Contents

Section 1: Important Information Regarding the Use of this Manual .......................... 1
    Oxford Medicare Advantage Exceptions to UnitedHealthcare Supplement ...................... 1
    Network Bulletin .......................................................................................................................... 2
    Medical policy changes .............................................................................................................. 2
    How to contact us .......................................................................................................................... 3

Section 2: Member Eligibility and Benefits ............................................................................. 6
    Member health care identification (ID) cards ........................................................................... 6
    Confirming eligibility and benefits ............................................................................................ 6
    Determining the primary payer among commercial plans ......................................................... 6
    Coordinating with Medicare plans ............................................................................................ 7
    Member Rights and Responsibilities ......................................................................................... 7
    Primary care physician (PCP) selection ..................................................................................... 7
    Newly enrolled members who may need transitional care or continuity of care ....................... 8

Section 3: Referrals and Prior Authorization .............................................................................. 9
    Referrals ..................................................................................................................................... 9
    Referral policies and guidelines ................................................................................................. 9
        Submitting and verifying referrals ......................................................................................... 9
        Automated fax notification .................................................................................................... 9
        Standing referrals to specialty care centers ......................................................................... 10
    Prior Authorization or Notification .......................................................................................... 10
        Services requiring Prior Authorization .............................................................................. 11
        Prescription medications requiring Prior Authorization ....................................................... 11
        Prior Authorization and referral guidelines when coordinating benefits ............................... 12
        Submitting and verifying Prior Authorization requests ........................................................ 12
    Using non-participating physicians, other health care professionals or facilities ................... 12
    Participating Gastroenterologists Using Non-Participating Anesthesiologists In-Office - NY Only ..................................................................................................................................... 13
    Providing Advance Notice to Oxford Members when Involving Non-Participating Providers in Members’ Care – New Jersey and Connecticut Only ...................................................................................................................................... 14

Section 4: Urgent Care, Emergencies, Hospitalization, Inpatient and Outpatient Services,
Behavioral Health Care Services .............................................................................................. 15
    Urgent Care ............................................................................................................................... 15
    Emergency hospitalization ........................................................................................................ 15
        Definition of a medical emergency ......................................................................................... 15
            Emergency admission review ........................................................................................... 15
            Emergency room visits ....................................................................................................... 16
    Non-emergency hospitalization ................................................................................................ 16
    Hospital services, admissions and inpatient and outpatient procedures ................................. 16
        Inpatient hospital copayment ............................................................................................... 17
        Concurrent Review: Clinical Information .......................................................................... 17
        Neonatal Intensive Care Unit (NICU) level of care .............................................................. 17
        Hospital responsibilities ......................................................................................................... 18
        Retrospective review of inpatient stays (notification of admission after discharge) ............ 18
    Electronic Medical Records (EMR) ........................................................................................ 19
        HIPAA compliance and security ............................................................................................ 19
        Our responsibilities ................................................................................................................ 19
    Clinical process definitions ....................................................................................................... 20
        Readmissions .......................................................................................................................... 21
        Diagnosis-related group (DRG) hospitals ............................................................................ 21
Section 5: Ancillary Services ................................................................. 25

Outpatient laboratory policies and procedures ........................................... 25

Radiology ......................................................................................... 25

Imaging requiring Prior Authorization ......................................................... 26
Radiation therapy .............................................................................. 27
Radiology utilization review process ......................................................... 27
Radiation utilization review of Oxford products ........................................ 29
Referrals ......................................................................................... 29
Claims processing ............................................................................. 29

Infertility Utilization Review Process ......................................................... 29

Physical and Occupational therapy services ............................................... 30

Utilization review process .................................................................. 30
Referrals ......................................................................................... 30
Claim processing ............................................................................. 31

Musculoskeletal Services ..................................................................... 31

Chiropractic guidelines .................................................................... 32

Acupuncture guidelines ................................................................... 33

Pharmacy .......................................................................................... 33

Pharmacy management programs .......................................................... 33
PDL management and pharmacy and therapeutics committee ................. 33
Quality management and patient safety programs drug utilization review (DUR) ......................................................... 34
Concurrent Drug Utilization Review (C-DUR) ....................................... 34
Retrospective Drug Utilization Review (R-DUR) ..................................... 34
FDA alerts and product recalls .............................................................. 35
High utilization narcotic program .......................................................... 35
Member identification and physician outreach ........................................ 35
Pharmacy limitation ........................................................................... 35

Clinical programs ............................................................................ 35

Prescription medications requiring Prior Authorization (subject to plan design) ......................................................... 35
Supply limits (subject to plan design) ...................................................... 35
Half Tablet program overview .............................................................. 36

Other Programs: ............................................................................. 36

Specialty Pharmacy Program ............................................................... 36
Refill and Save Program .................................................................. 36
Select Designated Pharmacy Program ................................................ 36
Mail order ......................................................................................... 37
Section 6: Quality Management Programs ................................................................. 38
  Quality management committee structure ....................................................... 38
  Scope of quality management program activities ............................................. 39
  Healthcare Effectiveness Data and Information Set (HEDIS) measures .......... 40
  Credentialing and recredentialing ................................................................. 41
  Medical record review .................................................................................... 42
    Monitoring the quality of medical care through review of medical records .... 42
    Communicating audit results ...................................................................... 42
    Standards for medical records ................................................................... 42
  Continuity of care ......................................................................................... 46
  Network termination guidelines ..................................................................... 46
    Reassignment of members who are in an ongoing course of care or who are being treated for pregnancy .................................. 47
  Disciplinary policies and procedures ............................................................. 47
    Disciplinary actions .................................................................................... 47
    Notice of contract termination and appeal rights ......................................... 47
    Appeal hearings ......................................................................................... 48
    Filing a disciplinary action appeal ............................................................... 48
    Reporting of disciplinary actions to regulatory agencies ......................... 48
  Disciplinary action and appeals process for administrative and quality of care ................................................................. 49

Section 7: Claims, Reimbursement and Member Billing ........................................... 50
  Claims Requirements ...................................................................................... 50
  Requirements for inpatient and outpatient claims ......................................... 50
  Requirements for claim submission with coordination of benefits (COB) .... 51
  Medicare Crossover ....................................................................................... 52
  Submission-Electronic Claims ...................................................................... 52
    Processing ................................................................................................ 53
  Modifiers ...................................................................................................... 54
  Global surgical package (GSP) ..................................................................... 54
  Fee schedules .............................................................................................. 54
  Release of information .................................................................................. 54
  Requests for additional information .............................................................. 54
  Reimbursement ............................................................................................. 54
    Electronic payments and explanations of benefits (EOBs) ......................... 55
  Member billing .............................................................................................. 56
    Balance billing policy ................................................................................ 56
    Member out-of-pocket costs ....................................................................... 57

Section 8: Payment Appeals .................................................................................. 58
  Participating physician and other health care professional appeals ............... 58
  Internal Utilization Management appeals process ........................................ 58
    Additional requirements for facilities ........................................................ 59
    Mandatory internal appeals process-Claims payment disputes ................ 59
  Post-appeal dispute resolution process ........................................................... 59
  Member appeals .............................................................................................. 62
  Medical necessity appeals ............................................................................. 63
    Standard medical necessity appeals process ............................................. 63
    Expedited medical necessity appeals process for members ....................... 63
  Benefit appeals ............................................................................................. 64
    Administrative appeals (Grievances) ........................................................... 64
    Second-level member appeals for members ................................................ 64
# Section 9: Participating physician and other health care professional responsibilities

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>External appeal process for members</td>
<td>65</td>
</tr>
<tr>
<td>Consumer complaints sent to regulatory bodies</td>
<td>65</td>
</tr>
<tr>
<td><strong>Primary Care Physicians (PCP)</strong></td>
<td>66</td>
</tr>
<tr>
<td><strong>Specialist services provided by PCPs</strong></td>
<td>67</td>
</tr>
<tr>
<td>Primary care or specialist physician change</td>
<td>68</td>
</tr>
<tr>
<td>Transferring member medical records</td>
<td>68</td>
</tr>
<tr>
<td>HIV confidentiality</td>
<td>68</td>
</tr>
<tr>
<td>Standing referrals</td>
<td>69</td>
</tr>
<tr>
<td><strong>Hospitals and ancillary facilities</strong></td>
<td>69</td>
</tr>
<tr>
<td>Participating hospitals agree to:</td>
<td>70</td>
</tr>
<tr>
<td>Ancillary facilities and physicians (including facilities providing ancillary services)</td>
<td>70</td>
</tr>
<tr>
<td>New York physicians and other health care professionals and the New York Health Care Reform Act of 1996 (HCRA)</td>
<td>71</td>
</tr>
<tr>
<td><strong>Medically necessary services</strong></td>
<td>71</td>
</tr>
<tr>
<td><strong>Basic administrative procedures</strong></td>
<td>71</td>
</tr>
<tr>
<td>Appropriate site of service</td>
<td>71</td>
</tr>
<tr>
<td>Alternative level of care</td>
<td>71</td>
</tr>
<tr>
<td>Notification</td>
<td>72</td>
</tr>
<tr>
<td>Office standards</td>
<td>72</td>
</tr>
<tr>
<td>Insurance</td>
<td>72</td>
</tr>
<tr>
<td>Access and availability standards</td>
<td>73</td>
</tr>
<tr>
<td><strong>Practice guidelines</strong></td>
<td>74</td>
</tr>
<tr>
<td>Basic standards of practice</td>
<td>74</td>
</tr>
<tr>
<td>Member cost of services</td>
<td>74</td>
</tr>
<tr>
<td><strong>Americans with Disabilities Act (ADA) guidelines</strong></td>
<td>74</td>
</tr>
<tr>
<td>Suggested accessibility standards</td>
<td>75</td>
</tr>
<tr>
<td>Identifying members with disabilities</td>
<td>75</td>
</tr>
<tr>
<td>Suggested methods for compliance</td>
<td>76</td>
</tr>
<tr>
<td>Patient education for members with disabilities</td>
<td>76</td>
</tr>
<tr>
<td>Clinical care and effective communication</td>
<td>77</td>
</tr>
<tr>
<td>Care for members who are hearing-impaired</td>
<td>77</td>
</tr>
<tr>
<td>Locating qualified interpreters for members who are hearing-impaired</td>
<td>78</td>
</tr>
<tr>
<td><strong>Translator assistance for non-English speaking members</strong></td>
<td>78</td>
</tr>
<tr>
<td><strong>Patient education and treatment</strong></td>
<td>78</td>
</tr>
<tr>
<td><strong>Advance medical directives</strong></td>
<td>79</td>
</tr>
<tr>
<td><strong>Disease and intensive case management</strong></td>
<td>79</td>
</tr>
<tr>
<td><strong>Transitional Case Management</strong></td>
<td>80</td>
</tr>
<tr>
<td><strong>Examples of fraud, waste and abuse behaviors</strong></td>
<td>81</td>
</tr>
<tr>
<td><strong>Utilization Management</strong></td>
<td>81</td>
</tr>
<tr>
<td>Appropriate service and coverage</td>
<td>82</td>
</tr>
<tr>
<td>Compliance with quality assurance and utilization review</td>
<td>82</td>
</tr>
<tr>
<td>Utilization review of services provided to New York members</td>
<td>82</td>
</tr>
<tr>
<td>Requirements for initial utilization review determinations</td>
<td>82</td>
</tr>
<tr>
<td><strong>Criteria for determining coverage</strong></td>
<td>83</td>
</tr>
<tr>
<td>Requirements for appeals of initial adverse utilization review determinations</td>
<td>83</td>
</tr>
<tr>
<td>Components of a Final Adverse Determination Notice</td>
<td>85</td>
</tr>
<tr>
<td><strong>Criteria and guidelines</strong></td>
<td>85</td>
</tr>
<tr>
<td><strong>Clinical guidelines</strong></td>
<td>85</td>
</tr>
<tr>
<td><strong>Members’ rights to external appeal</strong></td>
<td>86</td>
</tr>
</tbody>
</table>
Section 1: 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, 2013 for physicians, health care professionals, facility and ancillary providers 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 Advantage Exceptions to UnitedHealthcare Supplement

For services provided to members enrolled in the UnitedHealthcare Medicare Advantage plans offered under the AARP® MedicareComplete®, AARP® MedicareComplete® Mosaic, and UnitedHealthcare Medicare Advantage brands on the Oxford Health Plan platform, please refer to the 2013 UnitedHealthcare Administrative Guide located at UnitedHealthcareOnline.com> Tools & Resources> Policies, Protocols and Guides.

The 2013 UnitedHealthcare Administrative Guide will include policies and procedures for your Medicare members with the exception of the services listed below.

Details relating to these exceptions can be found in the Oxford Medicare Advantage Supplement also included with the 2013 UnitedHealthcare Administrative Guide.

List of exceptions:*  
- Contracted hospital notification of admissions  
- Inpatient concurrent review - day-of-service decision-making program  
- Preauthorization 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 2013 UnitedHealthcare Administrative Guide and were effective on 1/1/13, can also be found on OxfordHealth.com > Providers or Facilities > Tools & Resources > Practical Resources > Medicare Information > Medical and Administrative Policies.
Network Bulletin

UnitedHealthcare publishes 6 online editions of the Network Bulletin annually, which includes notices of updates to policies, protocols, programs and other items that affect our business relationship with you. 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. Oxford information is included in the Affiliates section. 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 one person in your office - you can have everyone sign up! Postcard announcements are mailed to all participating providers in January and where required by law to send written notice the remainder of the year.

In 2013, the Network Bulletin will be available on UnitedHealthcareOnline.com and through email on the following dates:

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

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

Medical policy changes

A monthly Policy Update Bulletin summarizing all recently approved and/or revised policies is available for your reference at OxfordHealth.com. This online communication provides 30 days advance notice of medical policy updates and gives you access to new and/or revised policies, in their entirety, along with an overview or summary of changes, 30 days prior to implementation. A new Policy Update Bulletin is published on the first calendar day of every month and can be accessed via OxfordHealth.com > Providers or Facilities > Tools & Resources > Practical Resources > Medical and Administrative Policies > Policy Update Bulletin.

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

Oxford Policy Requests and Information
48 Monroe Turnpike
Trumbull, CT 06611
# How to contact us

## Contact information and resources

<table>
<thead>
<tr>
<th>Commercial Products</th>
<th>WHERE TO GO</th>
<th>WHAT YOU CAN DO THERE</th>
</tr>
</thead>
</table>
| **Website**         | OxfordHealth.com | • Determine whether a CPT code requires Prior Authorization (up to 12 codes at one time)  
• Submit and check referrals and Prior Authorization  
• Check claim status and print an Explanation of Benefits (EOB)  
• Submit notifications of inpatient admissions (facilities only)  
• Check patient benefits and eligibility  
• Change your address (physicians only), e-mail, username, password, and referral fax number  
• Keep apprised of news in the Messages section  
• Request materials  
• Search for a physician, laboratory or hospital  
• Learn about new business arrangements  
• View radiology and laboratory program information  
• View our prescription drug information  
• View our medical and administrative policies  
• Review/print a current copy of this Manual  
• View our clinical and preventive practice guidelines  
• View our disease management initiatives |
| **Registration for physicians:** | Go to OxfordHealth.com 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). |  |
| **Registration for facilities:** | You can start the process online or call our Web Help Desk at (800) 811-0881. |  |
| **Need Help?** | For step-by-step instructions to using our website transactions, go to OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > Provider Quick Reference or Facility Quick Reference. We also offer instructor-led webcast training sessions at OxfordHealth.com > Tools & Resources > Manage Your Practice > Administrative Ease > Electronic Solutions Training Schedule. |  |
| **Automated Voice Portal** | Phone: (800) 666-1353 | Available options:  
• Check patient eligibility and benefits  
• Submit referrals and Prior Authorization request  
• Check the status of referrals and Prior Authorization request  
• Check the status of claims |
| **Behavioral Health Department** | Phone: (800) 201-6991  
Fax: (800) 760-4041 | • Prior Authorization only |
| **Centers for Disease Control (CDC) National AIDS hotline** | Phone: (800) 232-4636 | • Anonymous counseling and HIV testing program information |
| **Crisis Intervention Hotline – Connecticut** | Phone: (800) 203-1234 | • Provides referrals to all Connecticut local hotlines and resources. |
| **Crisis Intervention Hotline – New Jersey** | Phone: (800) 624-2377  
New Jersey phone: (973) 926-7443 | • Available 24 hours a day, 7 days a week, this number is only accessible when calling from New Jersey |
<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>WHERE TO GO</th>
<th>WHAT YOU CAN DO THERE</th>
</tr>
</thead>
</table>
| Crisis Intervention Hotline – New York       | • State of New York and New York City information: (800) 541-2437             | • Pretesting counseling is conducted over the phone, and appointments are made for callers at testing centers throughout the 5 boroughs  
• This service is linked to a crisis intervention hotline |
|                                              | • Spanish/bilingual information: (800) 233-7432                              |                                                                                                                                                    |
|                                              | • TTY/TDD (for the hearing-impaired): (800) 369-2437                          |                                                                                                                                                    |
|                                              | • Department of Health Testing Hotline: (800) 825-5448                        |                                                                                                                                                    |
| Claim submission                             | For claims submitted electronically: Payer ID 06111                          | For paper claims, please mail to: UnitedHealthcare  
Attn: Claims Department  
PO Box 29130  
Hot Springs, AR 71903 |
| Clinical Appeals                             | Fax (877) 220-7537                                                          | Submit appeal requests                                                                                                                                                                                                |
| Complementary & Alternative Medicine         | Fax: (800) 201-7025                                                        | Fax treatment care plans  
• Physician claim/authorization questions  
Inquiry about claims status, claims payment, authorization status, first level appeals  
• Submit Prior Authorization requests |
| For Chiropractic Services – OptumHealth       | Provider Services/Claims Phone: (800) 985-3293                              |                                                                                                                                                    |
|                                              | Prior Authorization by                                                     |                                                                                                                                                    |
|                                              | Fax: (845) 382-6294                                                        |                                                                                                                                                    |
| Electronic Solutions Support                 | Phone: (800) 599-4EDI (4334)                                                | • Understanding the benefits of electronic claims  
• Resolving problems with your practice management vendor  
• Addressing issues with your clearinghouse  
• Reading your electronic claims tracking reports  
• Setting up electronic claim payments and remittances  
• Majority of referral issues are handled by Team.com |
|                                              | Assistance with electronic solutions for your administrative needs, and helpful information regarding Electronic Data Interchange (EDI) |                                                                                                                                                    |
| Fraud Hotline                                | Phone: (866) 242-7727                                                       | • Report fraudulent activity                                                                                                                                                                                          |
| Inpatient admission                          | Web: OxfordHealth.com > Transactions > Precert Requests                     | • Prior Authorization of inpatient admission                                                                                                                                                                        |
|                                              | Phone: (800) 666-1353                                                      |                                                                                                                                                    |
|                                              | Fax: (800) 303-9902                                                        |                                                                                                                                                    |
| Laboratory information:                     | (888) LabCorp or (888) 522-2677                                            | Patient service center locator number for members Visit OxfordHealth.com for the following:  
• Inventory of patient service centers  
• List of available laboratories  
• Answers to frequently asked questions |
<p>| Laboratory Corporation of America (LabCorp)  | Or visit OxfordHealth.com for a complete list of participating laboratories. |                                                                                                                                                    |
| Client services:                             | (800) 666-1353                                                            |                                                                                                                                                    |
| Clinical Services Inpatient and Outpatient   | Online: UnitedHealthcareOnline.com &gt; Most Visited &gt; Network Bulletin        | • Oxford medical and administrative information is included in the Affiliates section of this bi-monthly online publication.                                                                                |
|                                              | Email: Sign up to receive the Network Bulletin via email in the News section of the UnitedHealthcareOnline.com home page |                                                                                                                                                    |</p>
<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>WHERE TO GO</th>
<th>WHAT YOU CAN DO THERE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxford On-Call™</td>
<td>Phone: (800) 201-4911</td>
<td>• Available 24 hours a day, 365 days a year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Staffed by registered nurses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assistance for urgent and non-urgent medical problems</td>
</tr>
<tr>
<td>Pharmacy customer service</td>
<td>Phone: (800) 905-0201 TTY/TDD: (800) 759-1089 Available 24 hours per day, 7 days per week, including holidays</td>
<td>• Obtain information pertaining to prescription benefits</td>
</tr>
<tr>
<td>Pharmacy notification</td>
<td>Phone: (800) 753-2851</td>
<td>• Obtain medication notification/Prior Authorization for members</td>
</tr>
<tr>
<td>Physical and occupational therapy – OptumHealth</td>
<td>Provider services/claims: (877) 369-7564 Prior Authorization by fax: (866) 695-6923 Claims inquiry: (800) 666-1353</td>
<td>• Physician authorization questions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Submit Prior Authorization requests</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inquiry about authorizations, In-Network Exceptions, First Level UM Appeals</td>
</tr>
<tr>
<td>Outpatient Diagnostic Radiology CareCore National LLC (radiology)</td>
<td>Phone: (877) PREAUTH Online: <a href="http://www.CareCoreNational.com">www.CareCoreNational.com</a></td>
<td>• Outpatient Radiology Prior Authorization</td>
</tr>
<tr>
<td>Radiation Therapy CareCore National LLC</td>
<td>Phone: (877) 773-2884 Online: <a href="http://www.CareCoreNational.com">www.CareCoreNational.com</a></td>
<td>• Radiation Therapy Prior Authorization</td>
</tr>
<tr>
<td>Service Solutions</td>
<td>OxfordHealth.com &gt; Providers or Facilities &gt; Tools &amp; Resources&gt; Practical Resources &gt; How to Guide: Service Solutions for UnitedHealthcare (CT, NJ, NY and RI)</td>
<td>• Information about features on UnitedHealthcareOnline.com, OxfordHealth.com and UHCCommunityPlan.com</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• When and where to call or write to us</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Frequently Asked Questions</td>
</tr>
<tr>
<td>Website Help Desk</td>
<td>Phone: (800) 811-0881</td>
<td>• Assistance with OxfordHealth.com</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Assistance with Facility registration to use the website</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Learn about submitting electronic referrals</td>
</tr>
</tbody>
</table>
Section 2: Member Eligibility and Benefits

Member health care identification (ID) cards

Each member is given a health care ID card that is for identification only and does not establish eligibility for coverage. The member should present his/her card when requesting any type of covered health care service. We suggest that each time you check a member’s health care ID card, you also request a photo identification to minimize any risk of an unauthorized use of the member’s card. To view sample health care ID cards, go to OxfordHealth.com > Providers or Facilities > Tools & Resources > Practical Resources > Oxford Member ID Card Transition

Confirming eligibility and benefits

Checking your patient’s eligibility and benefits prior to rendering services will ensure that you submit the claim to the correct payer, allow you to collect copayments, determine if a referral is required and reduce denials for non-coverage. Our goal is to make all administrative processes involving physicians and other health care professionals as efficient as possible. To check eligibility and benefits, use any of the following methods:

- **Online**: OxfordHealth.com > Providers or Facilities > Transactions > Check > Eligibility & Benefits. For assistance using our website, refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > OxfordHealth.com Quick Reference OR the Electronic Solutions Training Schedule.
- **Voice Portal**: Call (800) 666-1353, and say “benefits and eligibility” when prompted. For assistance refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > Voice Portal Quick Reference.

Vendors: Examples include OptumInsight, Post-n-Track, Office Ally or a clearinghouse of your choice. For additional information about these options, visit OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > Electronic Eligibility & Benefits.

You can also contact:

- Electronic Solutions Support Team at (800) 599-4EDI (4334).
- Provider Services: call (800) 666-1353 (Monday - Friday, 8 a.m. - 6 p.m. ET).

Determining the primary payer among commercial plans

When a member has more than one commercial health insurance policy, primacy is determined based upon model regulations established by the National Association of Insurance Commissioners (NAIC).

1. **COB provision rule**: The plan without a COB provision is primary.
2. **Dependent/non-dependent rule**: The plan that covers the individual as an employee, member or subscriber or retiree is primary over the plan that covers the individual as a dependent.
3. **Birthday rule**: The “birthday rule” applies to dependent children covered by parents who are not separated or divorced. The coverage of the parent whose birthday falls first in the calendar year is the primary carrier for the dependent(s). 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; or
- 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 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; or
- Eligible for Medicare due to ESRD and services are after 33 months of the first date of dialysis.

---

### Member Rights and Responsibilities

For the entire list of Member Rights and Responsibilities, go to [OxfordHealth.com > Providers or Facilities > Tools & Resources > Practical Resources > Medical and Administrative Policies > Managed Care Act Disclosure Materials > Member Handbook](OxfordHealth.com).

---

### Primary care physician (PCP) selection

All HMO products require members to select a PCP to provide primary care services and coordinate the member’s overall care. In addition, female members may also select an obstetrician/gynecologist (OB/GYN) whom that female member may see without a referral from her PCP.

- **Selection** - Members can only select a PCP within their network (e.g., a Liberty PlanSM member must select a Liberty Network participating PCP).
- **Gated plans** – These are plans in which all covered services* performed by in-network physicians and/or other in-network health care professionals, other than those covered services performed by the member’s PCP or OB/GYN, require: (a) a referral from the member’s PCP to an in-network provider; or (b) a precertification from the plan.

---

*Emergency services and urgent care services never require a PCP referral or precertification.*
obtained by the member’s PCP, approving an in-network exception,** for the member to receive covered services from an out-of-network provider at the member’s in-network level of benefits. Members of gated plans will have “In-Network Referral Required” printed on the back of their ID card.

› For gated plans with in-network only benefits, covered services obtained without the required referral or in-network exception** will be denied.

› For gated plans with out-of-network benefits, covered services obtained without the required referral or in-network exception** will be covered, but subject to the member’s out-of-network benefits and cost sharing requirements.

• Non-gated plans - These are plans in which all covered services* performed by in-network physicians and/or other in-network health care professionals do not require a referral from the member’s PCP to an in-network provider, but do require a precertification from the plan, obtained by the member’s PCP, approving an in-network exception,** for the member to receive covered services from an out-of-network provider at the member’s in-network level of benefits. Members of non-gated plans will have “No Referral Required” printed on the back of their ID card.

› For non-gated plans with in-network only benefits, covered services obtained from an out-of-network provider without an approved in-network exception will be denied.

› For non-gated plans with out-of-network benefits, covered services obtained from an out-of-network provider without an approved in-network exception will be covered, but subject to the member’s out-of-network benefits and cost sharing requirements.

Newly enrolled members who may need transitional care or continuity of care

When a new member enrolls with us, the member may qualify for coverage of transitional care services rendered by his/her non-participating physicians or other health care professionals. If the member has a life-threatening disease or condition, or a degenerative and disabling disease or condition, the transitional care period is 60 days. If the member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include the provision of postpartum care directly related to the delivery. Treatment by the non-participating physician or other health care professional must be determined to be medically necessary by our Medical Director. Transitional care is available only if the physician or other health care professional agrees to accept as payment our negotiated fees for such services. Further, the physician or other health care professional must agree to adhere to all of our Quality Management procedures as well as all other policies and procedures required by us regarding the delivery of covered services. For more information about transitional care, members may call Customer Service at (800) 444-6222.

* Emergency services and urgent care services never require a PCP referral or precertification.

** Please see Section 3: Referrals and Prior Authorization for additional information regarding the in-network exception process for circumstances where the plan does not have an in-network provider available to provide covered services to a member.
Section 3: Referrals and Prior Authorization

Referrals

Our physician contracts require referrals be issued to participating physicians and other health care professionals for members with a gated plan, except in cases of emergency or when there are no participating physicians or other health care professionals who can treat the member's condition. If you would like to direct a member to non-participating physicians and other health care professionals, you must request an in-network exception from our Clinical Services department and receive approval before the service is rendered. If the member requests to see a specialist and is unable to reach his/her PCP or OB/GYN (after-hours, weekends or holidays), the PCP may issue a referral up to 72 hours after services have been received.

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 > Referrals.

Submitting and verifying referrals

A PCP or OB/GYN can issue a referral to participating physicians and other health care professionals online, through our automated telephone system or through an electronic data interchange (EDI) vendor. Once the referral is entered, the referring physician or other health care professional will receive a reference number.

- **Online:** Go to OxfordHealth.com > Providers or Facilities > Transactions > Submit Referrals. For assistance using our website, refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease.
- **Voice Portal:** Call (800) 666-1353 and say “referral” when prompted. For assistance refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > Voice Portal Quick Reference.
- **Vendors:** Examples include OptumInsight, Post-n-Track, Office Ally or a clearinghouse of your choice. For additional information, visit OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > Electronic Data Interchange (EDI). You can also contact the Electronic Solutions Support Team at (800) 599-4EDI (4334).
- **Provider Services:** call (800) 666-1353 (Monday - Friday, 8 a.m. - 6 p.m. ET)

All submitted referrals are available immediately for inquiry by facilities and physicians; this includes those submitted electronically and those initiated by Oxford On-Call®. Referrals can be verified online at OxfordHealth.com > Providers or Facilities > Transactions > Check > Referrals, through the Voice Portal at (800) 666-1353, or through an EDI vendor.

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.
Standing referrals to specialty care centers

Standing referrals to a network specialty care center may be requested if a member has a life-threatening condition or disease, or a degenerative and disabling condition or disease. This referral is available only if the condition or disease requires specialized medical care over a prolonged period of time. Further, the center must have the necessary medical expertise and be properly accredited or designated (as required by state or federal law or a voluntary national health organization) to provide the medically necessary care required for the treatment of the condition or disease. The services to be provided will be covered only to the extent they are otherwise covered by the member’s Certificate of Coverage.

Our Medical Director will consult with the member’s PCP, the network specialty care center and the network specialist to determine if such a referral is appropriate. The referral will be provided pursuant to a treatment plan that will be developed by the specialty care center and approved by our Medical Director. The member, PCP or participating network specialist may call Clinical Services and request a standing referral.

Prior Authorization or Notification

• Prior Authorization should be submitted as far in advance of the planned service as possible to allow for review. Prior Authorization is required at least 14 business days prior to the planned service date (unless otherwise specified within the Prior Authorization List).

• Obstetrical admissions for normal delivery should be Authorized as early as possible in the course of prenatal care, based on the expected date of delivery.

• Participating physicians and other health care professionals and facilities are responsible for contacting us for all procedures requiring Prior Authorization; however, an active referral* must also be on file for services to be covered in-network, depending on the member’s benefits.

• Neither Prior Authorization nor referral is required for members to access a participating women’s health specialist for routine and preventive health care services. Women’s health specialists include, but are not limited, to gynecologists and/or certified nurse midwives. Routine and preventive health care services include breast exams, mammograms, and Pap tests.

• 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 Authorized 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.
Services requiring Prior Authorization

- You can log on to OxfordHealth.com to use the Precert Required Inquiry tool on the Transactions tab to check Prior Authorization requirements for up to 12 CPT codes at one time.

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

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

- The list of services requiring Prior Authorization requirements for physicians, other healthcare professionals and ancillary providers does not indicate or imply coverage. Prior Authorization 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 Clinical Services department.

- Prior Authorization requirements may differ by individual physicians, health care professionals and ancillary provider and ancillary providers. If additional Prior Authorization requirements apply, the physician or other health care professional will be notified in advance of the Prior Authorization rules being applied.

A list of services requiring Prior Authorization is available for your reference at OxfordHealth.com > Providers or Facilities > Tools & Resources > Practical Resources > Medical and Administrative Policies > Services Requiring Prior Authorization. A copy of the most current list can also be obtained by sending a written request to:

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

Changes to this list are announced at OxfordHealth.com > Providers or Facilities > Tools & Resources > Practical Resources > Medical and Administrative Policies > Policy Update Bulletin (published monthly).

Prescription medications requiring Prior Authorization

Based on the member’s benefit plan design, select high-risk or high-cost medications may require advance notification in order to be eligible for coverage. This process is also known as Prior Authorization and requires that you submit a formal request and receive advance approval for coverage of certain prescription medications. 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 Prior Authorization is available for your reference at OxfordHealth.com > Provider or Facilities > Tools & Resources > Practical Resources > Prescription Drug Information > Drugs Requiring Prior Authorization. A copy of the most current list can also be obtained by sending a written request to:

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

Changes to the Prior Authorization requirements for prescription medications are announced at OxfordHealth.com > Providers or Facilities > Tools & Resources > Practical Resources > Medical and Administrative Policies > Policy Update Bulletin (updated monthly).

Please note: Prior Authorization requirements may vary depending on the member's benefit plan. See Section 5 Ancillary Services for additional information on prescription drug coverage.
Prior Authorization and referral guidelines when coordinating benefits

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

- Referral and Prior Authorization guidelines will be waived, deferring to the requirements of the primary carrier. **Note:** Other requirements are not waived (e.g., itemized bills, student verification, consent for Behavioral Health exchange, etc.).
- Exception: Referral and Prior Authorization guidelines will apply if the primary carrier does not cover a service or applies an authorization penalty. Referral and Prior Authorization guidelines will apply when a motor vehicle accident or workers' compensation is involved.

Submitting and verifying Prior Authorization requests

We recommend that physicians and other health care professionals perform a Prior Authorization status first to determine if there is already a Prior Authorization on file.

Physicians and other health care professionals can submit and verify the status of Prior Authorization requests several different ways:

- **Online:** Submission- OxfordHealth.com > Providers or Facilities > Transactions > Submit > Precert Requests. Status: OxfordHealth.com > Providers or Facilities > Transactions > Check > Precert Status.
- **Voice Portal:** For submission or status, call **(800) 666-1353** and say “Prior Authorization” when prompted. For assistance refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > Voice Portal Quick Reference.
- **Vendors:** Examples include OptumInsight, Post-n-Track, Office Ally or a clearinghouse of your choice. For additional information, visit OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > Electronic Data Interchange (EDI). You can also contact the Electronic Solutions Support Team at **(800) 599-4EDI (4334).**
- **Fax:** You may submit our facsimile form, which can be found on OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Forms. We will not accept any faxes that are not submitted on our form.

The following requests must be made directly to our Clinical Services department at **(800) 666-1353** or the appropriate delegated vendor for Prior Authorization:

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

Using non-participating physicians, other health care professionals or facilities

As a participating physician or other health care professional, you are required to utilize participating physicians, other health care professionals and facilities within the network (i.e., Liberty Network) applicable to the member’s plan. We have implemented a compliance program to identify participating physicians and other health care professionals who regularly use physicians and other health care professionals and facilities that do not participate in our network, and will take the appropriate measures to enforce compliance.
If you would like to direct a member to a non-participating physician or other health care professional because there are no participating physicians or other health care professionals able to perform the specific service in the area, then the PCP is responsible for obtaining Prior Authorization for an in-network exception on behalf of the member by calling (800) 666-1353. A referral cannot be made to a non-participating provider without our approval.

If a member asks you for a recommendation to a non-participating physician or other health care professional, you must tell the member that you may not refer to a non-participating provider, and the member must contact us to obtain the required Prior Authorization. The member may obtain all required Prior Authorizations by calling (800) 444-6222.

If you contact us for authorization to perform a non-emergency procedure at a non-participating facility for a member who has out-of-network benefits, the procedure will be authorized as out-of-network.

• This means that the reimbursement to the non-participating facility will be subject to the member’s out-of-network deductible and coinsurance obligations. Also, the non-participating facility’s charges are only eligible for coverage up to the reimbursement levels available under the member’s plan, using either a usual, customary and reasonable (UCR) fee schedule, or a Medicare reimbursement system (called the Out-of-Network Reimbursement Amount for our New York Members).

• Additionally, we may make the claim payment directly to the member instead of to the non-participating facility. In such cases, the non-participating facility will be instructed to bill the member for services rendered. The member will then be responsible for making payment to the non-participating physician or other health care professional for the full amount of the check mailed to them by us, in addition to any applicable copayment, deductible, coinsurance or other cost share allowances, according to the member’s benefit plan.

• Members will be responsible for paying their out-of-pocket cost as well as the difference between the UCR fee or other out-of-network reimbursement and the non-participating facility’s billed charges. Please remind the member that his/her expenses may be significantly higher when using a non-participating provider.

If you contact us for authorization to perform a non-emergency procedure at a non-participating facility on a member who does not have out-of-network benefits (HMO and EPO plan members), the services will be denied.

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.

Participating Gastroenterologists Using Non-Participating Anesthesiologists In-Office - New York Only

Many of our participating gastroenterologists are performing endoscopy procedures with anesthesia in the office setting with the assistance of a non-participating anesthesiologist. While in-office endoscopy can be convenient for both physicians and patients, and can help promote high-quality, cost-effective care, the use of non-participating anesthesia providers often results in higher costs and financial liability for members.

Therefore, all non-emergent procedures being performed with anesthesia in the office setting in New York, including endoscopy and surgical suites, must be performed using a participating anesthesiologist unless:

1. After discussing a member’s referral options with them in advance of the service, the member explicitly agrees to receive services from a non-participating anesthesiologist by marking the appropriate box and signing Oxford’s Non-Participating Provider Consent Form and understands that the use of this provider will be out-of-network (OON).

• For members with OON benefits, these non-participating anesthesiologist claims will be paid at the OON benefit level. OON cost shares and deductibles will apply.

Oxfordhealth.com
For members with no OON benefits, there is no coverage for services provided by nonparticipating providers and member’s will therefore be responsible for the entire cost of the service, OR

2. An in-network exception has been requested and approved at least 14 days in advance of the service

Providers are required to keep a signed copy of the Non-Participating Provider Consent Form on file in order to provide us upon request. If the participating gastroenterologist cannot provide the signed Non-Participating Provider Consent Form, within 15 days of the request, We will administratively deny the participating gastroenterologist claim. The participating gastroenterologist cannot balance bill the member for claims denied for administrative reasons.

For additional details and copies of the Non-Participating Provider Consent Form, please refer to the complete policy, at OxfordHealth.com> Providers > Tools & Resources > Practical Resources > Medical and Administrative Policies > Participating Gastroenterologists Utilizing Non-Participating Anesthesiologists for In-Office Procedures.

---

Providing Advance Notice to Oxford Members when Involving Non-Participating Providers in Members’ Care – New Jersey and Connecticut Only

In order to help our members make informed decisions regarding their health care and effectively control their out-of-pocket healthcare costs, it is imperative that, in non-urgent or non-emergent situations, prior to services being rendered, a member know when his or her participating provider involves a non-participating physician, facility or other health care provider in their care.

Therefore, physicians and other health care professionals participating in the Oxford commercial networks must:

1. Discuss with members, the option to utilize a participating provider in non-emergent situations where the participating provider is planning on involving the following types of non-participating providers or services in the member’s care: ambulatory surgery centers, home health, laboratory services, outpatient dialysis, and specialty pharmacy.

2. If, after the discussion with the member, the member elects to receive services from a non-participating provider, the participating provider must complete the Member Advance Notice Form and obtain the member’s signature on the form. Participating providers are required to keep the signed form on file to provide us upon request.

We will monitor the involvement of non-participating providers in our members’ care and may request a copy of the signed Member Advance Notice Form at any time. Failure to comply with the protocol may result in appropriate action under your participation agreement.

For additional details and copies of the Member Advance Notice Form, please refer to the complete policy, at OxfordHealth.com> Providers > Tools & Resources > Practical Resources > Medical and Administrative Policies > Protocol for Providing Advance Notice to Commercial Customers when Involving Non-Participating Providers in Customers’ Care.
Section 4: Urgent Care, Emergencies, Hospitalization, Inpatient and Outpatient Services, Behavioral Health Care Services

Urgent Care

Urgent care is medical care for a condition that needs immediate attention to minimize severity and prevent complications but is not a medical emergency and does not otherwise fall under the definition of emergency care as defined below. 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 Prior Authorization is not required.

Emergency hospitalization

Definition of a medical emergency

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.

New York
An “emergency condition” is defined as a medical or behavioral condition, that manifests itself by acute symptoms of sufficient severity, including severe pain, such 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; (iv) serious disfigurement of such person; or a condition described in clause (i), (ii), or (iii) of section 1867 (c)(1)(A) of the Social Security Act.

Emergency admission review

If your patient is admitted to a hospital as a result of an emergency (as defined above), we will review the hospital admission for medical necessity and determine the appropriate length of stay based on our approved criteria for concurrent review. Review begins when we become aware of the admission. We must be notified of all emergency inpatient admissions (no later than 48 hours from the date of admission, or as soon as reasonably possible).
If the member is admitted to a contracted hospital, we will use reasonable efforts to transmit a decision about the admission to the hospital (to the facsimile number and contact person designated by the hospital) within 24 hours of making the decision. We may also communicate our Prior Authorization 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 PCP and are subject to the standard referral process.
- When a patient is unstable and not capable of providing coverage information, the facility should submit the Prior Authorization as soon as the information is known and communicate the extenuating circumstances.

**In-area emergency services**
You do not need to provide notification or obtain Authorization for in-area emergency room treatment and subsequent release. 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 Prior Authorization 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 Authorized. Newborn coverage varies from plan to plan and state to state.

**Hospital services, admissions and inpatient and outpatient procedures**
Facilities are responsible for obtaining Prior Authorization for the following types of inpatient admissions:
- All planned/elective admissions for acute care
- All unplanned admissions for acute care
- All Skilled Nursing Facility (SNF) admissions
• All admissions following outpatient surgery
• All admissions following observation
• All newborns admitted to Neonatal Intensive Care Unit (NICU)
• All newborns who remain hospitalized after the mother is discharged (within 24 hours of the mother’s discharge)

Prior Authorization by the facility is required even if Prior Authorization was supplied by the physician and a pre-service approval is on file.

Physicians, health care professionals and ancillary providers are responsible for obtaining Prior Authorization outpatient surgical and major diagnostic testing performed in an outpatient clinic or any ambulatory or freestanding surgical or diagnostic facility.

Prior Authorizations can be submitted online at OxfordHealth.com > Transactions > Submit Precert Requests, use your EDI vendor, or call the Clinical Services department at (800) 666-1353.

**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.

**Concurrent Review: Clinical Information**

• Upon admission, Clinical Services will accept concurrent review information provided by the admitting physician or other health care professional and/or the hospital’s Utilization Review department. Furthermore, if not already submitted, the hospital will provide us with the discharge plan on the day of admission. If a patient requires an extended length of stay or additional consultations, please call our Clinical Services department at (800) 666-1353 to update the Prior Authorization.

• For Behavioral Health, all calls related to inpatient Prior Authorization should be directed to (800) 201-6991.

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

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

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

• UnitedHealthcare uses Milliman Care Guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. This includes acute and sub acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. You may request a copy of the clinical criteria from your Case Reviewer.

**Neonatal Intensive Care Unit (NICU) level of care**

NICU bed levels are based on the intensity of services and identifiable interventions received by the neonate. The NICU bed levels of care are linked to a revenue code that is defined by the National Uniform Billing Committee. We will assign NICU levels for those facilities contracted with more than one level of NICU. Claims reimbursement is based on the pay codes and Bed Types (levels of care per contract).
Hospital responsibilities

• 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 preauthorized outpatient service); the hospital must also notify us of any transfer admissions of members.

• The hospital must preauthorize 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).
Electronic Medical Records (EMR)

EMR is any type of electronic concurrent medical information management system. This process improves efficiency and quality inpatient care through integrated decision support which allows for better information storage, retrieval and data sharing capabilities. EMR systems allow physicians, nurses and other health care staff to be able to access and share information smoothly and quickly, to enable them to work more efficiently and make better quality decisions.

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.

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 Prior Authorization 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 pre authorized or received concurrent review approval unless:

• The member is retroactively disenrolled as explained in the section titled Hospital responsibilities – concurrent inpatient stays
• The certification or concurrent review approval was based on materially erroneous information.
• The services are not provided in accordance with the proposed plan of care.
• Hospital delays in providing an approved service prolong the length of stay beyond what was approved.

Clinical process definitions

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

Alternative level of care (ALC)*
We will determine that an inpatient ALC applies in any of the following scenarios:

• An acute clinical situation has stabilized.
• 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.

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.

* 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
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 8 Payment Appeals 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.

Disposition determination
A disposition determination is a technical term describing a process of care determination that results in payment as agreed at specific contracted rates, and is designed to eliminate certain areas of contention among participating parties and allow processing of claims. Specific instances where a disposition determination may apply:

- Delay in hospital stay
- APPAD/AMPAD when so contracted
- ALC determinations when so contracted, unless there is a separate ALC rate
- Discharge delays that prolong the hospital stay under a case rate

Late and no notification
Late notification is defined as notification of a hospital admission after the contracted 48-hour notification period and prior to discharge. No notification is defined as failure to notify us of a member's admission to a hospital after discharge, up to and including at the time of submitting the claim.

Behavioral health care services
The Behavioral Health (BEH) department specializes in the management of mental health and substance abuse treatments. The department consists of a Medical Director who is licensed in psychiatry, facility care advocates (licensed RNs and licensed/certified social workers) and Behavioral Health intake staff, who collectively handle certification, referrals and case management for our members.

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.

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 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 Prior Authorization 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.

**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 Prior Authorization.

Partial hospitalization
Partial hospitalization always requires certification through the BEH department. If clinical criteria are met, the Case Manager will facilitate certification and management at a contracted facility with a partial hospitalization program; the Case Manager will continue to follow the member’s treatment while he or she is in the program.

Prior Authorization Outpatient mental health services - New York Only
Covered services are those received on an outpatient basis from duly licensed psychiatrists or practicing psychologists, certified social workers, or a facility issued operating certificate by the commissioner of mental health, a facility operated by the office of mental health, a professional corporation or university faculty practice corporation including:

- Diagnosis
- Treatment planning
- Referral services
- Medication management
- Crisis intervention

Coverage will be provided to the maximum number of visits shown on the member’s Summary of Benefits.

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 Authorized two partial hospitalization visits may be substituted for one inpatient day. Coverage will be provided for active treatment to the maximum number of days shown on the member’s Summary of Benefits.

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 5: Ancillary Services

Our network of laboratory service providers consists of an extensive selection of walk-in patient service centers, many regional and local laboratories and a national provider of laboratory services, Laboratory Corporation of America (LabCorp). Quest Diagnostics is a non-participating laboratory.

Outpatient laboratory policies and procedures

It is important that you refer your patients to participating patient service centers and laboratories to help patients avoid unnecessary costs. We offer a broad scope of laboratory services within our network from which you can choose.

Only a physician's prescription or lab order form is required when using participating laboratories to process specimen, referrals are not required.

We review laboratory ordering information periodically 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.

A list of available laboratories, an inventory of patient service centers and other network 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 list must be performed by one of the participating laboratories in our network. For the most up-to-date list, access our website at OxfordHealth.com as a provider or a facility and select Tools & Resources > Practical Resources > Laboratory Services > In-Office Laboratory Testing and Procedures List.

Specimen handling and venipuncture:

If specimen handling and venipuncture codes are billed in conjunction with a lab code on the in-office Laboratory Testing and Procedures List, only the lab and venipuncture codes will be reimbursed.

If specimen handling and venipuncture codes are billed without a lab code on our In-Office Laboratory Testing and Procedures List or with other non-laboratory services, the specimen handling and venipuncture codes will be paid per our fee schedule.

Radiology

The outpatient imaging self-referral policy is designed to promote appropriate use of diagnostic imaging by PCPs, specialty physicians and other health care professionals in the office and outpatient setting. In addition to which imaging procedures shall be payable by Oxford by provider specialty, Oxford also requires a minimum accreditation and certification requirements for ultrasound, echocardiography and nuclear medicine studies. The outpatient imaging self-referral policy or privileging program does not apply to radiology services performed during an inpatient stay, ambulatory surgery, urgent care, emergency room visit, or pre-operative/pre-admission testing. 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/Plans). All X-rays performed at an urgent care facility are payable.

These procedures require Prior Authorization and medical necessity review. To Authorize 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 Prior Authorization

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

The following radiology procedures require Prior Authorization and medical necessity review through CareCore National for Oxford products:

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

Radiology Prior Authorization policy for urgent cases

It is the imaging facility's responsibility to confirm that an Authorization number has been issued prior to providing a service. In the case of urgent examinations, 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 Authorized 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 in 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 Prior Authorization request, both routine and urgent, can be initiated 24 hours a day 7 days a week on www.CareCoreNational.com.

Radiology Prior Authorization online

CareCoreNational provides a secure, interactive web-based program where Prior Authorization requests can be initiated and determined in real time. If medical necessity is demonstrated during this process an Authorization number will be issued immediately. If medical necessity is not demonstrated through the online process, physicians may submit additional information at the conclusion of the session and print a procedure request summary page. Requests for an Authorization that do not meet medical necessity criteria online are forwarded for clinical review and additional information may be requested by CareCore National for medical necessity review with a CareCore Medical Director. In the event that criteria has not been met the physician's office as well as the member will be notified in writing of the denial. Log into 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.

* For specific guidelines, refer to OxfordHealth.com > Tools & Resources > Practical Resources > Medical and Administrative Policies > Reimbursement Policies > Obstetrical Ultrasonography.
Radiation therapy
For Oxford products, a Prior Authorization and medical necessity review program for all outpatient radiation therapy services.

Radiation therapy Prior Authorization is managed through CareCore National, LLC. The Oxford product program details are available online at OxfordHealth.com > Tools & Resources > Practical Resources > Radiology Information.

The following radiation therapy treatments require Prior Authorization through CareCore national for Oxford products:
- Ionizing radiation
- Brachytherapy
- Conventional external beam radiation therapy (CRT)
- Three-dimensional conformal radiation therapy (3D CRT)
- Intensity modulated radiation therapy (IMRT)
- Image-guided radiation therapy (IGRT)
- Proton beam therapy (PBT)
- Stereotactic radiosurgery (SRS)
- Other emerging therapies that use ionizing radiation to treat cancer such as hyperthermia and neutron beam therapy

For Oxford products, the rendering radiation therapists office is required to request Prior Authorization and, guided by the Physician Worksheets, provide sufficient information to determine the medical necessity of the requested services. If a treating physician does not obtain an Authorization number from CareCore National for a radiation therapy course of treatment, corresponding claims may not be reimbursed.

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 > Criteria > Radiation Therapy Criteria.

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 and board certified cardiologists for cardiac based diagnostic procedures. Data collection for clinical certification of imaging services may be assigned to non-medical personnel working under the direction of qualified health professionals. You will receive communication of review determinations for non-urgent care by fax/telephone within 2 business days of receiving all the necessary information. Communication received for a determination involving an urgent request is given within 24 hours of the receipt of information necessary to make a medical necessity determination.

For members, requests for retrospective clinical certification review of medically urgent care are accepted up to 2 business days after the care has been given, 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 and medical necessity review, 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 > Providers or Facilities > Tools & Resources > Practical Resources > Medical and Administrative Policies > Policy Update Bulletin.

When you call to request to the Radiology Prior Authorization unit, please provide the following information:

**Patient identifiers:**
- Health plan name
- The healthcare 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
- Physician's NPI

**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 and select Criteria > Radiology Management > Oxford.
Radiation utilization review of 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 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, or by calling toll-free at (877) 773-2884, Monday through Friday, 7 a.m. to 7 p.m. ET, and Prior Authorization request can be initiated 24 hours a day 7 days a week on 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.

Clinical criteria consistent with Oxford product policies are available at www.CareCoreNational.com, and updated clinical policies are available at 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 > 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:

UnitedHealthcare
Attn: Claims Department
PO Box 29130
Hot Springs, AR 71903

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.

Infertility Utilization Review Process

Oxford has delegated OptumHealth, a UnitedHealth Group company, to perform medical necessity review for outpatient infertility services under their Managed Infertility Program (MIP) for all Oxford commercial members with an infertility benefit. OptumHealth’s MIP is intended to promote both quality of care and continuity of service by supporting patients through every aspect of the infertility process. The program is supported by OptumHealth infertility nurse case managers who will assist patients in making informed decisions about their infertility treatment and care through: treatment education, considerations in choosing where to obtain care, and assistance in navigating the health care system.

* 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, under Physician Resources > Physician Tools > Oncology > Radiation Therapy Physician Worksheets.
The Oxford MIP details and list of services requiring precertification, medical necessity review and/or notification are available online at oxfordhealth.com > Providers > Tools & Resources > Medical and Administrative Policies > Infertility procedures requiring notification and/or precertification.

For Oxford products, the rendering physician is required to request precertification and/or notification of services. This is accomplished by using the Managed Infertility Program Treatment form* and providing sufficient information to determine the medical necessity of the requested services.

OptumHealth has been diligent in their research to help ensure that the clinical policies and guidelines they are using are consistent with best practices and state mandates. The clinical guidelines will be subject to ongoing review by these board-certified reproductive endocrinologists. These guidelines may be found on myoptumhealthcomplexmedical.com > health care providers > infertility guidelines.

**Physical and Occupational therapy services**

OptumHealth Care Services, a UnitedHealth Group company, administers the physical and occupational therapy benefit for 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 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 approval or 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.

---

* The MIP precertification template can be found on the OptumHealth website at myoptumhealthcomplexmedical.com or by calling OptumHealth at (877) 512-9340 or email: MIP@optum.com
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:

UnitedHealthcare
Attn: Claims Department
PO Box 29130
Hot Springs, AR 71903

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 myoptumhealthphysicalhealth.com.

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 Authorization 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.
Chiropractic guidelines

OptumHealth Care Solutions currently manages our chiropractic benefit. To receive the standard chiropractic benefit coverage, members must obtain an electronic referral from their PCP. PCPs should perform the customary initial comprehensive differential diagnosis with the necessary and appropriate work-up.

A chiropractic referral can be generated for a maximum of one visit within 180 days (6 months). Once the referral is made (if applicable, all participating chiropractors must complete and submit Patient Summary Forms to OptumHealth Care Solutions (formerly ACN Group) for services performed. Members will need to obtain approval of the services as a condition of reimbursement. Form submissions for chiropractic services must be faxed directly to OptumHealth Care Solutions at (845) 382-6294.

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 (845) 382-6294. 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

Acupuncture guidelines

Acupuncture is only covered for members who have the alternative medicine rider. If a member does not have the rider, all requests to cover acupuncture will be denied, even if a letter of medical necessity has been submitted. Acupuncture is covered on an in-network basis and must be performed by one of following provider types:

• Participating licensed acupuncturist (LAC)
• Participating licensed naturopaths
• Participating physician (MD or DO) who has been credentialed as physician acupuncturist

Pharmacy

Pharmacy management programs

The pharmacy benefit plan includes a dynamic medication list, referred to as the Prescription Drug List (PDL), and various clinical drug utilization management programs. These programs are based upon FDA-approved indications and medical literature or guidelines. 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 Prior Authorization 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.

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 UnitedHealth Group National Pharmacy and Therapeutics Committee (P&T) is responsible for evaluating and providing clinical evidence to the PDL Management Committee to assist them in assigning medications to tiers on the PDL. The information provided by the P&T Committee includes, but is not limited to, evaluation of a medication's place in therapy, its relative safety and its relative efficacy.

The P&T Committee also determines whether supply limits or Prior Authorization/notification requirements are necessary.
In addition to medications covered under the pharmacy benefit, the P&T Committee is responsible for evaluating clinical evidence for medications, which require administration or supervision by a qualified, licensed health care professional. The P&T Committee is comprised of medical directors, network physicians, consultant physicians, clinical pharmacists and pharmacy directors. The P&T Committee meets at least quarterly.

**Quality management and patient safety programs drug utilization review (DUR)**

The majority of prescription claims are submitted electronically for payment. Within seconds, the member’s claim is recorded and the past prescription history is reviewed for potential medication-related problems. DUR helps review for potentially harmful medication interactions, inappropriate utilization and other adverse medication events in an effort to maximize therapy effectiveness within the appropriate medication usage parameters. There are two types of DUR programs: concurrent and retrospective.

**Concurrent Drug Utilization Review (C-DUR)**

The C-DUR program performs online, real-time DUR analysis at the point of prescription dispensing. This program screens every prescription prior to dispensing for a broad range of safety and utilization considerations. C-DUR uses a clinical database to compare the current prescription to the member’s inferred diagnosis, demographic data and past prescription history. Criteria are used to identify potential inappropriate medication consumption, medical conflicts or dangerous interactions that may result if the prescription is dispensed.

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 Drug Utilization Review (R-DUR)**

The R-DUR program involves a quarterly review of prescription claims data to identify medication prescribing and/or medication utilization patterns that may indicate inappropriate or unnecessary medication use. The program uses a clinical database to review patient profiles for potential over- or under-dosing as well as duration of therapy, potential drug interactions, drug-age considerations and therapy duplications.

On a quarterly basis, physicians and other prescribers receive a patient-specific report that outlines the opportunities for intervention and asks them to respond to the issues and concerns raised. 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

Prescription medications requiring Prior Authorization (subject to plan design)
Based on the member’s benefit plan design, select high-risk or high-cost medications may require advance notification in order to be eligible for coverage. This process is also known as Prior Authorization and requires that you submit a formal request and receive advance approval for coverage of certain prescription medications. You may be asked to provide information explaining medical necessity and/or past therapeutic failures. A representative will collect all pertinent clinical data for the service requested. If the requests does not meet the criteria for approval, it will be sent to our Medical Director for further clinical review and you will be notified of this and the final determination.

The list of prescription medications (including generic equivalents, if available) that require Prior Authorization is available for your reference at OxfordHealth.com > Tools & Resources > Practical Resources > Prescription Drug Information > Drugs Requiring Precertification.

Changes to Prior Authorization requirements for prescription medications are announced at OxfordHealth.com > Providers or Facilities > Tools & Resources > Practical Resources > Medical and Administrative Policies > Policy Update Bulletin (published monthly).

Please note: Prior Authorization 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 > Provider or Facilities > 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.

**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

For members enrolled on NY line of business, new and renewing on or after 01/01/12, if a retail pharmacy has contracted with the Pharmacy Benefits Manager, in advance, for the same rates and terms and conditions as the mail order or specialty pharmacy, covered prescriptions will be available at the same co-payment or other reimbursement level that would apply to the mail-order or non-retail specialty pharmacies (should any of these pharmacies be available in the service area).
Section 6: Quality Management Programs

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

- Identification of the scope of care and services rendered by the physician or other health care professional
- Development of clinical guidelines and service standards by which clinical performance will be measured
- Objective evaluation and systematic monitoring of the quality and appropriateness of services and medical care received from our physicians and other health care professionals
- Assessment of the medical qualifications of participating physicians and other health care professionals
- Continued improvement of member health care and services
- Efforts to ensure patient safety* and confidentiality of member medical information
- Resolution of identified quality issues

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

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

Oxford Quality Management Department
Attn: Regional Quality 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 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.

* For additional details on Patient and Hospital Safety, go to OxfordHealth.com > Oxford Programs > Patient Safety. This site requires you to log in using your provider ID and password.
The National Provider Sanctions Committee (NPSC) provides a forum for qualified physicians to discuss and take action on sanction reports that raise issues regarding compliance with UnitedHealthcare's credentialing plan, and/or patient safety concerns. Sanctions are monitored from state licensing boards, Office of the Inspector General and other sanctioning bodies or entities. 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, 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 (Center for Medicare and Medicaid Services), 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:

<table>
<thead>
<tr>
<th>Category</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult BMI</td>
<td>• Weight assessment and counseling for nutrition and physical activity for children/adolescents</td>
</tr>
</tbody>
</table>
| Pediatric preventive care | • Childhood immunization rates up to age 2  
• Lead and growth screening up to 25 months  
• Appropriate testing for upper respiratory infection (URI)  
• Appropriate testing for pharyngitis  
• Well-child visits by age 15 months  
• Well-child visits at ages 3, 4, 5, and 6 |
| Adolescent preventive care | • Adolescent immunization rates  
• Adolescent well-care |
| Prenatal | • Prenatal and postpartum care |
| Adult preventive care | • Advising smokers to quit  
• Influenza and pneumonia vaccinations for older adults  
• Breast cancer screening rates  
• Cervical cancer screening rates  
• Chlamydia screening rates for women  
• Colorectal cancer screening  
• Osteoporosis management for women with a fracture  
• Care for older adults  
• Flu shots |
| Chronic/acute care | • Annual monitoring for patients on persistent medications  
• Medication reconciliation post-discharge  
• Potentially harmful drug disease interactions in the elderly  
• Avoidance of antibiotic treatment in adults with acute bronchitis  
• Comprehensive diabetes care (eye examination, HbA1c testing, LDL screening, medical attention for nephropathy)  
• Beta-blocker treatment after heart attack  
• Controlling high blood pressure  
• Use of appropriate medicines for the treatment of asthma  
• Use of imaging studies for low back pain  
• Use of spirometry testing in the assessment and diagnosis of COPD  
• Disease modifying anti-rheumatic drug therapy for rheumatoid arthritis  
• Pharmacotherapy management of COPD exacerbation  
• Follow-up care for children prescribed ADHD medications  
• Use of high-risk medications in the elderly  
• Cholesterol management for patients with cardiovascular conditions  
• Follow-up after hospitalization for mental illness  
• Antidepressant medication management |
| Behavioral health care | • Follow-up after hospitalization for mental health  
• Antidepressant medication management |

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.
Credentialing and recredentialing

We are dedicated to providing our Customers with access to effective health care and, as such, we periodically review the credentials of participating physicians and other health care professionals in order to maintain and improve the quality of care and services delivered to our Customers. Our credentialing standards are fully compliant with the NCQA CMS requirements and any state specific requirements.

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

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

Rights related to the credentialing process

Physicians and other health care providers applying for our network have the following rights regarding the credentialing process:

• To review the information submitted to support your credentialing application;
• To correct erroneous information; and
• To be informed of the status of your credentialing or recredentialing application, upon request. You can check on the status of your application by calling the United Voice Portal at (877) 842-3210.

For behavioral health providers, you may submit a credentialing status update request beginning 120 days after receiving a join our network acceptance letter. Submit your credentialing status inquiry to Credentialing.status@optumhealth.com. Please include your full name with middle initial, license, full address and tax identification number(s) in your email submission.

While current board certification is not a requirement for network participation, it is a requirement for designation in the UnitedHealth Premium designation program. Providing updated board certification is part of the credentialing application.

Physicians and other health care providers can view the Credentialing and Recredentialing Plan at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Credentialing & Recredentialing Plan.

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 or to request a copy, call Provider Services at (800) 666-1353. For more information on CAQH, please visit www.caqh.org or call CAQH Support at (888) 599-1771.
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 9 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

Behavioral health providers should call (877) 614-0484

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

**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 Provider Sanctions Committee (NPSC)
- UnitedHealthcare 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 contract termination and appeal rights**

We grant physicians and certain health care professionals the right to appeal certain disciplinary actions imposed by us. The appeals process is structured so that most appeals for terminations, not including non-renewal of the physician’s contract with us, can be heard prior to disciplinary action being implemented. In these cases terminations from the plan are effective as follows:
• 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.
  › 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, consistent with the applicable terms of the UnitedHealthcare Credentialing plan

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:

• Quality-of-care issues that may result in imminent harm to a member or members as determined by the National Peer Review Committee
• Failure to meet recredentialing criteria that results in denial of participation with us that does not include 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, consistent with the applicable terms of the UnitedHealthcare Credentialing plan

**Filing a disciplinary action appeal**

The practitioner must request an appeal in writing within 30 days of delivery of notice of the Disciplinary Action. Failure to submit an appeal within the 30 days will be deemed a waiver of any appeal rights. The physician should indicate whether or not he or she wishes a hearing or review. The physician is encouraged to submit any additional information about his/her case together with the appeal.

**Reporting of disciplinary actions to regulatory agencies**

Web-based reporting systems were implemented by the National Practitioner Data Bank (NPDB) to report disciplinary actions when required.

In accordance with the Federal Health Care Quality Improvement Act of 1986 and accompanying regulations, we must report applicable disciplinary actions to the NPDB and the appropriate state licensing board(s).

**The following actions are reported:**

• Termination due to alleged mental or physical impairment, misconduct or impairment of patient safety or welfare
• Voluntary or involuntary termination of a contract or affiliation to avoid the imposition of disciplinary action
• Termination for determination of fraud
• Knowledge of any 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.
Connecticut
Connecticut Division of Medical Quality Assurance
150 Washington Street
Hartford, CT 06106
Telephone (860) 509-8000

New Jersey
New Jersey State Board of Medical Examiners
28 W. State Street, Room 60
Trenton, NJ 08608
Telephone (609) 292-4843

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

The Quality of Care department is responsible for completing the reporting procedure to State Licensing Authority, National Practitioner Data Bank (NPDB), and Healthcare Integrity and Protection Data Bank (HIPDB), as applicable.

Disciplinary action and appeals process for administrative and quality of care

A physician or health care professional may request an appeal (fair hearing or review) after UnitedHealthcare takes adverse action to restrict, suspend or terminate a physician or health care professional’s ability to provide health care services to UnitedHealthcare enrollees/members for reasons relating to the professional competence or conduct that adversely affects or could adversely affect the health or welfare of an enrollee/member.

A notice will be provided within 30 calendar days after the adverse action is taken that will include the following:

1. UnitedHealthcare has determined an adverse action is necessary and the final action will be reported to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank and appropriate state licensing board.

2. A description of and reason for the action.

3. Right to request an appeal in writing within 30 calendar days after receipt of the notice. Failure to file such request shall constitute a waiver of all right to the appeal process, unless such a right is provided under applicable state law.

4. A summary of the physician’s or health care professional’s appeal rights provided

After receipt of a request for an appeal, the physician or health care professional will be notified of the fair hearing or review date within 30 calendar days of the receipt of request for appeal, or within the timeframe required by applicable state law.

The fair hearing or review will take place within 60 calendar days of the date UnitedHealthcare receives the request for appeal, or within the timeframe required by applicable state law.
Section 7: Claims, Reimbursement and Member Billing

Claims Requirements

Time frame for claims submission
In order to be considered timely, physicians, other health care professionals and facilities are required to submit claims within the specified period from the date of service:

- Connecticut - 90 days from date of service
- New Jersey - 90 days from date of service OR 180 days from date of service if submitted by a New Jersey participating physician for a New Jersey Line of Business member.
- New York - 120 days from date of service

The claims filing deadline is based on the date of service on the claim; it is not based on the date the claim was sent or received. Claims submitted after the applicable filing deadline will not be reimbursed; the reason stated will be “filing deadline has passed” or “services submitted past the filing date.”

Exceptions:

- If an agreement currently exists between you and Oxford or UnitedHealthcare containing specific filing deadlines, the health plan’s agreement will govern.
- If coordination of benefits has caused a delay, you will need to provide proof of denial from the primary carrier and will have 90 days from the date of the primary carrier Explanation of Benefits to submit the claim to us.
- If the member has a health benefits plan with a specific time frame regarding the submission of claims, the time frame in the member’s Certificate of Coverage will govern. Claims submitted after the 90-day filing deadline that do not fit one of these exceptions will not be reimbursed; the reason stated will be “filing deadline has passed” or “services submitted past the filing date.”

For claims submitted after April 1, 2010, if a claim is submitted past the filing deadline due to an unusual occurrence (e.g., provider illness, provider’s computer breakdown, fire, or flood) and the provider has a historical pattern of timely submissions of claims, the provider may request reconsideration of the claim.

Clean and unclean claims / Required information for all claim submissions
For complete details and required fields for claims processing, please go to Oxfordhealth.com > Provider or Facilities > Transactions > Submit > Claims Submission Information. Appropriate state and federal guidelines are applied to determine whether the claim is complete and can be processed.

Requirements for inpatient and outpatient claims
All claims must be submitted on a timely basis or payment for that service may be reduced or denied.

- 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.
- Include the current NDC 11-digit number for all claims submitted with drug codes. The NDC number must be entered in the 24D field of the CMS-1500 form or the LIN03 segment of the HIPAA 837 electronic form.
- 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.
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. You can obtain complete lists of these codes by contacting:

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 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.

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 > Provider or Facilities > Tools & Resources > Practical Resources > Medical and Administrative Policies > Reimbursement for Comprehensive and Component CPT Codes.

Medical notes
Notes are not required with the initial claim submission. If medical notes are needed to process your claim, we will request them. Examples of requested documentation include surgical notes, anesthesia and inpatient medical records. After clinical review, the claim will be paid based on the codes that have been substantiated in the medical record.

Requirements for claim submission with coordination of benefits (COB)
Under COB, the primary plan pays its normal plan benefits without regard to the existence of any other coverage. The secondary plan pays the difference between the allowable expense and the amount paid by the primary plan, provided this difference does not exceed the normal plan benefits which would have been payable had no other coverage existed.

If Oxford is secondary, you should bill the primary insurance company first and when you receive the primary carrier’s explanation of benefits (EOB), submit it to us along with the claim information.

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

1. **Copy of the claim.** For a CMS-1500 claim, fields 10 a, b and c should contain the other carrier information (only) including any policy numbers; for a UB-04 claim, field 50 should be populated with the other carrier information;
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.

**Medicare Crossover**

We participate in Medicare Crossover for all of our members who have Medicare primary. This means Medicare will automatically pass the EOB to us electronically after the claim has been processed. We can then process the claim as secondary without a claim form or EOB from your office. When you receive your EOB from Medicare, it should indicate that the claim has been forwarded. If it does not, please submit the claim following the above COB guidelines.

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

**Submission-Electronic Claims**

Electronic claims submission is a critical step in our ongoing process to simplify and automate the entire payment process. Benefits of this process include:

- Faster receipt and turnaround of claims, which may lead to lower outstanding receivables
- Fewer submission errors that delay processing
- Reduction in administrative expenses - Milliman Inc. estimates savings of 50% to 90% per transaction for the typical physician office.

All claims can be submitted electronically with the exception of the following:

- Claims that were processed by a commercial carrier as the primary payer
- Claims submitted with unspecified CPT and Healthcare Common Procedure Coding System (HCPCS) procedure Codes, which require medical notes
- Corrected claims which require a participating provider claim review form

Most providers use a clearinghouse vendor for electronic claims submission. Examples include OptumInsight, Post-n-Track, Office Ally or a clearinghouse of your choice. For additional information, visit [OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease> Electronic Data Interchange (EDI)].

You can also contact the Electronic Solutions Support Team at (800) 599-4EDI (4334).

Your clearinghouse vendor will ensure that you include all required information including Oxford’s Payer ID: 06111.

For more tips refer to [OxfordHealth.com> Providers or Facilities > Tools & Resources> Manage Your Practice> Administrative Ease> Electronic Data Interchange> EDI Claim Submission Guidelines](#).
Your electronic claim reports are an important tool to avoid denials for late filing. For assistance understanding your reports, refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > Electronic Data Interchange > Clearinghouse Reports & Timely Filing.

Processing

Time frame for processing claims
The state-mandated time frames for processing claims for our fully insured members are listed below. The time frames are applied based upon the situs state of the member’s product.

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

We strive to process all complete claims within 30 days of receipt. If you have not received an explanation of benefits (EOB) within 45 days, and have not received a notice from us about your claim, please verify that we have received your claim. Please refer to the Checking Claim Status section below.

Checking Claim Status
Physicians and other health care professionals have a variety of methods available to check the status of a claim:

- **Online:** Go to OxfordHealth.com > Providers or Facilities > Transactions > Check > Claims. For assistance using our website, refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > OxfordHealth.com Quick Reference OR the Electronic Solutions Training Schedule.

- **Voice Portal:** Call (800) 666-1353 and say “claims” when prompted. For assistance refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > Voice Portal Quick Reference.

- **Vendors:** Examples include OptumInsight, Post-n-Track, Office Ally or a clearinghouse of your choice. For additional information, visit OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > Electronic Data Interchange (EDI). You can also contact the Electronic Solutions Support Team at (800) 599-4EDI (4334).

- **Provider Services at (800) 666-1353** (Monday - Friday, 8 a.m. - 6 p.m. ET)

Factors impacting processing
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 > Providers or Facilities > Tools & Resources > Practical Resources > Medical and Administrative 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 > Providers or Facilities > Tools & Resources > Practical Resources > Medical and Administrative Policies > Policy Update Bulletin.
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 > 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 > Global Days Policy.

Fee schedules

Although our entire fee schedule is proprietary and cannot be distributed, we will, upon request, provide our current fees for the top codes you bill. 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.

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.

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
PO Box 29137
Hot Springs, AR 71903

Reimbursement

Address, phone or tax ID number changes

An accurate billing address is necessary for all claims logging and payment. Additionally, your correct practice address and telephone numbers are needed to list you correctly in our roster and for you to receive important mailings. It is critical that you notify us of any changes, such as retirement, relocation, closure of secondary office, or change of practice. For instructions and forms to notify us of changes, refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Forms > W-9 / FTIN Form & Provider Demographic Update Form.
Electronic payments and explanations of benefits (EOBs)
Oxford would like all providers to transition from paper checks and EOBs to the faster electronic versions. We use PNC Remittance Advantage to deposit claim payments into your preferred account(s) and for its web tool where you can view/download your EOBs. For more information, refer to OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > Electronic Payments Fact Sheet or call PNC at (877) 597-5489, option 1.

Additional Copies of EOBs
Should you misplace an EOB and need another copy, you can obtain one by logging in to OxfordHealth.com > Providers or Facilities > Transactions > Check > Claims. After using the claim status inquiry to find your claim, you will be able to save or print a PDF copy of the EOB.

Claim reconsideration
If you disagree with the way a claim was processed or need to submit corrected information, you have 180 days from the date of the EOB 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 EOB. To ensure a prompt response when requesting reconsideration of a claim, please use the correct forms:

- 1-12 claims: OxfordHealth.com > Tools & Resources > Manage Your Practice > Forms > Participating Provider Claim Review Request Form.
- 13 or more claims for the same FTIN: OxfordHealth.com > Tools & Resources > Manage Your Practice > Forms > Participating Provider Claim Research Project.

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 EOBs for your records.

Additionally, facilities can submit corrected claims electronically. For more information, refer to OxfordHealth.com > Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > Electronic Submission of Corrected Facility Claims.

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.

Claims recovery policy
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 1 year prior to the date of notice of the overpayment (the 1-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 1-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.

**Member billing**

**Balance billing policy**

Physicians and other health care professionals in our network may not bill members for unpaid charges above their specific member cost sharing (i.e., copayment, deductible, coinsurance excess), 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 Prior Authorization or a referral for those plans that require a referral

**Exception:** Commercial Freedom Plan® and Liberty PlanSM 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.
**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.

**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.

* 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.
Section 8: 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 29139  
Hot Springs, AR 71903

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.

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 29136
Hot Springs, AR 71903

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 healthcare 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 > Providers or Facilities > Tools & Resources > Manage Your Practice > Forms](http://OxfordHealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Forms).

For claim appeals, the form and the information must be sent to:

Oxford Physician Appeals Department
P.O. Box 29136
Hot Springs, AR 71903

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 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](http://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 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 Prior Authorization or concurrent review is required.

**Internal medical necessity appeal**

When denied retrospectively by our Clinical Services department, a participating provider seeking to pursue an external appeal must first follow the first-level member appeal process with our Clinical Appeals department. 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 180 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

**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 > Provider or Facilities > Tools & Resources > Manage Your Practice > Forms. Please also use the Participating Provider Review Request Form.

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.
Medical necessity appeals

Standard medical necessity appeals process
If members or their designees would like to file an appeal, they must hand-deliver or mail a written request within 180 days of receiving the initial denial determination notice to:

- Oxford Clinical Appeals Department
- P.O. Box 29139
- Hot Springs, AR 71903

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 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.

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 Clinical Services, Disease Management 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 Clinical Services department’s involvement are handled by the member appeals unit.

If a member would like to file an appeal on a claim determination, they must mail all administrative appeals to:

UnitedHealthcare Grievance Review Board
PO Box 29134
Hot Springs, AR 71903

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. Members with a CT line of business do not have the option of submitting a second-level appeal request for a benefit or administrative issue. The request for appeal and any additional information must be submitted to:

UnitedHealthcare Grievance Review Board
PO Box 29134
Hot Springs, AR 71903

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.

---

* In New York, a second-level appeal is not required by us in order to be eligible for an external appeal.
**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
Section 9: Participating physician and other health care professional responsibilities

Primary Care Physicians (PCP)

As a PCP, it is your responsibility to deliver medically necessary primary care services, and you are the coordinator of your patients’ total health care needs. Your role is to provide all routine and preventive medical services and coordinate all other covered services, specialist care and care at our participating facilities or at any other participating medical facility where your patients might seek care (e.g., emergency care). You are responsible for seeing all members on your panel who need assistance, even if the member has never been in for an office visit. You may not discriminate on the basis of race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, place of residence, health status, or source of payment.

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 Prior Authorization 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 > Assignment of Benefits to Non-Network Providers.

• Arrangement of coverage for the provision of medical services 24/7, 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 24/7; 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 Prior Authorization 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.

**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 > Doctor. 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.

See Section 3 Referrals and Prior Authorization for additional information.
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.

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 following policies and procedures:
  - HIV testing must be performed on all newborns.
  - Prenatal care physicians should counsel expectant mothers regarding the required testing of newborns and the importance of the mother getting tested.
  - Expectant mothers should also be advised of the counseling and services offered when results are positive.

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 Clinical Services 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 Prior Authorization

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 Clinical Services 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 Prior Authorization, 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 Prior Authorization/authorization from us or a delegated vendor for all hospital services that require Prior Authorization/authorization must be obtained prior to rendering services
- Generally, all hospital services require our Prior Authorization (See Section 3 Referrals and Prior Authorization for additional information on what services require Prior Authorization).
- 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

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 Prior Authorization, 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

* 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.
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 surchargable 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.

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 sub-acute 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 Prior Authorization 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:

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

<table>
<thead>
<tr>
<th>Type of service (Mental health/substance abuse)</th>
<th>Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Immediate</td>
</tr>
<tr>
<td>Non-life-threatening emergency</td>
<td>Within 6 hours</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Routine care</td>
<td>Within 10 business days</td>
</tr>
</tbody>
</table>

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, Prior Authorization, 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 recredentialing, 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 (ADA) guidelines
Participating physicians and other health care professionals must have practice policies that demonstrate that they accept for treatment any member in need of the health care they provide. The organization and its physicians and other health care professionals must make public declarations (i.e., through posters or mission statements) of their commitment to nondiscriminatory behavior in conducting business with all members. These documents should explain that this expectation applies to all personnel, clinical and nonclinical, in their dealings with each member.

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 for the 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

---

* 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 test 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.
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 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.

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

**Connecticut**

State of Connecticut Commission on Deaf and Hearing-Impaired ........................ (860) 708-6796 (TTY/Voice)

(860) 231-8756 (TTY/Voice)

(860) 231-7623 (Interpreting Emergencies)

**New Jersey**

New Jersey Department of Human Services Division of the Deaf and Hard of Hearing ............ (609) 984-7281

**New York**

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.

**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.

Active Care Engagement℠ (ACE)  (877) 759-3059
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.

Better Breathing® Asthma Intervention Program  (800) 665-4686
The asthma program is designed to emphasize patient education and promote compliance with the guidelines established through the National Institutes of Health. 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.

Living with Diabetes℠  (800) 665-4686
Our diabetes program is structured to educate members with diabetes and to improve their self-management by providing them with resources such as educational materials and support organizations. 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.

Heart Smart℠ Programs:

Cardiovascular Disease  (800) 665-4686
The Heart Smart cardiovascular disease (CVD) program is designed to address the health needs and concerns of members who are at risk or at high risk for CVD (primary), and 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.

Heart Failure  (800) 665-4686
The Heart Smart heart failure (HF) population health management program is a comprehensive, population-based health management program for people with heart failure. 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.
Oxford Cancer Support Program℠ (800) 835-8021
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.

Preventive Health Program (800) 665-4686
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.

Rare Chronic Care Program (866) 217-2921
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.

Transplant Program (888) 936-7246
OptumHealth is contracted to manage all aspects of every transplant to ensure medically appropriate care, including Prior Authorization and coordination of services.

Standard Care Coordination Program (800) 444-6222
OptumHealth is contracted to manage Transitional Case Management and Complex Case Management (CCM) Programs.

Transitional Case Management
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.

Complex Case Management
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 program 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.

NICU Program (888) 936-7246
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 Clinical Services department monitors services provided to members to identify potential areas of over and underutilization. UM decision making is based only on appropriateness of care and service and existence of coverage. We do not specifically reward or offer incentives to practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

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, Prior Authorization procedures, referral processes or protocols and reporting of clinical accounting data
- Member and physician and other health care professional grievances
- Timely provision of medical records upon request by us or our contracted business associates;
- Cooperation with quality of care investigations including timely response to queries and/or completion of improvement action plans;
- Physician and other health care professional credentialing
- Any similar programs developed by us

**Utilization review of services provided to New York members**

All adverse utilization review (UR) determinations (whether initial or on appeal) will be made by a clinical peer reviewer, while appeals of adverse UR determinations will be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the initial adverse determination.

**Requirements for initial utilization review determinations**

UR decisions will be made by the following methods and in the following time frames:

**Preauthorization** - UR decisions will be made and notice will be provided to you and the member, 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.

---

* Per Section 4 of this manual, the telephonic notification to members has been delegated to you. Please remember to call the member.
**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 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 Clinical Services 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.
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 and ambulatory care where no specific Oxford policy exists.

In addition to these guidelines, we develop specific policies related to covered services; each policy describes the service and its appropriate utilization.

We employ several means to review the consistency and quality of clinical decision making, as directed through policies and adopted guidelines. In addition to those required by regulatory agencies and NCQA are the following processes:

- Interrater reliability tests developed in conjunction with an external consultant
- Monthly Medical Director consistency meetings and case discussions
- Monthly blind reviews done by all Medical Directors on a common set of clinical factors

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
> Providers or Facilities > Tools & Resources > Practical Resources > Clinical & Preventive Guidelines > Clinical Practice Guidelines.
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, appropriateness, healthcare setting, level of care or effectiveness 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 or disease is one for which standard health services are ineffective or medically inappropriate or
- There does not exist a more beneficial standard health service or procedure covered by the health care plan; or
- There exists a clinical trial; and
- The member’s attending physician must have recommended either:
  - A health service or procedure [including a pharmaceutical product within the meaning of PHL 4900(5)(b) (B)] that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or
  - A rare disease treatment for which the member’s attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to the member than the requested service, the requested service is likely to benefit the member in the treatment of the member’s rare disease and such benefit outweighs the risk of the service. In addition, the attending physician must certify that the member’s condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year; 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 4 months 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.