription Drug Information** > **Drugs Requiring Precertification**

Changes to the advance notification/precertification requirements for prescription medications are announced at [OxfordHealth.com](http://OxfordHealth.com) via the monthly Policy Update Bulletin.

**Please note:** Precertification/Advance Notification requirements may vary depending on the member's pharmacy benefit plan.



## **Supply limits (subject to plan design)**

Certain medications may be subject to supply limits (SL). 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. Supply limits can be a quantity level limit (QLL) or a quantity duration limit (QDL). The QLL establishes a maximum quantity covered per prescription or copayment. A QDL establishes a maximum quantity that is covered for a defined time period. 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. 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.

Affected medications are noted with a SL designation in the PDL, which is available online at [OxfordHealth.com > Tools & Resources > Practical Resources > Prescription Drug Information > Oxford's Prescription Drug List](#).

## **Half Tablet program overview**

The voluntary Half Tablet program allows members to save up to half of a copayment when they split eligible medications. Our P&T Committee determines which medications are eligible based upon set criteria. To qualify, multiple strengths of a medication must be available at a comparable unit price and easily split with no adverse impact on how the medication is released from the tablet. Once the physician or other health care professional determines that tablet splitting is appropriate for the individual patient, he or she should write the prescription for twice the desired dosage and half the quantity and instruct the patient to take one-half tablet.

Members receive the prescribed dose while reducing the number of dispensed tablets and, therefore, the ingredient cost for the prescription. Members with a coinsurance plan may save up to 50 percent. The plan sponsors can also save up to 50 percent through reduced ingredient costs.

When processing a prescription for a medication in the Half Tablet program, pharmacists will receive messaging at the point of service informing them of the Half Tablet program.

The medications that are part of the Half Tablet program are noted in the PDL or may be found: [www.halftablet.com/faq.html](http://www.halftablet.com/faq.html).

## **Other Programs:**

### **Specialty Pharmacy Program**

The majority of members may have coverage for self-administered injectable medications, including specialty medications, through their pharmacy benefit plan. We have developed an enhanced specialty pharmacy network that is part of our Specialty Pharmacy Program. The specialty pharmacy network includes specialty pharmacies, each selected based on their clinical expertise for the targeted therapeutic classes, quality of services and cost. Their pharmacists are trained to help educate members and create personalized plans, if needed, for these specialty medications, which may help improve treatment adherence. Participating members should be instructed to call our toll-free Specialty Pharmacy Referral Line at **(866) 429-8177** where a representative will answer questions about our program and then transfer them to a specialty pharmacy based on their particular specialty medication prescription.

### **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 or stay at retail with a lower-tier alternative. Each option has a different savings potential, but the member must choose one of the following options to continue receiving network benefits:

- Fill their prescription through the mail order pharmacy
- Switch to a lower cost option
- Save the most by doing both

The medications that are part of the Select Designated Pharmacy program are noted in the PDL.

### **Mail order**

We offer members the ability to obtain up to a 90-day supply of certain medications within several therapeutic categories of medications by mail. Maintenance medications are prescription medications associated with the treatment of certain chronic conditions, such as diabetes, hypertension and epilepsy. All members whose plans include the mail-order benefit are entitled to use this service.

Medco by Mail  
P.O. Box 747000  
Cincinnati, OH 45274-7000

## Section 7: 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 Improvement Director and Senior Medical Director.

To request information regarding our Quality Management program, please write to:

Oxford Quality Management Department  
Attn: Regional Quality Improvement Director  
44 South Broadway  
White Plains, NY 10601

### Quality management committee structure

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

The Board of Directors has delegated responsibility for the oversight of health plan quality improvement activities to the Regional Quality Oversight Committee (RQOC). The RQOC is the decision-making body responsible for the implementation, coordination and integration of all quality improvement activities for the health plans within its geographic scope.

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) to make decisions relating to quality of care and quality of service. Recommendations related to restrictions, suspensions or termination of practitioners or providers are referred to the NPRC for final disposition.

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 NPRC is a subcommittee of the National UnitedHealthcare Clinical Services Quality Oversight Committee, which has oversight responsibility for actions taken pursuant to the Quality of Care policy. The NPRC has been delegated decision-making authority for final disposition relating to restrictions, suspensions or termination of practitioners or providers due to unresolved quality of care/competency issues.

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 concern. Sanctions are monitored from state licensing boards, Office of the Inspector General and other sanctioning bodies or entities. The NPSC has been delegated decision-making authority by the National Quality Oversight Committee (NQOC) to make decisions relating to continued credentialing status as a result of external sanctions imposed to participating physicians and other health care professionals.

## 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 the ability to make a significant impact upon important aspects of care
- **Undertaking quality improvement studies** in clinical areas identified through careful claims data analyses; these include 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); additional clinical areas are identified and studied per government contract requirements and health care industry standards.
- **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 and other health care professional satisfaction, employer (client) satisfaction, and reasons for voluntary physician and other health care professional 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.

**Please note:** This is not the only reason we conduct such audits. Audits by the QM department do not review appropriateness of coding of medical claims. 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.

As part of our ongoing clinical quality improvement activities, we review a sample of medical records from primary physicians who practice in the specialties of family/general practice, internal medicine, or pediatrics and use performance standards to measure project results.

- **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 (Medicare), state regulators (commercial), and prospective members use to evaluate the demonstrated value and quality of different health plans. Disenrollment rates, information on member satisfaction and health outcomes data for Medicare members to CMS are also disclosed.

### HEDIS effectiveness of care – our measures

Category	Measure
Adult BMI	Weight assessment and counseling for nutrition and physical activity for children/adolescents
Pediatric preventive care	<ul style="list-style-type: none"> <li>• Childhood immunization rates up to age 2</li> <li>• Lead and growth screening up to 25 months</li> <li>• Appropriate testing for upper respiratory infection (URI)</li> <li>• Appropriate testing for pharyngitis</li> <li>• Well-child visits by age 15 months</li> <li>• Well-child visits at ages 3, 4, 5, and 6</li> </ul>
Adolescent preventive care	<ul style="list-style-type: none"> <li>• Adolescent immunization rates</li> <li>• Adolescent well-care</li> </ul>
Prenatal	Prenatal and postpartum care
Adult preventive care	<ul style="list-style-type: none"> <li>• Advising smokers to quit</li> <li>• Influenza and pneumonia vaccinations for older adults</li> <li>• Breast cancer screening rates</li> <li>• Cervical cancer screening rates</li> <li>• Chlamydia screening rates for women</li> <li>• Colorectal cancer screening</li> <li>• Osteoporosis management for women with a fracture</li> <li>• Care for older adults</li> <li>• Flu shots</li> </ul>
Chronic/acute care	<ul style="list-style-type: none"> <li>• Annual monitoring for patients on persistent medications</li> <li>• Medication reconciliation post-discharge</li> <li>• Potentially harmful drug disease interactions in the elderly</li> <li>• Avoidance of antibiotic treatment in adults with acute bronchitis</li> <li>• Comprehensive diabetes care (eye examination, HbA1c testing, LDL screening, medical attention for nephropathy)</li> <li>• Beta-blocker treatment after heart attack</li> <li>• Controlling high blood pressure</li> <li>• Use of appropriate medicines for the treatment of asthma</li> <li>• Use of imaging studies for low back pain</li> <li>• Use of spirometry testing in the assessment and diagnosis of COPD</li> <li>• Disease modifying antirheumatic drug therapy for rheumatoid arthritis</li> <li>• Pharmacotherapy management of COPD exacerbation</li> <li>• Follow-up care for children prescribed ADHD medications</li> <li>• Use of high-risk medications in the elderly</li> <li>• Cholesterol management for patients with cardiovascular conditions</li> <li>• Follow-up after hospitalization for mental illness</li> <li>• Antidepressant medication management</li> </ul>
Behavioral health care	<ul style="list-style-type: none"> <li>• Follow-up after hospitalization for mental health</li> <li>• Antidepressant medication management</li> </ul>

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.

## **Patient safety program**

A series of initiatives designed to improve the safety and security of our members has been established. The patient safety program involves the measurement, monitoring, trending, and reporting of key indicators. The initiatives include efforts to:

- Improve continuity and coordination of care among physicians and other health care professionals to encourage optimum outcomes for members
- Improve continuity and coordination between sites of care, such as facilities and nursing homes, to increase and encourage timely and accurate communication
- Use visit credentialing reports and recommendations to improve safe practices among physicians, other health care professionals and medical facilities
- Evaluate current clinical practices against aspects of national practice guidelines and recommend changes where appropriate
- Analyze and take action on complaint and satisfaction data that relate to clinical safety

In addition, we are a member of, and support the initiatives of, the Leapfrog Group, which is a coalition of more than 150 public and private organizations that provide health care benefits to employees. Leapfrog is a voluntary program aimed at mobilizing major health care purchasers to alert the health care industry that big leaps in patient safety and customer value will be recognized and rewarded. We encourage the physicians and other health care professionals in our network to complete the Leapfrog Web survey and share information with their communities about their efforts to reduce preventable medical mistakes.

## **Hospital safety measures**

As a member and supporter of The Leapfrog Group, we annually encourage our network hospitals to report their progress on four key factors that affect patient safety. We have identified four hospital safety measures that are a focus for performance comparison in the Leapfrog Group Facility Quality and Safety survey.

### **Computer Physician Order Entry (CPOE)**

With the CPOE systems, hospital staff enter medication orders via a computer linked to prescribing-error-prevention software. CPOE has been shown to reduce serious prescribing errors in hospitals by more than 50 percent.

### **Evidenced-based Hospital Referral**

Research Consumers and health care purchasers should choose hospitals with extensive experience and the best results with certain high-risk surgeries and conditions. Research indicates that when patients needing certain complex medical procedures are referred to hospitals offering the best survival odds based on scientifically valid criteria – such as the number of times a facility performs these procedures each year or other process of outcomes data – the hospital's risk of patient deaths could be reduced by more than 30 percent by referring patients needing complex medical procedures to hospitals offering the best clinical outcomes based on valid criteria.

### **Intensive Care Unit (ICU) Physician Staffing (IPS)**

Staffing ICUs with physicians who have credentials in critical care medicine has been shown to reduce risks of patients dying in ICUs by 40 percent.

### **Leapfrog Safe Practices Score Quality Index**

The National Quality Forum-endorsed 30 Safe Practices covers a range of practices that, if utilized, would reduce the risk of harm in certain processes, systems or environments of care. Included in the 30 practices are the original three Leapfrog leaps.

Additional educational information regarding patient safety is located on our website at **OxfordHealth.com** and includes the following:

- Questions to ask surgeons prior to surgery
- Information on drug-to-drug interactions
- Up-to-date information on research findings, new treatments, and medications
- Link to FDA alerts for physicians and other health care professionals
- A hospital's discharge program, to help ensure that post-facility services are provided on time, as planned
- Monitoring medical record legibility and in-office procedures for follow-up of laboratory results as part of the medical record review process
- Monitoring of office safety issues for PCPs and institutional safety issues for health delivery organizations via site evaluations as part of credentialing and recredentialing activities
- Drug utilization program with Medco to prevent drug interactions, overutilization, adverse events, prevent misuse and abuse, and to target populations with special clinical needs
- Adverse outcomes monitoring of individual occurrences, as well as trends at the physician or other health care professional/practitioner and system-wide level, medication assessments and patient-specific education regarding medication adherence as regular components of all disease management programs
- Monitoring of continuity and coordination of care from multiple perspectives

## Credentialing and recredentialing

We are dedicated to providing our members with access to effective (medically necessary) health care and, as such, we periodically review the credentials of every network physician and other health care professional in order to maintain and improve the quality of care and services delivered to our members. Our credentialing standards are more extensive than (though fully compliant with) NCQA requirements.

A credentials file is maintained on all participating physicians and other health care professionals. Credentialing decisions are made by the UnitedHealthcare National Credentialing Committee. Recommendations for action are passed to this committee and the Medical Director on a timely basis, and all applicants are notified by a letter of any decision made by the Committee.

### Provider types that can be credentialed

- Physicians (MDs)
- Osteopaths (DOs)
- Dentists (DDS or DMDs)
- Podiatrists (DPMs)
- Select health delivery facilities:
  - › Hospitals
  - › Home health care agencies
  - › Skilled nursing facilities
  - › Ambulatory surgery centers
  - › Mental health facilities
  - › Birthing centers

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\* Credentialing process and requirements may differ depending on specialty of the ancillary or facility.

- › Alcohol/drug rehabilitation facilities
- › Subacute centers
- Physicians and other health care professionals affiliated with freestanding ancillary facilities that do not already have accreditation satisfactory to us
- Non-physician health care professionals:\*
  - › Social workers (CSWs and MSWs)
  - › Marriage and family therapists
  - › Psychologists
  - › Nurse midwives
  - › Physical therapists
  - › Occupational therapists
  - › Speech therapists/pathologists
  - › Speech therapy/pathology physicians
  - › Audiologists
  - › Optometrists
  - › Nurse practitioners
  - › Registered dietitians
  - › Psychiatric clinical nurse specialists
  - › Naturopathic doctors
  - › Acupuncturists
  - › Chiropractors
  - › Massage therapists
  - › Nutritionists
  - › Yoga instructors
  - › Physician assistants
  - › Licensed professional counselors

**Please note:** Some of the above specialties are credentialed as part of an ancillary program of health care professionals. Such credentialing does not guarantee that we provide coverage for all services that the health care professional renders. Applicable policies and procedures or the member's Certificate of Coverage may limit or exclude certain services.

### **Physicians licensed or double-boarded**

A double-boarded physician is a physician who has been certified by the American Board of Medical Specialties to practice in more than one specialty/area of medicine. Physicians who participate in our network can continue to be double boarded as both a PCP and a specialist.

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\* Some networks are closed due to network integration activities. Further information can be obtained by calling Provider Services at **(800) 666-1353**.



# Credentialing requirements

## Individual physicians and other health care professionals

**The following credentials and documents are required for physicians and osteopaths (MDs, DOs, DDS, DMDs, DPMs):**

- Current, valid state license
- Current, valid Drug Enforcement Agency (DEA) registration certificate
- Current, valid Controlled Dangerous Substances (CDS) certificate (NJ only)
- Board certification or satisfactory completion of an approved residency program within the last 5 years
- Malpractice insurance in the amounts of \$1,000,000 per occurrence, \$3,000,000 in the aggregate
- Admitting privileges at a participating hospital for all PCPs and most specialists (when applicable)
- History of professional liability claims
- Medicaid and Medicare sanctions history verification
- A work history with explanations of any gaps in employment over the last 5 years

### **Non-physician health care professionals**

- Current, valid state license
- Certification/registration
- Advanced degree
- Graduation from appropriate school
- Malpractice insurance in the amounts of \$1,000,000 per occurrence, \$3,000,000 in the aggregate
- History of professional liability claims
- Medicaid and Medicare sanctions history verification
- Collaborative practice agreement, as applicable by specialty
- Post-graduate training, as applicable by specialty
- Documentation of a formal arrangement for psychiatric medication consultation, as applicable by specialty
- A work history with explanations of any gaps in employment over the last five years

### **Ancillary health care professionals**

- Health care professionals affiliated with an accredited facility that is participating with us may not need to be credentialed.

See *Facilities Credentialing* in this section for a list of approved accreditation agencies.

- Physicians and other health care professionals affiliated with nonaccredited facilities may be credentialed by us following the criteria previously outlined.

## Credentialing application

We are a member of the Council for Affordable Quality Healthcare (CAQH) and, as such, utilize the CAQH Universal Credentialing DataSource (UCD) for gathering credentialing data for all the physicians and other health care professionals whose data we made available to CAQH during the initial rollout of the prepopulated database.

CAQH is a not-for-profit alliance of more than 90 national, regional and local health plans and networks. Created in 1999, CAQH member organizations provide and administer health care coverage for more than 100 million Americans. CAQH's UCD promotes collaborative initiatives to help make health care more affordable, to share knowledge to improve

the quality of care, and to ease the administrative burden of the credentialing process in order to allow physicians to dedicate more time to patient care.

The UCD employs many features that make a difference and improve the quality of physician and other health care professional data submitted via CAQH, such as:

- Automatic check for errors
- Only asks questions relative to the practice
- Allows physicians and other health care professionals to save a partially completed application and return later
- Enables common data on multiple physicians and other health care professionals to be entered only once
- Assists in quickly locating contact information for colleges, medical schools and facilities

The CAQH process is available to physicians at no charge. Additionally, the process creates cost efficiencies by eliminating the time necessary to complete redundant credentialing applications for multiple health plans, reduces the need for costly credentialing software and minimizes 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. All new physicians and other health care professionals applying for participation in our network and those scheduled for recredentialing are instructed on the proper methods for accessing the CAQH UCD.

We encourage physicians and other health care professionals to familiarize themselves with the CAQH Universal Credentialing DataSource prior to being requested to complete an application online. Simply access the UCD demo at <https://upd.caqh.org/OAS/> and click on **Overview**.

**For New Jersey physicians and other health care professionals**, Universal Physician Applications can be downloaded from the New Jersey Department of Health and Senior Services website at [www.state.nj.us/health](http://www.state.nj.us/health) or to request a copy, call Provider Services at (800) 666-1353. For more information on CAQH, please visit [www.caqh.org](http://www.caqh.org) or call CAQH Support at (888) 599-1771.

**Completed applications include:**

- General demographic and practice information
- Educational history, both undergraduate and medical/dental school
- Postgraduate training
- Continuing medical education (CME) [physicians who are not board certified must submit documentation of CME credits obtained within the last 3 years; we require either 150 CME credits every 3 years or submission of the American Medical Association (AMA) Physicians Recognition Award]
- Malpractice insurance policy information
- Details of continuous work history with any explanation in gaps over the past 5 years
- Attestation by the physician or other health care professional alerting us of any malpractice issues or sanctions against the physician or other health care professional by federal or state agencies, facilities or other health care institutions to which the physician or other health care professional has been appointed
- Unaltered and signed Physician Agreement

## Credentialing review process for physicians

- We verify state license, postgraduate training, DEA certification, CDS certification (New Jersey only), and board certification.
- We contact the National Practitioner Data Bank (NPDB) concerning malpractice settlements or any reported actions; NPDB reports whether any facility or managed care organization has sought to limit, suspend or abolish your privileges; NPDB also verifies current state and federal listings of physicians and other health care professionals barred from providing Medicare or Medicaid services.
- Site visits are conducted at offices of all PCPs, OB/GYNs and high-volume behavioral health care professionals to evaluate office procedures, safety precautions, emergency protocols, and medical record-keeping.

We may enter into contracts with third parties to perform services for us in connection with the credentialing review process; we may disclose information to the third party; however, the information is kept confidential; participating physicians and other health care professionals may request a copy of their file at any time. Physicians also have a right to obtain the status of their credentialing or recredentialing application, and to correct any erroneous information in the event that credentialing information we obtain from other sources varies significantly from the information provided by the practitioner. Requests must be submitted in writing to the following address:

Oxford Credentialing Department  
44 South Broadway  
White Plains, NY 10601

We will complete credentialing activities and notify physicians within 90 days of receiving a completed application. The notification to the physician will inform them as to whether they are credentialed, whether additional time is needed, or that we are not in need of additional physicians. If additional information is needed, we will notify the physician as soon as possible, but no more than 90 days from the receipt of the application.

## Recredentialing

To maintain the integrity of our network of physicians and other health care professionals, all participating physicians and other health care professionals must adhere to credentialing and recredentialing standards. An important standard that NCQA measures for recredentialing is the timeliness of recredentialing. The standard states that managed care organizations should formally recredential their physicians and other health care professionals at least every 3 years.

To remain in good standing as a network physician or other health care professional, it is imperative that you complete your recredentialing as instructed or update your CAQH application on a quarterly basis.

**For New Jersey physicians and other health care professionals**, Universal Physician Applications can be downloaded from the New Jersey Department of Health and Senior Services website at [www.state.nj.us/health](http://www.state.nj.us/health) or to request a copy, contact Provider Services at (800) 666-1353.

## Recredentialing review process for physicians

- Verification of state license, DEA certification and board certification through primary source verification
- Verify if there are any malpractice claims liability history through NPDB; this data bank provides us with data on civil judgments related to health care delivery, federal or state criminal convictions against physicians and other health care professionals, actions by federal or state licensing agencies against physicians and other health care professionals, and exclusions of health care physicians and other health care professionals from participation in federal or state health care programs.
- We may enter into contracts with third parties to perform services for us in connection with the recredentialing review process; we may disclose information to the third party; however, the information is kept confidential.

- Various departments contribute quality-related data on each physician or other health care professional undergoing the recredentialing process; the information gathered and the responsible departments are as follows:

Information	Department
Complaint profile	Quality Management
Medical record review data	Quality Management
Results of site evaluations	Provider Relations/Quality Management
Any adverse action	Various departments

## Notification

All information compiled during the recredentialing review process will be evaluated by the UnitedHealthcare Credentialing Committee or Regional Quality Improvement Director and Senior Medical Director, whose decision will be communicated to the physician or other health care professional by letter. We maintain documentation of all correspondence in the physician’s or other health care professional’s credentials file.

## Facilities

### Credentialing requirements:

We require that an initial quality assessment be completed for all newly participating facilities prior to the finalization of a contract relationship. All hospitals, home health care agencies, skilled nursing facilities, ambulatory surgery centers, mental health facilities, birthing centers, alcohol/drug rehabilitation and subacute centers must demonstrate good standing with state and federal regulatory agencies. In addition, we require all facilities to be accredited by a recognized and relevant accrediting agency (please see the following chart). Facilities that do not meet this accreditation standard may be included in our network of physicians and other health care professionals only if they are able to demonstrate compliance with our Standards for Participation.

Facility	Accreditation Required
Hospitals	JCAHO <sup>1</sup>
Home health agency	JCAHO or CHAP <sup>2</sup>
Skilled nursing facility	JCAHO or CARF <sup>3</sup>
Ambulatory surgical center	JCAHO or AAAHC <sup>4</sup> or AAAASF <sup>5</sup>
Mental health facility	JCAHO or CARF
Birthing centers	JCAHO, CABC <sup>6</sup> or AAAHC
Alcohol/drug rehabilitation facility	JCAHO or CARF
Subacute center	JCAHO or CARF or AAAHC

1 Joint Commission on Accreditation of Healthcare Organizations

2 Community Health Accreditation Program

3 Commission on Accreditation of Rehabilitation Facilities

4 Accreditation Association for Ambulatory Health Care

5 American Association for Accreditation of Ambulatory Surgery Facilities

6 Commission for the Accreditation of Birth Centers

### Credentialing review process for facilities

The credentialing entity/health plan network management will be responsible for obtaining the following documents from the facility to allow us to perform this initial assessment prior to contracting:

- A completed and signed Hospital and Ancillary Credentialing (Assessment) Program letter attesting to the accuracy of the data provided
- A copy of current licensure, if applicable
- A copy of current general and professional liability coverage

- A copy of the face sheet from the accreditation agency
- Ensuring the appropriate information is forwarded to Network Data Management to create or update a physician identification number for the facility

### **Facility recredentialing**

- Home health care agencies, ambulatory surgical centers, skilled nursing facilities, and freestanding surgical centers must be recredentialed every 3 years.
- The UnitedHealthcare Credentialing Committee along with other constituencies such as the credentialing entity/health plan network management, and the Regional Quality Improvement Director and Senior
- Medical Director will work together to ensure that participating components are assessed according to the UnitedHealthcare Credentialing Plan, NCQA and/or other accreditation standards, and in compliance with any applicable federal and state regulations.
- The facility being credentialed must confirm the information submitted for the original credentialing process and provide updated copies of all credentialed materials.
- Those facilities not accredited will have an on-site review from one of our representatives.
- All documents submitted, as well as documents we may have obtained while verifying the facilities credentials, are added to the file.
- All facilities receive written notification of the status of their recredentialing.

## **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.

Such review does not focus on coding for services, but rather on the quality issues rendered to the services documented in the medical records. In addition to these standards, medical records are also reviewed for compliance with nationally recommended preventive and chronic care measures, as well as selected HEDIS measures. Reviews of this type are performed on-site at the physician's or other health care professional's office.

### **Communicating audit results**

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.

Individual results of all such reviews are tabulated in a report mailed to each reviewed physician or other health care professional. Each report contains the reviewed physician's or other health care professional's scores, both aggregate and for each measure, indicating levels of passage, areas of strength and opportunities for improvement. Physicians and other health

care professionals who fall below established thresholds in such an audit are encouraged to develop a plan of corrective action that addresses deficient areas. Implementation and effectiveness of the plans are re-evaluated within the following year.

### **Standards for medical records**

We have established the following standards for medical record keeping for PCPs in recognition of the importance of maintaining organized, up-to-date and detailed medical records as an aid in the delivery of quality care:

- Charts must be kept for individual patients in a secured area, away from patient access but readily available to practitioners.
- Charts must be legible and organized in a manner that reflects continuity and allows for easy identification of major medical problems.
- The office must have policies in place for maintaining patient confidentiality in accordance with state and federal laws.
- Physicians and other health care professionals must follow applicable professional and clinical guidelines for documenting care provided to members.
- Physicians and other health care professionals must retain patient medical records for a period of at least 10 years or the period required under applicable state and federal laws.

### **Confidentiality of medical records**

We take confidentiality of patient medical information very seriously. Physicians and other health care professionals are required to maintain member confidentiality related to medical records in accordance with current applicable state and federal laws.

### **Medical records documentation**

Medical records should include the following documentation, as well as any other information deemed appropriate or required by applicable standards.

#### **General information**

- Patient name on each page
- Address, phone number, or other identifiers
- Name of next of kin
- Date of visit
- Signature of person making the entry

#### **Immunization record**

- For all children of school age
- For adolescents
- Record of tetanus-diphtheria (Td) booster, flu vaccine and pneumococcal vaccine for applicable adults

#### **Treatment plan**

- Documentation to support that the treatment plan is appropriately carried out through:
  - › Diagnostic testing
  - › Use of medication
  - › Referrals to specialists
  - › Surgical interventions

## **Medical history**

- Documentation of past medical, surgical, family, and social history
- Birth history should be noted for children under age 10
- Notation of the chief complaint or reason for each visit with history of the present illness

## **Preventive screening**

- Evidence of appropriate preventive screening, based on clinical guidelines, by sex and age  
See Section 3 *Preventive Care Guidelines* for additional information.

## **Continuity of care**

- Evidence of continuity of care in the following areas:
  - › Problems of previous visits are addressed
  - › Physician reports (dated and initialized) showing review of diagnostic testing results and abnormal results are noted and followed up appropriately
  - › Consultation reports or notes made by the physician reflecting the results of specialist referrals with evidence that recommendations are followed through
  - › Recent hospitalizations, ER visits, ambulatory surgeries, etc. are recorded and follow-up is completed as needed
  - › A complete problem list and medication list are maintained for patients with multiple and/or chronic problems
  - › Documentation of communication between PCP and behavioral health physician for those members in ongoing behavioral health treatment

## **Allergies**

- Notation of allergies or lack of allergies on a face sheet or initial visit sheet
- Allergies to medications or any other severe, potentially life-threatening allergic reactions should be flagged (e.g., severe food allergies, bee stings, contrast dye)

## **Physical exam information**

- Documentation of a pertinent physical exam that includes:
  - › Height, weight and BMI, as applicable, for pediatrics and adolescents, obesity, etc.
  - › Record of vital signs, including baseline heart rate, respirations and temperature, as applicable, for any complaint indicating possible infection
  - › Blood pressure, recorded as appropriate for age and history
  - › Immunization history and growth charts
  - › Allergies and adverse reactions
- Complete review of systems for a complete physical exam and/or review of pertinent systems for any acute care or follow-up visits
- Notation and revision of a working diagnosis
- Written plan consistent with the diagnosis

## **Family communications**

- Evidence of communication with the patient/family about the following:
  - › Patient/family notification of abnormal test results

- › Need for return visit
- › Assessment, counseling or education on nutrition, need for special diet, therapeutic exercise, restriction of activity, or any other special instruction
- › Assessment, counseling or education on risky behaviors and preventive action associated with sexual activity
- › Assessment, counseling or education regarding depression, counseling or education on risks of tobacco usage and substance abuse (including alcohol)
- › Signed consent form for all invasive procedures
- › Signed release of confidential information as necessary

### **General documentation guidelines**

We also expect you to follow these commonly accepted guidelines for medical record information and documentation:

- Date all entries, and identify the author and their credentials when applicable. For records generated by word processing software or electronic medical record software, the documentation should include all authors and their credentials. It should be apparent from the documentation which individual performed a given service.
- Clearly label or document subsequent changes to a medical record entry by including the author of the change and date of change. The provider must also maintain a copy of the original entry.
- Generate documentation at the time of service or shortly thereafter.
- Make entries legible.
- Cite medical conditions and significant illnesses on a problem list and document clinical findings and evaluation for each visit.
- Documentation that is not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the function of a malformed body member (over documentation) should not be considered when selecting the appropriate level of an E&M service. Only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate E&M level.
- Give prominence to notes on medication allergies and adverse reactions. Also, note if the member has no known allergies or adverse reactions.
- Make it easy to identify the medical history, and include chronic illnesses, accidents and operations.
- For medication records, include name of medication and dosages. Also, list over-the-counter drugs taken by the member.
- Records reflect all services provided, ancillary services/tests ordered, and all diagnostic/therapeutic services referred by the physician/health care professional.
- Clearly label any documentation generated at a previous visit as previously obtained, if it is included in the current record.

### **Document these important items:**

- Tobacco habits, including advice to quit, alcohol use and substance abuse for members age 11 and older
- Immunization record
- Family and social history
- Preventive screenings/services and risk screenings
- Screening for depression and evidence of coordination with behavioral health providers
- Blood pressure, height and weight, body mass index



- Goals
- 90 percent of medical records will contain documentation of critical elements. Critical elements appear in bold text in this section.
- 80 percent of medical records will contain documentation of all other elements when those elements are included in quality improvement medical record audits.
- Documentation of allergies and adverse reactions must be documented in 100 percent of the records.

### **Demographic information**

The medical record for each member should include:

- Member name and date of birth, or member name and health care ID number, on every page
- Gender
- Age or date of birth
- Address
- Marital status
- Occupational history
- Home and/or work phone numbers
- Name and phone number of emergency contact
- Name of spouse or relative
- Insurance information

### **Member encounters**

When you see one of our members, document the visit by noting:

- Member's complaint or reason for the visit
- Physical assessment
- Unresolved problems from previous visit(s)
- Diagnosis and treatment plans consistent with your findings
- Growth charts for pediatric members
- Developmental assessment for pediatric members
- Member education, counseling or coordination of care with other providers
- Date of return visit or other follow-up care
- Review by the primary physician (initialed) on consultation, lab, imaging, special studies, and ancillary, outpatient and inpatient records
- Consultation and abnormal studies are initialed and include follow-up plans

## **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. To further address the continuum of care, the PCP should note in the medical record any emergent or inpatient care received from facilities or ancillary services, as well as any specialist care received by their

patient. The PCP should specifically request this history from their patients.

**Please note:** 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

Physicians and other health care professionals requesting to terminate their participation must do so by calling Provider Services at **(800) 666-1353** or writing to:

Oxford Network Management  
44 South Broadway, 14th floor  
White Plains, NY 10601

## **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.

Physicians and other health care professionals will not be terminated or receive a refusal to renew their contract solely because the individual has:

- Advocated on behalf of a health plan member
- Filed a complaint against the health plan
- Appealed a decision of the health plan
- Provided information or filed a report pursuant to PHL4406-c regarding prohibitions of plans
- If you are a Medicare physician and you have been terminated from the Medicare Network for administrative reasons (e.g., lack of response to a recredentialing request, network reconfiguration, etc.), you have the right to appeal this decision. You can do this by contacting your Network Management representative at **(877) 842-3210** (request "Other Professional Services") or you may go online to **UnitedHealthcareOnline.com > Contact Us > Network Contacts**.

## **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.

\* 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.

## **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.

Potential issues can be identified through a number of sources including, but not limited to, complaint investigation and credentialing issues.

The following entities have the authority to recommend and implement disciplinary action:

- UnitedHealthcare National Physician Sanction Committee
- The National Peer Review Committee (NPRC)
- Our Medical Director (in rare situations) may institute immediate disciplinary action in response to imminent threat of patient harm; such action will later be reported and reviewed by the appropriate committee for their region.

### **Notice of termination for contract and appeal rights**

We grant all physicians 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:

- 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: In the following scenarios the physician may be terminated immediately whether or not the physician has the right to an appeal.

- Severe quality-of-care issues that may result in imminent harm to a member or members
- 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

All other sanctions under this policy shall be effective immediately, whether or not the physician has a right to appeal.

### **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:

- › Severe quality-of-care issues that may result in imminent harm to the member(s)
- › Failure to meet recredentialing criteria that results in denial of participation with us that does not include non-renewal 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

### **Filing an 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 information that reasonably appears to show that a health professional is guilty of professional misconduct
- Any disciplinary action imposed for quality reasons that adversely affects the clinical privileges of a physician or other health care professional 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.

### **New York**

Office of Professional Medical Conduct Office of Professions

New York State Education Department

One Park Avenue

New York, NY 10016-5802

Telephone **(800) 663-6114**

### **New Jersey**

New Jersey State Board of Medical Examiners

28 W. State Street, Room 60

Trenton, NJ 08608

Telephone **(609) 292-4843**

### **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 quality of care/ utilization issues**

The severity levels, sanction levels, and administrative disciplinary actions process flow associated with various administrative violations are as follows:

### **Severity Level 1 when Sanction Level 1**

Administrative disciplinary actions taken for issues ranked at Severity Level 1 may include, but are not limited to, any of the following:

- A letter that advises the practitioner of the findings and requests an explanation and/or a plan of corrective action
- Educational discussion relating to the issue and the practitioner's plan for corrective action
- Closure of the practitioner's panel to new members or removal of name from the physician roster
- Require precertification review by our Medical Management department for procedures or services that do not otherwise require such precertification
- Impose a withhold, fee reduction or other financial penalty
- A requirement that the physician submit notes or other medical records prior to processing of a claim
- Placement on probation with close observation

### **Severity Level 2 when Sanction Level 2**

Administrative disciplinary actions taken for issues ranked at Severity Level 2 may include, but are not limited to, any of the following:

- Any of the actions under Sanction Level 1, with a notation that the action constitutes final notice
- Limitations on reimbursement for certain procedures that are part of the practitioner's practice (e.g. refusal to pay for certain procedures, or only reimbursed for treatment to certain types of patients; in each case, the physician is prohibited from balance billing members), except for quality reasons, which shall be only accomplished by the MAC
- Non-renewal of practitioner's contract with the Plan; or termination from participation with the Plan

In the case of termination, the practitioner is notified in writing within 30 days of the determination. For non-termination actions, the practitioner is requested to submit a plan of corrective action in addition to having the sanction imposed.

For sanctions not involving terminations or non-renewal of contract, when informing the physician of the sanction, the Committee will provide guidance as to the time period for remeasurement. After remeasurement, depending on the practitioner's response to the Level 2 sanction, the committee may take one of the following actions:

- Conditionally accept the plan of correction, and establish a follow-up time period for re-evaluation, allowing the sanction to continue in effect during the follow-up period and for a suitable period thereafter; or terminate the practitioner if the plan of correction is unacceptable, or the physician remains non-compliant with the request imposed by us.

# Section 8: Claims, Billing and Reimbursement

## Claims

### Explanation of the claims process

#### 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 date of service:

- Connecticut – 90 days from date of service
- New York – 120 days from date of service
- New Jersey – 90 days from date of service OR 180 days from date of service if New Jersey Physician and New Jersey Line of Business member.

Untimely claims will be denied. 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.

For claims with dates of service on or after April 1, 2010, the minimum time frame for claims submitted by New York licensed providers for services rendered to members with New York lines of business (New York situs plans) has changed to 120 days from the date of service.

We strive to process all complete claims within 30 days of receipt. Physicians and other health care professionals have a variety of methods available to verify and ensure that claims are received within the filing deadline.

If a physician or other health care professional does not receive a Remittance Advice within 45 days, he or she should check the status of the claim at that time. We offer multiple tools for checking claims status:

- Oxford Express at **(800) 666-1353** (automated self-service system available 24 hours a day, seven days a week)
- Our website at **OxfordHealth.com** (available 24 hours a day, 7 days a week\*)
- Provider Services at **(800) 666-1353** (Monday – Friday, 8 a.m. – 6 p.m. ET)

\* With the exception of Scheduled System Maintenance that occurs daily from 2am to 3am EDT and Saturday 1pm to Monday 6am EDT

#### Exceptions:

- If a claim is disputed, you have 180 days from the date of the Remittance Advice statement to appeal the claim, with the exception of claims for New Jersey members; in this case, you have 90 days from the date of the Remittance Advice statement for such claims.
- 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

Because we process claims according to state and federal requirements, a clean claim is defined as a complete claim or an itemized bill that does not require any additional information to process it. A clean claim includes at least the following:

- Patient name and member ID number
- Provider ID number
- Provider information, including federal tax ID number (FTIN)
- Date of service
- Place of service
- Diagnosis code
- Procedure code
- Individual charge for each service
- Physician or other health care professional signature

An unclean claim is defined as an incomplete claim, a claim that is missing any of the above information or a claim that has been suspended in order to get more information from the physician or other health care professional. If you submit incomplete or inaccurate information, we may reject the claim, delay processing or make a payment determination that must be adjusted later when complete information is obtained (e.g., denial, reduced payment).

## Reimbursement

Appropriate state and federal guidelines are applied to determine whether the claim is clean.

### Submission of CMS-1500 form drug codes

Attach the 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 CMS1500 form or the LIno3 segment of the HIPAA 837 electronic form.

### Prepayment anesthesia and surgical claim validation program

Physicians and other health care professionals may be requested to submit surgical notes and anesthesia records to validate the billed ICD-9 and CPT codes on surgical claims submitted. After clinical review, the claim will be paid based on the codes that have been substantiated in the medical record.

### Prepayment DRG validation program

Diagnosis Related Group (DRG) facilities may be requested to send the inpatient medical record prior to claim payment in order to 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.

## EDI claims submission policy

Electronic claims submission is a critical step in our ongoing process to simplify and automate the entire payment process. We have made significant investments in technology to facilitate the transmission and processing of electronic claims. As part of this effort, reimbursement of electronic claims is prioritized.

**Please note:** All physicians and other health care professionals can submit electronic claims – regardless of whether or not they participate with us. Benefits of this process include:

- Faster claims turnaround time and reimbursement of clean claims
- Lower outstanding receivables
- Claims tracking at the point of submission

- Fewer errors and fewer subsequent delays in processing time
- Overall reduction in administrative expenses

In accordance with our claim submission guidelines, all claims can be submitted electronically with the exception of the following:

- Claims that were processed by another carrier as the primary payer (Information for *Coordination of Benefits* in the Billing section for more details).
- Claims submitted with unspecified CPT and Healthcare Common Procedure Coding System (HCPCS) procedure codes
- Claim resubmissions  
See *Paper Claims* in this section for more information.

### **Submitting electronic claims**

To expedite payment on electronic claims, we must receive complete and accurate information from your office. Complete and accurate information includes the Payer ID, which is 06111, and the required information listed in this section. Additionally, you will need to include information which is listed in the section called *Required information for all claims submissions*.

#### **Required provider information**

- **Provider ID number and/or NPI (National Provider Identifier)** – Identification numbers assigned to the physician or other health care professional and the NPI enumerator, respectively
- **Federal Tax ID Number/Employer Identification Number (FTIN/EIN)** – Identification number assigned to the provider by the IRS
- **Physician or other health care professional name**
  - › Complete first name and last name of the physician or other health care professional rendering services

#### **Required patient information**

**Please note:** Prior to submitting a claim, please confirm the patient’s current eligibility information through our website at **OxfordHealth.com**, Oxford Express or an EDI vendor.

- **Patient’s name and member ID number** – Be sure to accurately enter the patient’s name and member ID number as it appears on the patient’s member ID card or the electronic eligibility transaction; do not include the asterisk or space when entering the ID number; however, the last two bold numbers must be included (Example: 12345602)
- **Patient’s date of birth** – Be sure to confirm that this date is correct

#### **Covering physician information**

It is essential that the covering physician be included in the Remarks/Comments field of electronic claims being submitted. This information should be included in the event that the member’s selected physician is unavailable at the time services are performed, requiring an alternate/covering physician:

“Covering for Dr. (First Name, Last Name)”

To help ensure correct payment, the provider ID number of the physician being covered should also be included.

#### **Durable medical equipment (DME) claims**

Because we no longer require providers to send scripts with their DME claims, you can send these claims electronically. In order to ensure correct and timely payment, the following information must be included on your electronic DME claims:

- The referring physician or other health care professional’s name
- The words “Script on File” in the EDI Remarks field



## **Anesthesia claims**

The following information must be included on your electronic anesthesia claims to ensure correct and timely payment:

- Total number of minutes
- Number of units (one unit equals 15 minutes)
- Actual start time and end time in the Remarks/Comments field

## **Ambulance claims**

Information about the “point of pickup” for ambulance services rendered to our members is required. Point of pickup refers to the complete address of the starting point where the ambulance service begins.

## **Clearinghouses for electronic solutions**

### **OptumInsight™ (formerly Ingenix)**

OptumInsight is the preferred clearinghouse for the submission of claims for all Oxford products. OptumInsight offers a secure, easy-to-use path to virtually all commercial and government payers. You have the option to submit claims for Oxford products directly through OptumInsight or indirectly through your current clearinghouse or gateway.

OptumInsight is dedicated to transforming organizations and improving health care with a portfolio of services to:

- Prevent erroneous claims submission
- Increase claims and payment efficiency with connectivity and automation
- Optimize revenue cycle management by streamlining coding, compliance, and reimbursement
- Control costs and improve health through data-driven disease prevention
- Improve health care decisions with innovative tools
- Ensure efficiency with comprehensive consulting and implementation services

For more information about OptumInsight solutions and services, visit [www.ingenix.com](http://www.ingenix.com) or call **(888) 445-8745**.

Electronic claims can be submitted directly to us at no cost via Post-n-Track. For information, log in to **OxfordHealth.com** as a provider or facility. Click on the Transactions tab and then on Post-n-Track in the Submit column.

## **Understanding your electronic claim reports**

When your electronic claims are submitted, they are transmitted to a clearinghouse that checks for errors. If a clearinghouse does not find errors, the claim is sent on to us. If we detect errors, the claim is returned to the clearinghouse with an explanation of what was submitted incorrectly. Your clearinghouse is responsible for relaying this information to you. You should then correct the errors and resubmit the claim. This process greatly reduces claim denials and expedites the correction process. The reports you receive from a clearinghouse are crucial for maintaining control over your electronic claims. These reports are designed to help you understand the status of your claims, showing which claims have been accepted and forwarded, as well as which claims need to be resubmitted with corrections.

The format and content of electronic claim reports varies by clearinghouse. Many send two reports:

- The first type of report contains information regarding the total number of claims submitted, accepted and rejected by your clearinghouse; rejected claims will have detailed error explanations to assist you in understanding what information will be needed to resubmit your claim.

Claims that are rejected by a clearinghouse are not forwarded for processing.

- The second type of report identifies claims that have been forwarded to us but cannot be processed; you must then correct any errors and resubmit the claims electronically.

## Electronic remittance advice (ERA) and electronic funds transfer (EFT)

When you enroll in PNC Remittance Advantage,\* your Oxford payments are electronically deposited into one or more bank account(s) that you designate. Explanations of Benefits (EOBs) are provided online, where you can review, store and print copies to use for manual posting. Alternatively, you can autopost an 835/ERA file that can be downloaded from the website or received through your clearinghouse.

ERA/EFT is the preferred payment method 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 [OxfordHealth.com](http://OxfordHealth.com) > **Providers or Facilities, click on the Transactions tab and then on Remittance Advice in the Check column.**

### eSolutions support team

We have a team of professionals dedicated to assisting you with electronic solutions for your administrative needs. They can also provide you with helpful information and assist you with a variety of topics related to EDI. Please call the eSolutions support team at **(800) 599-4334**.

### Paper claims

Claims submitted with the commercial carrier's coordination of benefits (COB) information (See Section 1 on *Claims Submission Addresses* for a list of claim addresses) or unspecified CPT and HCPCS codes are exceptions to the electronic claim requirement and should continue to be submitted on paper CMS-1500 or UB-04 forms.

### Time frame for processing claims

We strive to settle all complete claims within 30 days of receipt. If you have not received payment within 45 days, and have not received a notice from us about your claim, please use the contact information below to verify that we have received your claim.

### State time frames for claims payment

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.

- New York – 45 days (paper), 30 days (electronic)
- Connecticut – 45 days (paper and electronic)
- New Jersey – 40 days (paper), 30 days (electronic)

### Paid or denied claims

When a claim is paid or denied, you will receive a check and/or an explanation that we refer to as a Remittance Advice statement. This will explain the payment in detail. Physicians and other health care professionals must accept our fee schedules and reimbursement as payment in full. You may submit a claim for reconsideration or appeal a claims payment decision if you disagree with the determination. See Section 9 on *Appeals* for a full explanation.

In addition to your Remittance Advice, you may also check on the status of your claims using one of our electronic solutions. You can check the status of your claims on our website, [OxfordHealth.com](http://OxfordHealth.com), using Oxford Express (our automated phone system) or through an EDI vendor.

### Corrected/resubmitted claims (reconsideration) process

To ensure a prompt response when resubmitting a claim, you must include the following:

#### Physicians and other health care professionals

- A completed CMS-1500 or UB-04 claim form with the corrected or resubmitted information

\* The Remittance Advantage Solution offers direct deposit and electronic remittances (also known as ERA/EFT) through a direct connection with PNC Bank. PNC Remittance Advantage is controlled and operated by PNC Bank, not Oxford Health Plans, LLC. ("Oxford"). As such, neither Oxford, nor its suppliers or vendors are responsible or liable for any claims, loss or damage directly or indirectly resulting from your use of PNC Remittance Advantage or the information or resources contained on or accessible through this electronic transaction service. Access to this service is provided as a convenience to you and your practice and registration is strictly voluntary on your part. You access and use this service solely at your own risk.

- The words “Corrected Claim” or “Resubmitted Claim” written or stamped in Field 19 (Reserved for Local Use) of the CMS-1500 form or Field 84 (Remarks) of the UB-04 form
- A copy of our Remittance Advice or claim number written on the claim form in Field 19 (Reserved for Local Use) of the CMS-1500 form or Field 84 (Remarks) of the UB-04 form

## Facilities

For facility EDI, use payer ID 06111 and include appropriate bill type.

### Corrected/Resubmitted Claims (not requested by Oxford)

Oxford Correspondence Department  
P.O. Box 7081  
Bridgeport, CT 06601-7081

For additional information, refer to the Participating Provider Claim Review Request Form on [OxfordHealth.com](#) >

**Tools & Resources > Manage Your Practice > Forms.**

**Please note:** Do not use a highlighter or red ink to communicate the issue in question, **please use blue or black ink only.** Also, please keep copies of all Remittance Advice documents from us for your records.

## Requests for additional information

There are times when we will request additional information to process a claim. The request will either appear on the Remittance Advice or a separate communication. The requested information must be submitted promptly. If the information is not submitted within 45 days, an appeal must be submitted with the information.

### Corrected/Resubmitted Claims (requested by Oxford)

Oxford Corrected Claims Department  
P.O. Box 7027  
Bridgeport, CT 06601-7027

## Payment appeals

See Section 9 on *Appeals* for more information.

## Claim status inquiry and response

Benefits of the transactions include:

- **Flexibility (Web and EDI)** – You have more search options for retrieving claim status information; the search capability allows physicians and other health care professionals to narrow searches by selecting from a range of optional inquiry data including claim ID numbers, extended date range, bill type, billed amount, CPT code and more; additionally, inquiries by member Social Security Number return all claims for all member ID numbers associated with the requested Social Security Number.
- **Increased efficiency in practice administration (Web and EDI)** – Office administrators have the ability to inquire about submitted claims listed under the same federal tax ID number, allowing the user to conduct searches for all physicians or other health care professionals in a practice without having to log in using multiple passwords.
- **A global view** – Claim status responses include all claims that have been received by and forwarded to our third-party vendors.
- **More detailed claim status and code sets** (Web, EDI and interactive voice response (IVR))
  - › Claims show all relevant detailed statuses of a claim, both at the claim detail level and at the claim header level; this allows a full view of how claims are processed from beginning to end; HIPAA claim status codes consist of a combination of the following three code types:
  - › **Status Category Code** – Defines the category of the status; claims are “Acknowledged,” “Pended” or “Finalized”

- › **Status Code** – Identifies the reasoning behind the category location of a claim; for example, if a claim was paid at a contracted rate, the claim is in the “Finalized” category
- › **Entity Code** – Rarely used in the claim status response, this is used when business conditions apply or under error conditions, such as when a member or procedure code is not found; these codes further clarify the status category and status codes; status category and status codes will be used in most cases

**Performance highlights include:**

- **Timely information** – Claim inquiries are retrieved and returned within HIPAA-mandated time frames, 60 seconds for individual and multi-claim searches and 24 hours for batch inquiries.
- **Consistent response** – All of our electronic mediums (including Web, Oxford Express, our automated IVR system, and EDI) communicate a consistent and HIPAA-compliant claim status response; additionally, we support Batch EDI claim status inquiry transactions.
- **Fax-back option available for IVR claims** – The IVR claim status response offers you the ability to request and receive a faxed copy of the claims requested.

**Claims recovery policy (for individual physicians and other health care professionals)**

In situations resulting from isolated mistakes or where the physician or other health care professional is in no way at fault, we will not pursue collection of overpayments with individual participating physicians and other health care professionals that were made more than one year prior to the date of notice of the overpayment (the one-year period runs from the date of payment to the date we provide notice to the physician or other health care professional). Discussions and actions to collect overpayments for which a physician or other health care professional is given notice within the one-year period are appropriate under this policy. We will not use extrapolation, unless the situation fits into items 1, 2 or 3 below. This would include, but would not be limited to, situations involving duplicate claims, overpayments related to fee schedule issues, isolated situations of incorrect billing/unbundling, and situations where we were not the primary insurer.

This policy does not apply to facilities or ancillaries.

1. Reasonable suspicion of fraud exists or there is a sustained or high level of billing error.
2. A physician or other health care professional affirmatively requests additional payment on claims or issues older than one year, whether through suit, arbitration, or otherwise.
3. CMS makes a retroactive change to enrollment or to primary versus secondary coverage of a Medicare member. We will pursue collection of past overpayments beyond one year and utilize statistical methods and extrapolation.

Cases involving a reasonable suspicion of fraud or a sustained or high level of billing error would include extensive or systemic upcoding, unbundling, misrepresentation of services or diagnosis, services not rendered, frequent waiver of member financial responsibility, misrepresentation of physician or other health care professional rendering the services or licensure of such physician or other health care professional, and similar issues.

**ICD-9-CM, CPT, HCPCS, and place codes**

We use the International Classification of Diseases, 9th Revision, Clinical Modification Diagnosis and Procedure Codes (ICD-9-CM), Current Procedural Terminology (CPT), and the Healthcare Common Procedure Coding System (HCPCS) to determine payment. Physicians and other health care professionals must correctly use these codes on their claims in order to receive payment. Some codes are included in this manual; however, you can obtain complete lists of these codes by contacting St. Anthony’s Publishing:

St. Anthony’s Publishing  
 11410 Isaac Newton Square  
 Reston, VA 20190  
**(800) 632-0123, ext. 5814**

In addition to the codes mentioned above, we use the bill type, occurrence codes and revenue codes, when applicable, to determine payment. You can obtain complete lists of these codes\* by contacting the CMS.

If any of the information is not submitted correctly, the clearinghouse will return the claim to you so that you can correct the error(s) and resend the claim electronically.

## Required information for all claims submissions

### Using the correct fields on the CMS-1500 form

The following information is required for claims processing. If this information is not provided, the claim will be suspended and payment withheld until you resubmit the claim with the necessary information.

Information	CMS-1500 Line Number	Description
Patient name	2	Name of the patient receiving service
ID number	1a	The patient's Oxford ID number
Date of service	24a	Date on which service was performed
Other insurance coverage	9a	Coverage in addition to Oxford
Provider name/address	33	Name/address of treating physician or other health care professional
Provider number	33	Treating provider's Oxford ID number
Provider FTIN	25	Federal tax ID number
Diagnosis code	24E	ICD-9-CM code(s) for the primary and secondary diagnoses for which patient is being treated
Services/procedures	24D	Service(s) itemized by CPT-4 code and/or HCPCS code and modifiers, if applicable (i.e., per service or procedure)
Number of days and units	24G	Days or units of service as appropriate; must be whole numbers
Total charge	28	Sum of all itemized charges or fees
Certain conditions	10	If a visit is related to employment or accident
NPI number	17b	National Provider Identifier (NPI) number of the referring provider
Rendering provider	24J	NPI number of the rendering provider

### Using the correct place codes

To ensure timely and accurate payment of claims, we use place codes created by CMS and mandated by HIPAA for electronic transactions. All claims are required to be submitted with the correct CMS place code. These place codes must be used for services provided to members. CMS place codes include the following:

Code	Description
11	Office
12	Home
15	Mobile diagnostic unit
20	Urgent care facility
21	Inpatient facility
22	Outpatient facility
23	Emergency room facility
24	Ambulatory surgical center
25	Birth center
26	Military treatment facility
31	Skilled nursing facility
32	Nursing facility
33	Custodial care

\* For information on additional HIPAA Code Sets, please refer to Appendix C of the 837 Health Care Claim: Professional ASC X12N (004010X98) Implementation Guide or the 837 Health Care Claim: Institutional ASC X12N (004010X96) Implementation Guide.

Code	Description
34	Hospice
41	Ambulance – land
42	Ambulance – air or water
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse
56	Psychiatric residential treatment center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
65	End stage renal disease facility
71	State or local public health clinic
72	Rural health clinic
81	Independent lab
99	Other unlisted facility

### Required information for submission of hospital/facility claims

Required information	Description
Billing FTIN	Federal tax identification number of the organization requesting reimbursement
Facility ID/NPI number	Oxford-assigned provider identification number and NPI number of the facility requesting claim reimbursement, e.g., HO1234, ANC123
Billing facility name	Name of the organization requesting claim reimbursement
Billing facility city, state, ZIP code	City, state and ZIP code of the organization requesting claim reimbursement
Billing address	Street address of the organization requesting claim reimbursement
Patient Oxford ID number	Oxford identification number of person to whom services are being rendered (do not use a space or an asterisk when entering the Member ID number, e.g., 17935801)
Patient last name	Last name of the patient
Patient first name	First name of the patient
Patient gender	Sex of the patient
Patient date of birth	Date of birth of the patient (eight spaces are provided for the date of birth, e.g., 01011957 not 010157)
Revenue code(s)	Code that identifies a specific accommodation, ancillary service or billing calculation
Diagnosis code(s)	The ICD-9-CM code describing the principal diagnosis (i.e., the condition determined after study to be chiefly responsible for admitting the patient for care)
Date(s) of service	Date(s) on which service was performed (“From-To” dates are accepted for inpatient charges only; outpatient charges must be entered line-by-line for each date of service)
Place code(s) or place of service	Code(s) used to indicate the place where procedure was performed
Requested amounts	Total billing amount requested by the provider
CPT/HCPC code(s)	The charge or fee for the service itemized by each HCPC or CPT-4 code (i.e., per service or procedure; inpatient charges do not require CPT codes; outpatient charges require CPT codes)
Units of service	As appropriate – A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc.
Condition code(s)	As appropriate – Code(s) used to identify relating conditions that may affect processing
Occurrence code(s)	As appropriate – Hospital/facility codes and associated dates defining a significant event relating to this bill that may affect processing

Required information	Description
Occurrence span code(s)	As appropriate – Hospital/facility codes and the related dates that identify an event that relates to the payment of the claim
Assignment of benefits	As appropriate – Authorization for claim reimbursement to be made to billing provider
Coordination of benefits	As appropriate – Coverage in addition to Oxford
Statement covers date	The beginning and ending service dates of the period included on this claim
Covered days	The number of days covered by the primary insurer, as qualified by that organization
Non-covered days	Days of care not covered by the primary insurer
Coinsurance days	The inpatient Medicare days occurring after the 60th day and before the 91st day, or inpatient skilled nursing facility swing bed days occurring after the 20th and before the 101st day in a single period of illness
Lifetime reserve days	Under Medicare, each beneficiary has a lifetime reserve of 60 of additional days of inpatient facility services after using 90 days of inpatient facility services during a period of illness
Patient marital status	The marital status of the patient at date of admission, outpatient service or start of care
Admission/start of care date	The date the patient was admitted to the provider of inpatient care, outpatient service or start of care
Admission hour	The hour during which the patient was admitted for inpatient or outpatient care
Admission type	Hospital/facility code indicating the priority of this admission
Admission source	Hospital/facility code indicating the source of this admission
Discharge hour	Hour that the patient was discharged from inpatient care
Patient (discharge) status	Hospital/facility code indicating patient status as of the ending service date of the period covered on this bill, as reported in field 6 of the form
Medical/health record number	The number assigned to the patient's medical/health record by the provider
Treatment authorization codes	A number, hospital/facility code, or other indicator that designates that the treatment covered by this bill has been authorized by Oxford
Admitting diagnosis code	The ICD-9-CM diagnosis code provided at the time of admission, as stated by the provider
External cause of injury code	The ICD-9-CM code for the external cause of an injury, poisoning or (E-code) adverse effect

## Billing

### Requirements for inpatient and outpatient billing

All claims must be submitted within 90 days of completed services or payment for that service may be reduced or denied.

In addition:

- Claims must be submitted electronically or on a completed CMS-1500 or UB-04 form.
- Claims must be submitted with the appropriate CPT codes as established by the American Medical Association or HCPCS as established by CMS.
- The HIPAA transaction and code set rule requires usage of the medical code set that is valid at the time that the service is provided; CMS will no longer permit a 90-day grace period to use discontinued codes for services rendered in the first 90 days of the year; to help promote prompt and timely payment of claims, the new CPT/HCPCS codes rendered must be used for services beginning on or after January 1 of each year.

### 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 (i.e., copayment, deductible, coinsurance excess, or charges over UCR), except when services are determined by us to be non-covered services (i.e., services that are excluded from coverage in the “Exclusions and Limitations” section of the member’s *Certificate of Coverage (COC)/Evidence of Coverage (EOC)* and for which the member

is responsible for payment, or services incurred when the member was not eligible for coverage) or when the member has exceeded or exhausted a benefit limit.

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. Our network of physicians and other health care professionals may not bill a member for:

- Any difference between our payment to you for a covered service and your billed charges
- The entire amount or partial amount of a claim that was denied by us because you failed to obtain a required precertification or a referral for those plans that require a referral

**Exception:** Commercial Freedom Plan® and Liberty Plan<sup>SM</sup> members may access specialist services on an out-of-network basis without a referral. In such cases, plan members may be billed for deductible and coinsurance amounts by you. However, you may not bill the member for any difference between your billed charges and our fee schedule.

- The entire amount or partial amount of a claim that was denied solely because the service was determined to be not medically necessary
- Any line item in a claim for covered services that was included in, or excluded from, a more comprehensive payment code in accordance with our claims processing procedures
- Any line item that is adjusted in accordance with a reimbursement policy
- Fees for all or part of covered services before services are rendered (except for applicable copayments, coinsurance, and deductibles)
- Administrative services (e.g., faxing, mailing referrals, completing forms, or other standard office functions)

In those cases that require a referral, if you perform the service without a referral, the claim will be denied or paid out-of-network based on your contracted rate. In accordance with your Provider Agreement, the member is held harmless, and you cannot balance bill the member except for possible deductible and coinsurance, dependent upon member's benefit. Physicians and other health care professionals in our network who repeatedly violate these restrictions for billing members will be subject to discipline, which may include termination of your Agreement. Any notices to members that advise them that a bill has been forwarded to us must clearly state that no money is due.

## **Billing address, physician or other health care professional/practice information or tax ID number change**

We want to be sure the physician/other health care professional information in our database is as accurate as possible. Your correct practice address and telephone numbers are needed so that we may list you correctly in our roster and for you to receive important mailings. An accurate billing address is also necessary for all claims logging and payment. Additionally, it is important that you notify us of any changes, such as retirement, relocation, closure of secondary office, or change of practice.

When submitting an address change form or tax ID change, you must include the following:

- A completed Provider Demographic Update Form or a letter on your letterhead
- A signed W-9 form (needed for tax ID changes only)
- When submitting changes on your letterhead, you must include the following:
  - › A description of the change (new or additional address, telephone number or tax ID number change)
    - › The old and the new billing address
    - › The old and the new practice address
    - › Phone number change (if applicable)
    - › The tax ID number and your physician or other health care professional ID number



- › The effective date of change

All documentation should be faxed to **(866) 561-3966**. It's easy to change your practice address electronically; log in to your personalized page at **OxfordHealth.com** and click on **change address**.

## **National Provider Identifier (NPI) requirement**

We accept NPIs on all HIPAA electronic claims and real-time transactions. A valid NPI is required on all covered claims (paper and electronic) in addition to the tax identification number (TIN). We are also requesting the billing provider National Uniform Claim Committee (NUCC) taxonomy code be submitted on institutional claims. As of May 23, 2008, Medicare and many state Medicaid agencies require the use of your National Provider Identifier (NPI) on all electronic and paper claim submissions. If you have not already begun to do so, you must include a valid NPI on all Medicare and Medicaid claims. Providers who have not already done so can submit their NPI to us on their letterhead or by completing a Provider Demographic Update form.\* The form is available on **OxfordHealth.com > Tools & Resources > Forms > Manage Your Practice**. Please send completed forms and correspondence to us by fax: **(866) 561-3966**.

When submitting NPI information on your letterhead, please be sure to include the following:

- Practice/organization name
- Current tax identification number (TIN)
- National Provider Identifier and issue date
- NUCC taxonomy code(s) and basis for NPI (if you are an organization)
- Name and telephone number of the individual submitting NPI information to us
- If you have multiple NPIs representing your practice or organization, please refer to section III of the Provider Demographic Update form and use the grid to supply your organization or sub-part name, NPI and taxonomy code(s) associated with that NPI.

Providers and organizations who have already notified UnitedHealthcare of their NPI do not need to also inform us. NPI information received will be updated by both Oxford and UnitedHealthcare by the compliance date. Please go to **OxfordHealth.com** for additional NPI information, answers to frequently asked questions and more.

## **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.

### **Claim submission**

Before submitting a claim for processing, you must first determine if the patient has other coverage. 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. See *Coordination of benefits rules* in this section.

We now 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.

**Please note:** If Medicare is the secondary payer, you must continue to submit the claim to Medicare; we cannot crossover in reverse.

In order for us to coordinate claims for members, the following information is required:

- 1. Copy of the claim.** For a HCFA claim, fields 10 a, b and c should contain the other carrier information

\* For purposes of informing us of NPI, only sections I and III of the Provider Demographic Update form are necessary. If you have not begun to submit your NPI on claims, please work with your software vendor or clearinghouse to establish a timetable for doing so. The NPI information that you report to us now, and on all future claims, is essential in allowing us to efficiently process claims to avoid delays or denials.

(only) including any policy numbers; for a UB-04 claim, field 50 should be populated with the other carrier information; a complete list of required claim fields is located in this section.

2. **Legible copy of the primary carrier's EOB**, including the primary carrier's allowed amount, how much was paid by the primary carrier and the member's responsibility. In cases where the primary carrier has denied a service, an explanation of the denial must be included.

If information in our file does not match the COB information submitted with a claim, we will proceed accordingly:

1. If the claim indicates services are related to a work-related injury or a motor vehicle accident, we will validate the information, determine responsibility and release the claim for processing; claims with other coverage information that cannot be validated will be suspended and the provider will be notified of the claim's suspended status.
2. Claims may be suspended for up to 30 days.
3. If the COB department receives a response within the 30-day period, the member's file will be updated and the claim will be released for processing; if the member does not respond to the COB department within the 30-day period, the claim will be denied.

## Referral and authorization guidelines

When it is determined that we are the secondary or tertiary carrier, normal requirements for precertification and referrals are modified as follows:

- Referral and precertification 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 precertification guidelines will apply if the primary carrier does not cover a service or applies an authorization penalty. Referral and precertification guidelines will apply when a motor vehicle accident or workers' compensation is involved.

## Balance billing

In accordance with your agreement, you are not allowed to balance bill a member for those amounts in excess of your contracted rates. Balance billing of members is subject to disciplinary procedures as defined in Section 8, **Balance billing policy**. Please also refer to *Disciplinary policies and procedures* in Section 7.

## 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. This information is used for the purpose of coordinating and paying a member's claims. Failure to release requested information can result in a delay in processing or denial of claim payment.

## Right of recovery\*

We have the right to recover amounts paid in error. The Accounts Receivable team is responsible for collecting overpayments that have been identified by our audit teams.

We use 3 primary collection vendors to manage provider recoveries: JRP, Creditek and Allied Interstate. These vendors are responsible for sending initial letters, assessing refund status (telephone calls and letters), partnering with us to resolve overpayment disputes/appeals, using automated processes to exclude claims included in closed settlement time period and pending settlement discussions, excluding claims beyond the state compliance time frame.

Physicians and other health care professionals should follow the instructions outlined in the letter from the vendor.

Physicians or other health care professionals have 30-45 days to refund or appeal. Claims can be "down-adjusted" if still open after 90 days.

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\* Please refer to the Claims recovery policy in this section, for further information regarding this process.

## Coordination of benefits rules:

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). If the parents have the same birth date, then the primary coverage is the health plan that has covered the individual for the longest continuous period.
- 4. Custody/divorce decree rule:** If the parents are divorced or separated, the terms of a court decree will determine which plan is primary. If no specific terms are available, benefits are determined in this order; the plan of the parent with custody of the child, the plan of the spouse of the parent with custody of the child, the plan of the parent not having custody of the child and finally the plan of the spouse of the parent not having custody of the child.
- 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.

When the member is insured by an Oxford commercial product, 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;
- Eligible for Medicare due to end stage renal disease (ESRD) and services are within 33 months of the first date of dialysis
- When the member is insured by Oxford with a Medicare Advantage plan, we have primary responsibility if the member is:
  - 65 or older and retired;
  - 65 or older, actively working and his/her coverage is end stage renal disease (ESRD) sponsored by an employer with less than 20 employees;
  - Disabled, actively working and his/her coverage is sponsored by an employer with less than 100 employees;
  - Eligible for Medicare due to end stage renal disease (ESRD) and services are after 33 months of the first date of dialysis

## Reimbursement

**PCP/specialist reimbursement** – When joining our network, all PCPs and specialists agree to accept our fee schedule and the payment and processing policies associated with the administration of these fee schedules. All fees paid by us, together with the patient’s copayment, deductible and/or coinsurance (if applicable), are to be accepted as payment in full. Physicians and other health care professionals must not balance bill members for in-network covered services. If physicians

or other health care professionals fail to precertify services, they may not balance bill the member.

**Hospital reimbursement** – We will reimburse hospitals for services provided to members at the rates established in the fee schedule or in schedule or attachment of the hospital contract. Payment rates shall include payment for all professional services by physicians and other health care professionals covered by a facility’s TIN or who have a principal practice location at the hospital’s address. All fees paid by us, together with the member’s copayment, deductible and/or coinsurance (if applicable), are to be accepted as payment in full.

**Ancillary facility reimbursement** – We will 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. Ancillary health care professionals must not balance bill members for in-network covered services. If ancillary health care professionals fail to precertify services, they may not balance bill the member.

## **Other reimbursement guidelines**

We reimburse claims for medically necessary covered services in accordance with our medical and administrative policies, the contracted fee schedule that is applicable to the network in which you participate, and the member’s copayment, deductible and coinsurance, where applicable.

For a complete list of policies related to the reimbursement of claims, refer to **OxfordHealth.com > Tools & Resources > Practical Resources > Medical and Administrative Policies > Reimbursement Policies.**

Copies of our reimbursement policies can also be obtained by sending a written request to:

Oxford Policy Requests and Information  
48 Monroe Turnpike  
Trumbull, CT 06611

**Note:** Changes to our reimbursement guidelines are announced at **OxfordHealth.com** via the monthly Policy Update Bulletin. The following is a list of commonly requested administrative policies related to reimbursement of claims.

- Add-on codes
- After-hours and weekend care
- Assistants at surgery (assistant surgeon)
- Bilateral surgery
- Contrast agents for radiology procedures
- Cosurgeons/team surgery
- Credentialing guidelines for participation in the radiology network for radiologists and cardiologists
- Distinct procedural service (Modifier -59)
- Evaluation and management codes
- Global surgical package
- In-office laboratory testing and procedures list
- Maximum frequency
- Modifiers
- Modifier -25
- Modifiers -54, -55, -56
- Multiple imaging rules
- Multiple procedures (Modifier -51)
- Multiple surgery

- Obstetrical care
- Obstetrical ultrasonography
- Prolonged services
- Radiology privileging list
- Radiology procedures for CareCore National arrangement
- Radiology procedures requiring precertification
- Reduced services
- Reimbursement for comprehensive and component CPT codes
- Same day/same service
- Technical component and professional component (TC/PC)
- Telephone calls, e-mail and other non-personal communications
- Therapeutic and diagnostic injection policy
- Unusual services
- Vision services

## **Correct coding**

All claims submitted to us must be correctly coded using the appropriate CPT code(s) or HCPCS code(s). According to the American Medical Association and the Healthcare Common Procedure Coding System (HCPCS), when both a CPT and a HCPCS Level II code have virtually identical narratives for a procedure or service, the CPT code should be used. If, however, the narratives are not identical, the Level II HCPCS code should be used.

As set forth in our current reimbursement methodology for comprehensive and component code, the process of assigning a code to a procedure or service depends on both the procedure performed and the documentation that supports it. For complete details, refer to **OxfordHealth.com > Tools & Resources > Practical Resources > Medical and Administrative Policies > Reimbursement Policies > Reimbursement for Comprehensive and Component CPT Codes.**

## **Modifiers**

Placement of a modifier after a code does not ensure reimbursement. Modified procedures are subject to review for appropriateness in accordance with the guidelines outlined in our policies. Some modifiers are “informational” and do not affect the fee schedule reimbursement. For complete details regarding the reimbursement of recognized modifiers, refer to **OxfordHealth.com > Tools & Resources > Practical Resources > Medical and Administrative Policies > Reimbursement Policies > Modifiers.**

## **Global surgical package (GSP)**

A global period for surgical procedures is a long-established concept under which a “single fee” is billed and paid for all services furnished by a surgeon before, during and after the procedure. According to CMS, the services included in the GSP may be furnished in any setting (e.g., hospital, ambulatory surgery center, physician’s office). For complete details on the reimbursement for Evaluation and Management (E/M) or other services included in the global period, refer to **OxfordHealth.com > Tools & Resources > Practical Resources > Medical and Administrative Policies > Reimbursement Policies > Modifiers.**

## **Availability of policies and fees**

All of our clinical, reimbursement, and administrative policies are available for your reference on **OxfordHealth.com** and can be accessed from the provider or facility home page via **Tools & Resources > Practical Resources > Medical & Administrative Policies.**

Copies of our policies can also be obtained by sending a written request to:

Oxford Policy Requests and Information  
48 Monroe Turnpike  
Trumbull, CT 06611

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. Fees are adjusted periodically, and we will use reasonable efforts to notify you of fee changes applicable to your practice. Provider Services is available to provide this information and to answer questions regarding claims payment.

**Notice of changes or revisions to our medical and administrative policies**

A monthly Policy Update Bulletin summarizing all recently approved and/or revised policies is available for your reference at **OxfordHealth.com**. This communication provides online notice of medical and administrative policy updates. By accessing the monthly Policy Update Bulletin, you may view new and/or revised policies, in their entirety, along with an overview or summary of changes. A new Policy Update Bulletin is published on the first calendar day of every month and can be accessed via **OxfordHealth.com > Providers > Tools & Resources > Practical Resources > Medical and Administrative Policies > Policy Update Bulletin**.

# Section 9: 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. If, as a participating physician or other health care professional, you want to dispute a claim payment determination or a medical necessity determination, your dispute is eligible for an individual one-step internal appeal process. 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 that you wish to submit for consideration, including the entire medical record related to the service along with a Participating Provider Review Request Form. To avoid delays in processing your appeal request, please refer to the appeals process outlined in the denial letter or Explanation of Benefits (EOB) to appropriately route your appeal to the correct department. Time frames for appeal reviews do not begin until they are received by the appropriate department.

- **Decision-maker** – For decisions involving medical judgment, the appeal will be reviewed and decided by a different clinician than the reviewer who made the initial determination; for decisions involving payment disputes, the appeal will be reviewed and decided by a different decision-maker than the decision-maker who made the initial determination.
- **Untimely appeals** – If you submit an appeal after the appeal time frame has expired, we will uphold the denial for untimely submissions.
- **Pre-appeal claims review** – Before requesting an appeal, if you need further clarification of a payment determination, you may ask a service associate, verbally or in writing, for a review of the claims payment issue; the service associate will make every effort to explain our actions; if you or the member is found to be entitled to additional payment, we will reprocess the claim and remit the additional payment.

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, as a participating physician or other health care professional, 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 7078  
Bridgeport, CT 06601-7078

All pertinent clinical documentation should be submitted with the appeal request. Once the review is complete, we will send written correspondence notifying you of our decision. The Clinical Appeals department will make a reasonable effort to render a decision within 60 calendar days of receiving the appeal and supporting documentation. The decision of the Clinical Appeals department is our final position on the matter and is subject to the post-appeal dispute resolution process explained in this section.

### **Additional requirements for facilities**

- Any requests for reconsideration through the Day of Service program must be made prior to requesting an appeal.
- The entire medical record related to the denied service must accompany the appeal letter; if the medical records are not submitted, the denial will be upheld based on the available information, unless the information already submitted supports a reversal of the decision; under such circumstances, the facility is prohibited from balance billing the member.
- The Clinical Appeals department will make all reasonable efforts to render a decision within 60 calendar days of receiving the appeal request with supporting documentation.

**Please note:** There is a separate appeal process for member appeals.

### **Member appeals**

Appeals may be filed by a member or on a member's behalf by his/her representative, or physician or other health care professional, with the member's written consent. If a representative files an appeal on a member's behalf, he or she must provide the member's name, the claim number, an authorization or ID number, and a written designation signed by the member after the denial of services. This written designation permits the representative to appeal on the member's behalf. Our appeal designation form is available on our website at **OxfordHealth.com**.

If you appeal a claim decision or a clinical decision on behalf of a New Jersey member, you may use the state-approved consent form to appeal. Although the consent form is valid for 2 years, in order for the appeal to be considered a request on behalf of the New Jersey member, a copy of the form must be submitted with each subsequent request.

For appeals of benefit determinations concerning urgent care, a physician or other health care professional with knowledge of the member's medical condition shall be permitted to act as the member's authorized representative without written consent. A benefit determination concerning urgent care is defined as a determination which, if subject to the standard appeal time frames, could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or in the opinion of a physician with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the determination.

### **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 to:

Oxford Physician Appeals  
P.O. Box 7016  
Bridgeport, CT 06601-7016

#### **To be processed, an appeal must include:**

- Participating Provider Review Request Form for Commercial Members with the "appeal" box checked
- Reason(s) you believe that the claim was processed incorrectly (or the reasons additional reimbursement should be made)
- Member's name
- Member ID number
- Member's copy of the Remittance Advice for the claim (or the claim number) in question
- Any documentation (clinical or otherwise) that you believe supports reversal of our claim payment determination

The Correspondence department will make all reasonable efforts to render a decision within 30 days of receiving the appeal and supporting documentation.

**Please 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, under your contract with us, you have a right to arbitrate your individual dispute with us. Please consult your contract to determine the appropriate arbitration authority; most contracts provide for arbitration before the American Arbitration Association (AAA). The costs of arbitration are borne equally by the participating provider and the health plan, unless the arbitrator determines otherwise. The arbitrator's award must be in writing and include written factual findings, along with conclusions of law, which must be based upon and consistent with the law of the state identified and governing law section of your contract.

The decision in such arbitration is binding on you and us, pursuant to your provider agreement. To commence arbitration, you must file a statement of claim with the appropriate arbitration authority describing the dispute. In most instances, the arbitration authority will require that you file a specified form with your statement of claims, as well as pay an administrative fee to begin the proceeding. 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 [www.adr.org](http://www.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, or on a collection matter which commenced 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 [www.state.nj.us/dobi](http://www.state.nj.us/dobi) and on [OxfordHealth.com](http://OxfordHealth.com). Disputes involving medical necessity may not be appealed through this process. The first step of the claim appeal process allows you to submit a claim appeal through our internal appeal process and, if eligible, the second step allows your dispute to be referred to an independent arbitration entity selected by and contracted with DOBI.

**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 appeal will be resolved within 30 calendar days from the receipt of your appeal submission. To be eligible for this process, the appeal must be submitted on the "Health Care Provider Application to Appeal a Claims Determination" form ("NJ Internal Appeal Form") and include all required information (listed on form). The NJ Internal Appeal Form is available on our website at [OxfordHealth.com](http://OxfordHealth.com). For claim appeals, the form and the information must be sent to:

Oxford Physician Appeals Department  
P.O. Box 7016  
Bridgeport, CT 06601-7016

For appeals of collection issues, your appeal should be sent to the collection vendor address listed in the collection notice.

**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. While you may aggregate your claims to reach this number, you must initiate the arbitration proceeding on a form created by the Department of Banking and Insurance (DOBI) on or before the 90th calendar day following your receipt of this determination. The arbitration

will be conducted according to the rules of the arbitration organization (AO). The decision in such arbitration will be binding and will not be eligible for further appeal.

The appeal must be submitted on the application form created by the DOBI, which is available online at **www.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.)

Fees for the arbitration must be submitted by mail. Physicians and other health care professionals wishing to submit their application by mail should contact MAXIMUS using the contact information on their website, **<https://njpicpa.maximus.com>**.

### **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 Medicare or 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 on the basis that the service or treatment is not medically necessary, or is considered experimental or investigational (or is an approved clinical trial) to treat the member's life-threatening or disabling condition (as defined by the New York State Social Security Law). A retrospective adverse determination is one where the initial medical necessity review is requested or initiated after the services have been rendered. This process does not apply to services where precertification or concurrent review is required.

#### **Internal medical necessity appeal**

When denied retrospectively by our Medical Management department, a participating provider seeking to pursue an external appeal must first follow the first-level member appeal process with our Clinical Appeals department.

After the Clinical Appeals department issues a retrospective final adverse determination, you will be eligible to file an external appeal. All requests for such internal retrospective appeals must be made within 60 days of receipt of the initial retrospective medical necessity or experimental/investigational determination. Retrospective appeals will be resolved within 60 days from the Clinical Appeals department's receipt of the information necessary to review the appeal.

#### **External appeal process**

If the Clinical Appeals department upholds all or part of such an adverse determination, you, as the physician or other health care professional, or the member or member's designee has the right to request an external appeal. To do so, you must submit an external appeal form (including member signature), a fee and the notice of the retrospective final adverse determination to the New York State Insurance Department within 45 days of receiving such a notice from a first-level 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**

## Concurrent Review

The right to external appeal has been expanded to allow you to initiate the external appeal process in connection with concurrent services. Previously, external appeal rights were only available to you in cases of retrospective adverse determinations. 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. In other words, you are prohibited from pursuing reimbursement from the member for services determined to be not medically necessary by the external appeal agent (except with respect to copayments, deductibles, or coinsurance).

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. When you seek to submit an external appeal acting as the member's designee, the New York Department of Insurance has the authority to confirm the designation by requesting additional information from the member in writing on two separate occasions. The member has two weeks to respond to each request. If the member does not respond to the requests within the designated time frames, the DOI will make two written requests to you asking you to submit the external appeal on your own behalf. You will have 2 weeks to respond to each request. If the DOI does not receive your response within the designated time frame, the appeal will be rejected. If you respond to the request, payment for the external appeal will be made as outlined above.

To submit an external appeal, you must submit a completed external appeal form, a fee and the notice of the concurrent final adverse determination to the New York State Insurance Department within 45 days of receiving such a notice from a first-level 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 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 7078  
Bridgeport, CT 06601-7078

All pertinent clinical information should be sent with the appeal request. Verbal appeals can be submitted; however, we encourage the use of written submissions to help ensure that all issues are identified.

In the event that only a portion of the pertinent clinical information is received, our appeals department will request the missing information in writing within 5 days of receipt of the partial information. If information is not received within

the requested time frame, we will make a determination based on the information available to meet the appeal response deadlines.

### **Expedited medical necessity appeals process for members**

Members have the right to request an expedited appeal, and a physician or other health care professional may request an expedited appeal when requested to do so by the member.

In order to request an expedited appeal, the member or physician or other health care professional must:

- Request an expedited appeal verbally or in writing, and hand deliver, mail or fax the request (if in writing) to the address previously listed
- State specifically that the request is for an expedited appeal
- Based on the following criteria, the Clinical Appeals department will determine whether or not to grant an expedited request:
  - If the time frame involved in reaching a decision through the standard appeal process would seriously jeopardize the member's life or health
  - If the standard time frame involved in reaching a decision would jeopardize the member's ability to regain maximum function

If the Clinical Appeals department determines that the request does not meet expedited criteria, then the member will be notified verbally and in writing that the request will be handled through the standard appeal process. The appeal request will be reviewed within the standard time frame required by state regulations.

### **Benefit appeals**

Appeals of benefit denials issued by the Medical Management, Disease Management or Behavioral Health departments are handled by the Clinical Appeals department.

### **Administrative appeals (grievances)**

Administrative appeals (benefit appeals that do not involve a medical necessity determination for commercial members), in some states known as grievances, of decisions issued by the Claims or Customer Service department without the Medical Management 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:

Oxford Member Appeals  
P.O. Box 7073  
Bridgeport, CT 06601-7073

Verbal appeals may be submitted; however, written submissions are encouraged to help ensure that all issues are identified. Verbal appeals from a third party will not be accepted without written authorization from the member.

The request must be filed within 180 days of the member's receipt of the adverse claim determination notice.

### **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 or their authorized representative may appeal the first-level medical necessity, benefit or administrative determination to the GRB for further consideration. Requests for a second-level appeal must be made within 60 business days of receipt of the first-level appeal determination letter. Second-level appeal requests for Connecticut members involving a benefit or administrative issue must be filed within 10 business days of receipt of the first-level appeal determination letter. The request for appeal and any additional information must be submitted to:

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\* In New York, a second-level appeal is not required by us in order to be eligible for an external appeal.

Oxford Grievance Review Board  
48 Monroe Turnpike  
Trumbull, CT 06611

The member or their authorized representative must include all information requested previously by us (if not already submitted), and include any additional facts or information that the member believes to be relevant to the issue. The member or their representative may send us written comments, documents, records, or other information regarding the claim.

## **Member 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. Information concerning the appropriate external appeals process will be detailed in the appeals attachment included with the initial determination and appeals determination.

## **Consumer complaints sent to regulatory bodies**

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**  
  
Office of Managed Care  
Certification and Surveillance  
New York Department of Health  
Corning Tower, Room 1911  
Empire State Plaza  
Albany, NY 12237  
**(518) 474-2121**





