JULY 2018

network bulletin

An important message from UnitedHealthcare to health care professionals and facilities.

Enter

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

Where information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

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Stay up to date with the latest news and information.

Network National Laboratory Services Care Providers for 2019

In 2019, UnitedHealthcare is growing its national network of participating laboratory providers to better support our members and the care providers who order laboratory services. LabCorp will remain in-network and until Jan. 1, 2019, will serve as UnitedHealthcare's exclusive national laboratory care provider. Beginning Jan. 1, 2019, Quest Diagnostics will be an in-network laboratory care provider for all UnitedHealthcare members. ›

Counsyl, Inc. Will Be Out-of-Network for All UnitedHealthcare Members Starting July 16, 2018

Beginning July 16, 2018, Counsyl, Inc. will no longer be a participating network care provider for all UnitedHealthcare members. When working with patients who are UnitedHealthcare members, please refer their lab work to in-network labs. ›

Enhanced Prescription Functionality Now Available with Athena Health

The functionality in the UnitedHealthcare PreCheck MyScript app on Link is now integrated in the Athena Health system. Real Time Benefit Check allows you to check medication coverage, cost share, authorization requirements and more – without leaving your existing workflow. ›

Link Self-Service Updates and Enhancements

We're continuously making improvements to Link to better support your needs. Among the recent enhancements: new referralLink and Claim Submission tools have been added and UnitedHealthcareOnline.com and the original Link apps will be retired soon. ›

Tell Us What You Think of Our Communications

Please take a few minutes to complete an online survey and give us your thoughts about the Network Bulletin. ›

Updates to Notification/Prior Authorization Requirements for Specialty Medications for UnitedHealthcare Commercial and Community Plan Members

New procedure codes for injectable medications will become effective July 1, 2018 due to updates from the Centers for Medicare & Medicaid Services (CMS). Correct coding rules dictate that assigned and permanent codes should be used when available. ›

Pharmacy Update: Notice of Changes to Prior Authorization Requirements and Coverage Criteria for UnitedHealthcare Commercial and Oxford

A pharmacy bulletin outlining upcoming new or revised clinical programs and implementation dates is now available for UnitedHealthcare commercial at UHCprovider.com/pharmacy. ›

Front & Center

Stay up to date with the latest news and information.

Reminder: Successfully Submitting a Prescription to OptumRx

Our goal is to provide safe, easy and quick ways to get your patients the medication they need. **ePrescribe** is the fast and convenient way to do that. Just add the OptumRx profile in your electronic medical record (EMR) system and send the prescription to us. ›

UnitedHealthcare Medicare Advantage Prior Authorization Reduction Pilot Concludes

On Oct. 1, 2018, the UnitedHealthcare Medicare Prior Authorization Reduction Pilot will conclude, resulting in re-implementation of prior authorization for services previously removed from requirement. The pilot was implemented Jan 1, 2017. ›

Changes in Advance Notification and Prior Authorization Requirements

Some procedure codes will require prior authorization for dates of service on or after July 1, 2018 due to state requirements. Other requirements will take effect Oct. 1, 2018. ›

Process Change: Colony-Stimulating Factors

Beginning Oct. 1, 2018, the review process for colony-stimulating factors administered to patients with a cancer diagnosis in the outpatient setting will change. This requirement is for members of UnitedHealthcare commercial plan, UnitedHealthcare Oxford and UnitedHealthcare Community Plans that currently require prior authorization for outpatient injectable chemotherapy and colony-stimulating factors. ›

We Value Your Feedback

Your opinion is important to us. We'd like to get your thoughts on new initiatives, innovative technologies, and/or program and policy changes. If you are a participating provider in any of UnitedHealthcare's lines of business, please give us your feedback in an online survey. ›

Front & Center

Network National Laboratory Services Care Providers for 2019

In 2019, UnitedHealthcare is growing its national network of participating laboratory providers to better support our members and the care providers who order laboratory services:

- LabCorp will remain in-network and until Jan. 1, 2019 will serve as UnitedHealthcare's exclusive national laboratory care provider.*
- Beginning Jan. 1, 2019, Quest Diagnostics will be an in-network laboratory care provider for all UnitedHealthcare members.*

LabCorp offers nearly 5,000 frequently requested and specialty tests, including a wide range of clinical, anatomic pathology, genetic and genomic tests, delivered through LabCorp's broad patient access points, including a growing retail presence. Quest, which is an in-network lab for a limited number of UnitedHealthcare plans in some markets today, has 6,000 patient access points and will be in-network nationwide for all plan participants beginning Jan. 1, 2019.

For more information, please contact your UnitedHealthcare representative.

*Excluding existing lab capitation agreements

Counsyl, Inc. Will Be Out-of-Network for All UnitedHealthcare Members Starting July 16, 2018

Keeping you up-to-date on changes to laboratory network participation status can be important when you order services for UnitedHealthcare members. Beginning July 16, 2018, Counsyl, Inc. will no longer be a participating network care provider for all UnitedHealthcare members.

What This Means for You

When working with patients who are UnitedHealthcare members, please refer their lab work to in-network labs.

You can find a list of in-network labs, based on the member's health care plan, at UHCprovider.com > Menu> Find a Care Provider > **Search for a Provider**. If you have any questions, please contact your Provider Advocate or call the Provider Services number on the member's ID card.

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Enhanced Prescription Functionality Now Available with Athena Health

The functionality in the UnitedHealthcare PreCheck MyScript app on Link is now integrated in the Athena Health system. **Real Time Benefit Check** allows you to check medication coverage, cost share, authorization requirements and more — without leaving your existing workflow.

Adding a medication to your patient's electronic health record will automatically trigger a trial claim and give you all the information you need from UnitedHealthcare and Optum Rx before the patient leaves your office.

- If the medication is not covered or, non-preferred, or if prior authorization is needed, the electronic medical record (EMR) will let you know right away.
- The patient's cost share will be displayed along with lower cost alternatives for your consideration.
- When prior authorization is required, you will be prompted to provide the needed information and the e-prescription will be pended until an approval decision is made.
- If the medication is preferred and doesn't require prior authorization or has no alternatives, the e-prescription is routed to the pharmacy.

If you have any questions, please contact your Athena Health representative.

Don't use an EMR? You can use the PreCheck MyScript app on Link. For more information, go to UHCprovider.com/PreCheckMyScript.

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Link Self-Service Updates and Enhancements

We are almost to the finish line! You told us you wanted fewer websites to help make it easier to do business with us and we heard you. Consolidating websites required better technology, so we built Link, the new self-service website on an advanced cloud-based platform.

We wanted to give you better tools as soon as they were available, so that meant periodically adding functionality to Link and retiring transactions from UnitedHealthcareOnline.com rather than waiting to transition everything at once. It has been a journey with frequent changes and we thank you for your patience.

With the last few functions moving to Link, we are almost ready to retire UnitedHealthcareOnline.com. Don't worry; we will keep enhancing Link to better meet your needs – but at a more normal pace going forward.

Here are some recent enhancements:

New referralLink and Claim Submission Tools Available

- Now referralLink is the only app you need to submit or check referrals for all UnitedHealthcare benefit plans. You can access referralLink from within eligibilityLink or from the tile on your dashboard. For more information, go to **UHCprovider.com/referralLink**. The referralLink Limited Use app will be retired soon.
- The Claim Submission app allows you to key professional claims for UnitedHealthcare commercial, UnitedHealthcare Medicare Advantage, UnitedHealthcare Community Plan and UnitedHealthcare West at no charge. To learn more, go to **UHCprovider.com/claims**.

More Reports Added to Document Vault

- Reports for the **Physician** and **Hospital** Performance Based Compensation Programs have been added. To access these reports, sign in to Link and open Document Vault (the padlock icon) at the top of your Link dashboard. In Document Vault, click on the Physician Performance and Reporting button or the Hospital Perf-Based Comp button. To learn more, go to **UHCprovider.com/DocumentVault**.

Enhancements Made to the Prior Authorization and Notification App

- Cancelled cases now show a cross-reference to the associated new case(s).
- In the case status search using member information, date ranges are now optional and have been increased from 90 days to six months.

Manage My Account and UnitedHealthOne Apps on Link

- The My Profile function from UnitedHealthcareOnline.com has become **Manage My Account** on Link, where you can view or update your personal user information.

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Link Self-Service Updates and Enhancements

- When you look up a UnitedHealthOne member in eligibilityLink or claimsLink, you're taken to the UnitedHealthOne website without additional sign in. If you open UnitedHealthOne from your dashboard, an additional username and password are required. You can click Register Now on the right side of the UnitedHealthOne home page to create your login credentials if needed.

Original Link Tools Will Be Retired Soon

- Claims Reconsideration, Claims Management and UnitedHealthcare Eligibility & Benefits will be removed from the Link dashboard so that everyone uses the more advanced claimsLink and eligibilityLink tools. To learn more go to **UHCprovider.com/claimsLink** or **UHCprovider.com/eligibilityLink**.

Getting Started

An Optum ID is required to access Link and perform online transactions, such as eligibility verification, claims status, claims reconsideration, referrals, prior authorizations and more. To get an Optum ID, go to UHCprovider.com and click on ***New User*** to register for Link access.

For help with Link, call the UnitedHealthcare Connectivity Help Desk at **866-842-3278**, option 1, from 7 a.m. to 9 p.m. Central Time, Monday – Friday.

Tell Us What You Think of Our Communications

Your opinion is important to us. We'd like to get your thoughts about The Network Bulletin. Please take a few minutes today to complete the survey online at **uhcresearch.az1.qualtrics.com/jfe/form/ SV_08sAsRnUY2Kb153**. Thank you for your time.

Updates to Notification/Prior Authorization Requirements for Specialty Medications for UnitedHealthcare Commercial and Community Plan Members

New procedure codes will become effective July 1, 2018 due to updates from the Centers for Medicare & Medicaid Services (CMS). Correct coding rules dictate that assigned and permanent codes should be used when available. The following injectable medications that may be subject to prior authorization and/or Administrative Guide Protocols will have new codes for UnitedHealthcare commercial plans, UnitedHealthcare Community Plan and UnitedHealthcare Medicare Advantage Plans:

- Hemlibra (emicizumab-kxwh) – Q9995
- Sublocade (buprenorphine extended-release) – Q9991 and Q9992
- Luxturna (voretigene neparvovec-rzyl) – C9032

As a reminder, please consider requesting pre-service coverage review for medications listed on UnitedHealthcare's Review at Launch **commercial** or **Community Plan** Medication List. We'll add certain new drugs to the Review at Launch list and policy as soon as they're approved by the U.S. Food and Drug Administration (FDA). Drugs will remain on the list until we communicate otherwise.

For medications on the list, we encourage you to request pre-service coverage reviews so you can check whether a medication is covered before providing services. Some benefit plans may not cover certain medications under the medical benefit or may not cover them right away. Clinical coverage reviews can also help avoid starting a patient on therapy that may later be denied due to lack of medical necessity. Your claims may be denied if a pre-service coverage review is not completed.

UnitedHealthcare Commercial Plan Product and Sourcing Update for Hyaluronic Acid Product — TriVisc™

Beginning Oct. 1, 2018, UnitedHealthcare will require that TriVisc be acquired from a designated specialty pharmacy for members covered by UnitedHealthcare commercial plan. This is the same process currently required for acquiring Gel-one®, Supartz®, Hyalgan®, Orthovisc®, Gel-Syn®, Gelsyn-3®, Genvisc®, Durolane® and Hymovis®. These requests may be subject to medical policy review as part of benefit coverage review.

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Updates to Notification/Prior Authorization Requirements for Specialty Medications for UnitedHealthcare Commercial and Community Plan Members

Care providers may continue to purchase Euflexxa®, Synvisc® and Synvisc-One® and directly bill to UnitedHealthcare. Our network care providers often prefer this method because it offers them the opportunity to administer hyaluronic acid to their patients immediately. If care providers prefer not to “buy & bill,” they may acquire these medications from a UnitedHealthcare-designated specialty pharmacy. A list of these pharmacies and faxable prescription enrollment forms is available at UHCprovider.com, with enrollment forms available at UHCprovider.com > Resource Library >Drug Lists and Pharmacy > Specialty Pharmacy Program > **Enrollment Forms**.

Beginning Oct. 1, 2018, UnitedHealthcare of the Mid-Atlantic, Neighborhood Health Partnership, UnitedHealthcare of the River Valley and UnitedHealthcare Oxford will require prior authorization/pre-certification for TriVisc at all places of service for our commercial plan members. Failure to obtain preauthorization may result in non-payment of claims. Requests for retrospective authorization will not be accepted, and charges for these products cannot be billed to members.

Updates to Notification/Prior Authorization Requirements for Specialty Medical Injectable Drugs for UnitedHealthcare Commercial, Community Plan and Medicare Advantage Members

We’re making some updates to our coverage review requirements for certain specialty medications for many of our UnitedHealthcare commercial, Community Plan and Medicare Advantage members. Implementing these requirements is important to us to provide our members access to care that’s medically appropriate as we work toward the Triple Aim of improving health care services, health outcomes and overall cost of care. These requirements will apply whether members are new to therapy or have already been receiving these medications.

If you administer any of these medications without first completing the notification/prior authorization process, the claim may be denied. Members can’t be billed for services denied due to failure to complete the notification/prior authorization process.

What’s Changing for UnitedHealthcare Commercial Plans

The following requirements will apply to UnitedHealthcare commercial plans, including affiliate plans such as UnitedHealthcare of the Mid-Atlantic, UnitedHealthcare of the River Valley, UnitedHealthcare Oxford and Neighborhood Health Partnership:

For dates of service on or after Oct. 1, 2018, we’ll require notification/prior authorization for the following medication:

- **Parsabiv™ (etelcalcetide)** - This drug is approved by the FDA for the treatment of secondary hyperparathyroidism in adult patients with chronic kidney disease on hemodialysis and it’s administered post-dialysis.

For dates of service before Oct. 1, 2018, we encourage you to request pre-service coverage reviews so you can check whether a medication is covered before providing services. Clinical coverage reviews can help to avoid starting a patient on therapy that may later be denied due to lack of medical necessity. If you request a pre-service coverage review, you must wait for our determination before rendering the service.

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Updates to Notification/Prior Authorization Requirements for Specialty Medications for UnitedHealthcare Commercial and Community Plan Members

Clinical Coverage Reviews

Clinical coverage reviews will be conducted as part of our prior authorization process. If the member's benefit plan requires that services be medically necessary to be covered, the reviews will evaluate whether the drug listed above is appropriate for the individual member, taking into account:

- Our drug coverage policy
- Dosage recommendation from the FDA-approved labeling

Additional criteria may be considered. We encourage you to submit any information you want reviewed as part of your prior authorization request. When a coverage determination is made, we'll inform you and the member of the coverage determination. If an adverse determination is made, we'll provide you with appeal information.

Submitting Notification/Prior Authorization Requests

To submit notification/prior authorization requests for this medication, please use one of the following methods:

- **Go to UHCprovider.com/priorauth**
- **Call the Provider Services phone number** on the back of the member's health care identification card.
- **Send your request by fax:** Complete a prior authorization form and fax it to **866-756-9733**. Go to UHCprovider.com/priorauth > Clinical Pharmacy and Specialty Drugs > Forms and Additional Resources.

For UnitedHealthcare commercial plans, you can access forms at UHCprovider.com/priorauth. Some states require the notification/prior authorization to be submitted on a designated request form.

When Making Referrals

If you're referring a member to other care providers for this medication, we encourage you to refer to in-network care providers. If a non-participating care provider prescribes treatment, members may pay higher out-of-pocket costs. Members who don't have out-of-network benefits may be responsible for the entire cost of services from non-participating care providers.

For more information about the UnitedHealthcare commercial notification/prior authorization requirements for specialty medications, please refer to the Physician Health Care Professional, Facility and Ancillary Provider Administrative Guide at UHCprovider.com > Menu > Administrative Guides.

What's Changing for UnitedHealthcare Community Plan

For dates of service on or after Oct. 1, 2018, we'll require prior authorization for **Parsabiv** for UnitedHealthcare Community Plan members in many states.

Effective Oct. 1, 2018, UnitedHealthcare Community Plan in Florida will also require prior authorization for **Makena/hydroxyprogesterone caproate.**

For dates of service before Oct. 1, 2018, we encourage you to request pre-service coverage reviews so you can check whether a medication is covered before providing services. Clinical coverage reviews can help to avoid starting a patient on therapy that may later be denied due to lack of medical necessity. If you request a pre-service coverage review, you must wait for our determination before rendering the service.

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Updates to Notification/Prior Authorization Requirements for Specialty Medications for UnitedHealthcare Commercial and Community Plan Members

Clinical Coverage Reviews

Clinical coverage reviews will be conducted as part of our prior authorization process and evaluate whether the drug is appropriate for the individual member, taking into account:

- Terms of the member's benefit plan
- Our drug coverage policy
- Applicable state Medicaid guidelines
- The member's treatment history
- Dosage recommendation from the FDA-approved labeling

Additional criteria may be considered. We encourage you to submit any information you would like us to review as part of your prior authorization request. When a coverage determination is made, we'll inform you and the member of the coverage determination. If an adverse determination is made, we'll provide you with appeal information.

The following chart outlines the prior authorization requirement for UnitedHealthcare Community Plan members in each state:

State	Specialty Medication
Arizona	Parsabiv
California	Parsabiv
Hawaii	Parsabiv
Iowa	Parsabiv
Kansas	Parsabiv
Louisiana	Parsabiv
Maryland	Parsabiv
Michigan	Parsabiv
Mississippi	Parsabiv
Nebraska	Parsabiv
New Jersey	Parsabiv
New Mexico	Parsabiv
New York	Parsabiv
Ohio	Parsabiv
Pennsylvania	Parsabiv
Rhode Island	Parsabiv
Tennessee	Parsabiv
Virginia	Parsabiv
Washington	Parsabiv
Florida	Makena / hydroxyprogesterone Caproate, Parsabiv

Coverage of these products is also dependent on state Medicaid program decisions. Certain state Medicaid programs may choose to cover a drug through the state's fee-for-service program and not the managed care organizations such as UnitedHealthcare or they may provide other coverage guidelines and protocols. We encourage you to verify benefits for your patients before submitting the prior authorization request or administering the medication.

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Updates to Notification/Prior Authorization Requirements for Specialty Medications for UnitedHealthcare Commercial and Community Plan Members

Submitting Prior Authorization Requests

To submit prior authorization requests for these medications, please use one of the following methods:

- **Go to UHCprovider.com/priorauth**
- **Call the Provider Services phone number** on the back of the member's health care identification card.
- **Send your request by fax**, complete a prior authorization form and fax it to the number provided on the form.

Access forms are available at **UHCCommunityPlan.com** > For Health Care Professionals > Select your state > Provider Forms.

When Making Referrals

If you're referring a member to other care providers for these medications, we encourage you to refer to in-network care providers. If a non-participating care provider prescribes treatment, members may pay higher out-of-pocket costs. Members who don't have out-of-network benefits may be responsible for the entire cost of services obtained from non- participating care providers.

What's Changing for UnitedHealthcare Medicare Advantage Plans

The following requirement will apply to UnitedHealthcare Medicare Advantage Plans, including UnitedHealthcare Dual Complete Plans, UnitedHealthcare Connected Plans, Medica and Preferred Care Partners of Florida groups. For dates of service on or after Oct. 1, 2018, we'll require notification/prior authorization for the following medication:

- **Crysvita (burosumab)**

How the Notification/Prior Authorization Process Will Work for UnitedHealthcare Medicare Advantage Plans

When we receive notification for this medication, we'll determine if the member's benefit plan requires services to be medically necessary to be covered. If so, we'll conduct a clinical coverage review as part of our prior authorization process. Clinical coverage reviews conducted as part of our prior authorization process will evaluate whether the drug is appropriate for the individual member, taking into account:

- Terms of the member's benefit plan
- Our drug coverage policy
- Applicable Medicare guidance
- The member's treatment history
- Dosage recommendation from the FDA-approved labeling

Additional criteria may be considered. We encourage you to submit any information you would like us to review as part of your prior authorization request. When a coverage determination is made, we'll inform you and the member of the coverage determination. If an adverse determination is made, we'll provide you appeal information.

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Updates to Notification/Prior Authorization Requirements for Specialty Medications for UnitedHealthcare Commercial and Community Plan Members

Submitting Notification/Prior Authorization Requests

To submit notification/prior authorization requests, please use one of the following methods:

- Go to UHCprovider.com/priorauth
- Call the Provider Services phone number on the back of the member's health care identification card.

When Making Referrals

- If you're referring a member to other care providers for this medication, please refer to in-network care providers.

If you have any questions, please call the Provider Service number on the back of the member's ID card.

Pharmacy Update: Notice of Changes to Prior Authorization Requirements and Coverage Criteria for UnitedHealthcare Commercial and Oxford

A pharmacy bulletin outlining upcoming new or revised clinical programs and implementation dates is now available online for UnitedHealthcare commercial. Go to UHCprovider.com/pharmacy.

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Reminder: Successfully Submitting a Prescription to OptumRx

Our goal is to provide safe, easy and quick ways to get your patients the medication they need. **ePrescribe** is the fast and convenient way to do that. Just add the OptumRx profile in your electronic medical record (EMR) system using the following information and send the prescription to us:

OptumRx Mail Service
2858 Loker Ave East, Suite100,
Carlsbad, CA 92010
NCPDP ID=0556540
PID=P00000000020173

Call **800-791-7658** – Provide a verbal prescription directly to an OptumRx pharmacist dedicated to our health care providers.
Fax **800-491-7997** – Send us a complete prescription using the **Physician Fax Form**.

Before you send us a prescription and to minimize any delays or outreach, please:

- Verify with your patient OptumRx is their home delivery pharmacy.
- Verify the medication is covered by your patient's health care plan or if it will require a prior authorization.
- Verify prescription medication name, formulation, strength, directions, quantity and refills are complete.
- If using ePrescribe, help ensure you select the Carlsbad OptumRx address listed above.
- Verify all prescriptions for diabetic supplies are coordinated and provide specific brand and directions (i.e. maximum times a patient is to test daily).
- Verify collaborating/supervising physician information is included as required by your state for midlevel practitioners.

You and your patients will enjoy the convenience:

- You save time, staffing and supplies costs.
- You can maximize your patient's cost savings by ordering up to a 90-day supply of their maintenance medication, allowing them to make fewer trips to the pharmacy.
- Your patients get free standard shipping to anywhere in the United States.

For more information, send an email to **ORxProviderHelp@optum.com** or call **800-791-7658**.

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UnitedHealthcare Medicare Advantage Prior Authorization Reduction Pilot Concludes

On Oct. 1, 2018, the UnitedHealthcare Medicare Prior Authorization Reduction Pilot will conclude, resulting in re-implementation of prior authorization for services previously removed from this requirement. The pilot was implemented Jan 1, 2017, impacting:

- Medicare Advantage preferred provider organization (PPO) group retiree members (nationally)
- All Medicare Advantage plan members (*to include Dual Special Needs Plans) seeing care providers in:
  - Alabama (as of May 1, 2017)
  - Arkansas
  - Connecticut
  - Idaho
  - Kansas*
  - Missouri
  - North Carolina*
  - Rhode Island
  - Wisconsin

For dates of service on or after **Oct. 1, 2018**, the following service categories will require prior authorization for

UnitedHealthcare Medicare Advantage Plan care providers in Alabama, Arkansas, Connecticut, Idaho, Kansas, Missouri, North Carolina, Rhode Island and Wisconsin and care providers for UnitedHealthcare Group Retiree Plan National PPO (NPPO). All other UnitedHealthcare Medicare plans will continue to require prior authorization as applicable and published today. The procedure codes impacted under the list service categories can be found on the most up-to-date Advance Notification lists are available online:

- UnitedHealthcare Medicare Plans – UHCprovider.com/priorauth > Advance Notification and Plan Requirement Resources > Plan Requirement Resources
- UnitedHealthcare Community Plan/Medicare Plans — UHCCommunityPlan.com > For Health Care Professionals > Select your state.

Category	
Bone Growth Stimulator	Orthopedic Surgeries
Cardiology	Radiation Therapies (IMRT< SRS, SBRT)
Cochlear Implants & Other Auditory Implants	Radiology
Hysterectomy (regardless of place of service)	Spinal Stimulator for Pain Management
Hysterectomy (in-patient place of service only)	Sleep Apnea Procedures and Surgeries
Non-Emergent Transport – Air	Vagus Nerve Stimulation

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Changes in Advance Notification and Prior Authorization Requirements

Code Additions to Prior Authorization

For dates of service on or after **July 1, 2018 due to state requirements**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Pennsylvania (Medicaid Plan):**

Category	Codes
Human Milk Bank	T2101

For dates of service on or after **July 1, 2018 due to state requirements**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Massachusetts Senior Care Options:**

Category	Codes
Orthopedic Surgeries	27488, 29870, 29873-29877, 29879-29889

Effective for dates of service on or after **Oct. 1, 2018**, the following service categories will require prior authorization for **UnitedHealthcare Medicare Plan servicing providers in the states of Alabama, Arkansas, Connecticut, Idaho, Kansas, Missouri, North Carolina, Rhode Island, Wisconsin, and those providers servicing UnitedHealthcare Employer Group Retiree plan National PPO (NPPO)**. All other UnitedHealthcare Medicare plans will continue to require prior authorization as applicable and published today. The procedure codes impacted under the list service categories can be found on the most up-to-date Advance Notification lists are available online:

- UnitedHealthcare Medicare Plans – **UHCprovider.com/priorauth** > Advance Notification and Plan Requirement Resources > Plan Requirement Resources
- UnitedHealthcare Community Plan / Medicare Plans – **UHCCommunityPlan.com** > For Health Care Professionals > Select your state.

Category	
Bone Growth Stimulator	Orthopedic Surgeries
Cardiology	Radiation Therapies (IMRT< SRS, SBRT)
Cochlear Implants & Other Auditory Implants	Radiology
Hysterectomy (regardless of place of service)	Spinal Stimulator for Pain Management
Hysterectomy (in-patient place of service only)	Sleep Apnea Procedures and Surgeries
Non-Emergent Transport – Air	Vagus Nerve Stimulation

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Changes in Advance Notification and Prior Authorization Requirements

For dates of service on or after **Oct. 1, 2018**, the following procedure codes will require prior authorization for **UnitedHealthcare Medicare Plans** (UnitedHealthcare Medicare Advantage, UnitedHealthcare West, UnitedHealthcare Community Dual Special Needs Plans, UnitedHealthcare Institutional Special Needs Plans, UnitedHealthcare Community Plan Massachusetts Senior Care Options, UnitedHealthcare Community Plans-Medicare and Medica and Preferred Care of Florida health plan):

Category	Codes	Plans Impacted
Cosmetic and Reconstructive	31298	All
Vein Procedures	36473, 36475, 36478, 37700, 37718, 37722, 37780	All; excluding Medica and Preferred Care of Florida – existing requirement

Effective for dates of service on or after **Oct. 1, 2018**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Tennessee (Medicaid and LTSS Plans):**

Category	Codes
Sterilization	58671, 58661

For dates of service on or after **Oct. 1, 2018**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Texas STAR (Medicaid Plan):**

Category	Codes
Prescribed Pediatric Extended Care Services (PPEC)	T1025, T1026, T2002

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Changes in Advance Notification and Prior Authorization Requirements

For dates of service on or after **Oct. 1, 2018**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Louisiana (Medicaid Plan):**

Category	Codes
Radiology – PET Scans (Outpatient)	78608, 78609, 78811-78816, A9515, A9526, A9552, A9580, A9587, A9588, G0219, G0235, G0252

For dates of service on or after **Oct. 1, 2018**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Ohio (Medicaid Plan):**

Category	Codes
Cosmetic and Reconstructive	15830

For dates of service on or after **Oct. 1, 2018**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of New Jersey (Medicaid and LTSS Plans):**

Category	Codes
Speech Therapy	92507, 92508

For dates of service on or after **Oct. 1, 2018**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Florida (Medicaid Plans):**

Category	Codes
Outpatient Therapies	92610, 92597, 92609
Injectable Medications-Makena	J1726, J1729, J2675

For dates of service on or after **Oct. 1, 2018**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Iowa (Wellness Medicaid Plan):**

Category	Codes
Bariatric Surgery	64590, 43860, 43881, 43882, 95980, 95981, 95981

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Changes in Advance Notification and Prior Authorization Requirements

For dates of service on or after Oct. 1, 2018, for UnitedHealthcare Commercial Plans (UnitedHealthcare Mid Atlantic Health Plan, Navigate, Neighborhood Health Partnership, UnitedHealthOne, UnitedHealthcare Commercial, UnitedHealthcare of the River Valley and UnitedHealthcare West), the following procedure codes, which currently require prior authorization, will now only require prior authorization when billed with the defined diagnosis codes:

Category	Codes	Diagnosis Codes
Gender Dysphoria Treatment	58260	F64.0, F64.1, F64.2, F64.8, F64.9, Z87.890

Effective for dates of service on or after **July 1, 2018 due to state mandate**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Mississippi (CHIP and CAN Plan):**

Category	Codes
Hospice	T2042-T2045

New Process for Requesting Prior Authorization for Infertility Services – California Commercial HMO

We're changing the process for requesting prior authorization for advanced infertility rider California commercial HMO infertility services. Starting July 1, 2018, you'll have three ways to submit prior authorization requests for these members:

1. Use the Prior Authorization and Notification app on Link.
2. Fax the completed form to 855-349-8479. The form is available at UHCprovider.com/en/prior-auth-advance-notification.html.
3. Email the completed form to fertility_solutions@optum.com.

If you have questions, please call Fertility Solutions at **888-936-7246**.

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Changes in Advance Notification and Prior Authorization Requirements

Effective for dates of service on or after **July 1, 2018 due to state requirements**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Maryland (Medicaid Plan):**

Category	Codes
Cochlear Implants	L8614, L8619, L8690-L8692
Hearing Aid & Services	V5170, V5180, V5210, V5220, V5230, V5250, V5254-V5261, V5299

For dates of service on or after **Sept. 1, 2018 due to state requirements**, the following procedure codes will require prior authorization for the documented face-to-face form, for **UnitedHealthcare Community Plan of Kansas (Medicaid, CHIP, LTSS):**

Category	Codes
Home Healthcare (with form documenting face-to-face)	G0156, S0315, S0316, S9460, T1030, S9129, S9131, T1021, S5181, S9128, T1004, T1023, T1031, T1502, 99600-99602

Changes listed above will be published within 30 days of implementation. The most up-to-date Advance Notification lists are available online:

- UnitedHealthcare Medicare Plans – **UHCprovider.com/priorauth** > Advance Notification and Plan Requirement Resources > Plan Requirement Resources
- UnitedHealthcare Community Plan – **UHCCommunityPlan.com** > For Health Care Professionals > Select your state.

Front & Center

Process Change: Colony-Stimulating Factors

Beginning Oct. 1, 2018, the review process for colony-stimulating factors administered to patients with a cancer diagnosis in the outpatient setting will change. This requirement is for members of UnitedHealthcare commercial plans, UnitedHealthcare Oxford and UnitedHealthcare Community Plans that currently require prior authorization for outpatient injectable chemotherapy and colony stimulating factors.*

If the chemotherapy regimen is considered an intermediate risk for a neutropenia event according to the NCCN, the user will now be asked to provide clinical details to support the addition of a colony-stimulating factor to the treatment regimen. It's possible that some of the requests may require a peer to peer discussion based on the submitted clinical information. The process for chemotherapy regimens considered to be low risk for neutropenia events will not change.

Colony-stimulating factors include the following drugs and J codes:

- J1442 filgrastim (Neupogen)
- J1447 tbo-filgrastim (Granix)
- J2505 pegfilgrastim (Neulasta)
- J2820 sargramostim (Leukine)
- Q5101 filgrastim, bio similar (Zarxio)

We Value Your Feedback

UnitedHealthcare's Provider Digital Feedback Platform is a place to submit your feedback on how to improve experiences, provide ideas, and engage. We'd like to get your thoughts on new initiatives, innovative technologies, and/or program and policy changes. If you are a participating provider in any of UnitedHealthcare's lines of business, please click here to join the conversation **uhcresearch.az1.qualtrics.com/jfe/form/SV_cx6HuSh2NIKuifH**.

UnitedHealthcare Commercial

Learn about program revisions and requirement updates.

UnitedHealthcare Genetic and Molecular Testing Prior Authorization/Notification Updates

Effective Oct. 1, 2018, UnitedHealthcare will require prior authorization/notification for additional codes as part of the online prior authorization/notification program for genetic and molecular testing performed in an outpatient setting for our fully insured UnitedHealthcare commercial plan members. ›

Optum Neonatal Resource Services (NRS) Guidelines

On Oct. 1, 2018, revisions will become effective to the Neonatal Resource Services (NRS) Clinical Guidelines based on current clinical evidence and expert panel input. ›

Optum Fertility Solutions Infertility Guideline

On Oct. 1, 2018, revisions will become effective to the Infertility Medical Necessity Clinical Guideline based on current clinical evidence and expert panel input. ›

Tiered Benefit Plans Frequently Asked Questions

Check out the Update Tiered Benefit Plans Frequently Asked Questions guide on UHCprovider.com to learn more details the Tiered Benefit plan. ›

UnitedHealthcare Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates

UnitedHealthcare Commercial

UnitedHealthcare Genetic and Molecular Testing Prior Authorization/Notification Updates

Effective Oct. 1, 2018, UnitedHealthcare will require prior authorization/notification for additional codes as part of the online prior authorization/notification program for genetic and molecular testing performed in an outpatient setting for our fully insured UnitedHealthcare commercial plan members.*

New CPT codes included in the program:

Category	Codes
0012M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and XCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma
0013M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma
0036U	Exome (ie, somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses
0037U	Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden
0040U	BCR/ABL1 (t(9;22)) (eg, chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative
0045U	Oncology (breast ductal carcinoma in situ), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence score
0046U	FLT3 (fms-related tyrosine kinase 3) (eg, acute myeloid leukemia) internal tandem duplication (ITD) variants, quantitative
0047U	Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a risk score

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UnitedHealthcare Genetic and Molecular Testing Prior Authorization/ Notification Updates

Category	Codes
0048U	Oncology (solid organ neoplasia), DNA, targeted sequencing of protein-coding exons of 468 cancer-associated genes, including interrogation for somatic mutations and microsatellite instability, matched with normal specimens, utilizing formalin-fixed paraffin-embedded tumor tissue, report of clinically significant mutation(s)
0049U	NPM1 (nucleophosmin) (eg, acute myeloid leukemia) gene analysis, quantitative
0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements
0055U	Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism targets and two control targets), plasma
0056U	Hematology (acute myelogenous leukemia), DNA, whole genome next-generation sequencing to detect gene rearrangement(s), blood or bone marrow, report of specific gene rearrangement(s)
0057U	Oncology (solid organ neoplasia), mRNA, gene expression profiling by massively parallel sequencing for analysis of 51 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a normalized percentile rank
0060U	Twin zygosity, genomic targeted sequence analysis of chromosome 2, using circulating cell-free fetal DNA in maternal blood

* Laboratory services ordered by Florida network providers for fully insured UnitedHealthcare commercial members in Florida will not have to participate in this requirement due to their participation in the UnitedHealthcare Laboratory Benefit Management Program.

UnitedHealthcare Commercial

Optum Neonatal Resource Services (NRS) Guidelines

On Oct. 1, 2018 the following revisions will become effective to the Neonatal Resource Services (NRS) Clinical Guidelines based on current clinical evidence and expert panel input:

- Apnea and Bradycardia: The content of this guideline has been reorganized to separate apnea of prematurity (AOP) from other forms of apnea. A statement that the use of caffeine levels is not recommended has been added and the apnea/bradycardia countdown in a term infant has been clarified to indicate it should be based on etiology.
- Discharge Planning: A statement that there should be no smoking in the car or around the infant has been added.
- Feeding the Neonate: The volume of trophic feedings in extremely low birth weight (ELBW) infants has been revised to ≤ 24 mL/kg/day, shelf-stable homogenized donor milk has been added as an option of donor milk, the volume of trophic feedings for priming the gut and alternative oral feeding strategies have been removed, and the weight specific to a "larger preterm infant" has been added.
- Hyperbilirubinemia: The total serum bilirubin (TSB) level for a double volume exchange transfusion has been removed and replaced with direction to the American Academy of Pediatrics and U.S. Preventive Services Task Force guidelines. IVIG for acute hemolytic crises was clarified that it should be applicable to "immune mediated".
- Neonatal Abstinence Syndrome: Finnegan score values for initiation of pharmacologic management have been revised, the dosing of buprenorphine has been added, information on SSRI exposure and withdrawal has been provided, and the adoption of a rooming-in policy for clinically stable neonates (where possible) has been emphasized.

A new NRS medical necessity clinical guideline on Chronic Care will also become effective on Oct. 1, 2018. This guideline addresses the optimal management of infants with chronic medical conditions that require ongoing skilled care. The new and revised clinical guidelines are available at **UHCprovider.com/en/policies-protocols/clinical-guidelines.html?rfid=UHCOContRD**.

UnitedHealthcare Commercial

Optum Fertility Solutions Infertility Guideline

On Oct. 1, 2018, the following revisions will become effective to the Infertility Medical Necessity Clinical Guideline based on current clinical evidence and expert panel input:

- SART data has been updated.
- The indications for the post-coital test have been revised.
- The FSH, AMH and antral count levels as infertility indicators have been revised.
- Information on additional infertility factors and verbiage that there are no infertility benefits for autologous oocytes in females ≥ 44 years of age has been added.
- The non-indications for IUI and donor insemination have been revised.
- Information on ICSI has been added.
- The cycles of eSET for women aged 41-42 has been revised
- Information on multiple cleavage stage embryo transfers has been revised
- Additional information on natural cycle IUI has been provided

The revised clinical guideline is available at **UHCprovider.com/en/policies-protocols/clinical-guidelines.html?rfid=UHCOContRD.**

Tiered Benefit Plans Frequently Asked Questions

Check out the **Updated** Tiered Benefit Plans Frequently Asked Questions guide on UHCprovider.com.
Topics include:

- What is a UnitedHealthcare Tiered Benefit plan
- How do I know if a member is on a UnitedHealthcare Tiered Benefit plan
- Where do I go to find out if I'm a Tier 1 provider for a member
- Now available via EDI 271 response

For more information, go to **UHCprovider.com/en/health-plans-by-state/tiered-benefit-plans.html**.

UnitedHealthcare Commercial

UnitedHealthcare Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates

For complete details on the policy updates listed in the following table, please refer to the June 2018 Medical Policy Update Bulletin at UHCprovider.com > Menu > Policies and Protocols > Commercial Policies > Commercial Medical & Drug Policies and Coverage Determination Guidelines > Medical Policy Update Bulletins.

Policy Title	Policy Type	Effective Date
UPDATED/REVISED		
Ablative Treatment for Spinal Pain	Medical	July 1, 2018
Athletic Pubalgia Surgery	Medical	June 1, 2018
Breast Imaging for Screening and Diagnosing Cancer	Medical	July 1, 2018
Breast Reduction Surgery	CDG	June 1, 2018
Clinical Trials	CDG	June 1, 2018
Clotting Factors and Coagulant Blood Products	Drug	June 1, 2018
Corneal Hysteresis and Intraocular Pressure Measurement	Medical	July 1, 2018
Extracorporeal Shock Wave Therapy (ESWT)	Medical	July 1, 2018
Gene Expression Tests for Cardiac Indications	Medical	June 1, 2018
Hip Resurfacing and Replacement Surgery (Arthroplasty)	Medical	July 1, 2018
Intensity-Modulated Radiation Therapy	Medical	July 1, 2018
Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC)	Medical	June 1, 2018
Mifeprex® (Mifepristone)	Drug	June 1, 2018
Motorized Spinal Traction	Medical	June 1, 2018
Neuropsychological Testing Under the Medical Benefit	Medical	June 1, 2018
Preterm Labor Management	Medical	June 1, 2018
Preventive Care Services	CDG	July 1, 2018
Proton Beam Radiation Therapy	Medical	July 1, 2018

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UnitedHealthcare Commercial

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UnitedHealthcare Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates

Policy Title	Policy Type	Effective Date
UPDATED/REVISED		
Repository Corticotropin Injection (H.P. Acthar Gel®)	Drug	June 1, 2018
Sodium Hyaluronate	Medical	July 1, 2018
Specialty Medication Administration – Site of Care Review Guidelines	URG	July 1, 2018
White Blood Cell Colony Stimulating Factors	Drug	June 1, 2018
RETIRED		
Gait Analysis	Medical	June 1, 2018

Note: The inclusion of a health service (e.g., test, drug, device or procedure) on this list does not imply that UnitedHealthcare provides coverage for the health service. In the event of an inconsistency or conflict between the information in this bulletin and the posted policy, the provisions of the posted policy prevail.

UnitedHealthcare Commercial Reimbursement Policies

Learn about policy changes and updates.

Coordinated Commercial Reimbursement Policy: Rollout Begins July 1, 2018

Through your feedback, we heard you wanted policy changes combined together rather than introduced piece by piece, while also identifying opportunities to use more consistent reimbursement policies across all products (commercial, Medicare, Medicaid). This is an important step to create a more consistent, predictable experience, and that's why we are announcing several policy changes together that become effective during the second half of this year.

UnitedHealthcare Commercial Reimbursement Policies

Unless otherwise noted, the following reimbursement policies apply to services reported using the 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent or its successor form. UnitedHealthcare reimbursement policies do not address all factors that affect reimbursement for services rendered to UnitedHealthcare members, including legislative mandates, member benefit coverage documents, UnitedHealthcare medical or drug policies, and the UnitedHealthcare Care Provider Administrative Guide. Meeting the terms of a particular reimbursement policy is not a guarantee of payment. Once implemented, the policies may be viewed in their entirety at UHCprovider.com > Menu > Policies and Protocols > Commercial Policies > Reimbursement Policies for Commercial Plans. In the event of an inconsistency between the information provided in the Network Bulletin and the posted policy, the posted policy prevails.

UnitedHealthcare Commercial Reimbursement Policies

Coordinated Commercial Reimbursement Policy: Rollout Begins July 1, 2018

Care providers and payers both play important roles working together to build a more sustainable health system. By collaborating on efforts grounded in the Triple Aim of improving the patient experience and supporting better health while lowering overall costs, we can support the industry's move away from volume-based activity and toward incentivizing a focus on value. This move requires simpler administrative processes and lower costs coupled with payments that emphasize quality and better outcomes. Updating and simplifying our current reimbursement policies is just one of the ways we're supporting this movement.

What does this mean to care providers?

- **Combining Policy Changes into One Release:** Through your feedback, we heard you wanted policy changes combined together rather than introduced piece by piece, while also identifying opportunities to use more consistent reimbursement policies across all products (commercial, Medicare, Medicaid). This is an important step to create a more consistent, predictable experience, and that's why we are announcing several policy changes together that become effective during the second half of this year.
- **Increased Reimbursement for After Hours and Weekend Care:** We're increasing reimbursement to primary care providers (PCPs) for after hours and weekend care, recognizing the additional resources needed to serve our members, while enabling delivery of consistent care by their established PCP and resulting in lower member cost share. Many members incur higher out of pocket costs when accessing healthcare in the ER and/or Urgent Care settings. This is part of our ongoing efforts to redirect more payments to PCPs and strengthen the primary care model.
- Additional policy changes including, **Vision Screening CCI Editing, Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency, New Patient Visit and Non-Patient Facility Laboratory Services** policy updates are outlined in the chart below.

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UnitedHealthcare Commercial Reimbursement Policies

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Coordinated Commercial Reimbursement Policy: Rollout Begins July 1, 2018

How is this being communicated?

UnitedHealthcare remains committed to early, frequent and transparent communication with care providers about our ongoing relationship. We met with several medical societies before making these changes to ensure we're able to have important dialogues ahead of these policy changes and set clear expectations.

In addition, a variety of resources will be available to help care providers and administrators clearly understand the changes with upcoming training courses on UHC On Air and the release of an "E/M Back to Coding Basics" training course that is now available on UHCprovider.com.

Here's an overview of the policies, effective dates and an overview of the changes:*

Policy	Effective Date	Summary of Change (New Policy or change to an Existing Policy)
Vision Screening (CCI Editing Update)	July, 1, 2018	• The vision screening services revision aligns with the 7/1/2018 CMS NCCI update. • Procedure codes 99173, 99174 and 99177 will be considered reimbursable when reported with preventive medicine E/M services. • Modifiers will no longer be required for separate reimbursement of these services.
After Hours and Weekend Care (Policy Change)	Aug. 18, 2018	• UnitedHealthcare will allow reimbursement for code 99051 when billed with acute care services by PCPs. • This policy change supports reimbursement for primary care practices with additional hours providing convenient access for members to see their own PCPs.

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UnitedHealthcare Commercial Reimbursement Policies

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Coordinated Commercial Reimbursement Policy: Rollout Begins July 1, 2018

Policy	Effective Date	Summary of Change (New Policy or change to an Existing Policy)
Intraoperative Neuromonitoring (IONM) (New Policy)	Sept. 1, 2018	• This new policy is sourced from public policy from the American Academy of Neurology (AAN) and the Centers for Medicare and Medicaid Services (CMS). • Separate reimbursement for IONM services represented by CPT®/HCPC codes 95940, 95941 and G0453 will only be considered for reimbursement when performed in inpatient or outpatient hospital place of service (POS) 19, 21 or 22 when provided by a care provider who is not the surgeon or anesthesiologist. • To support quality of care and patient safety, IONM services reported in a POS other than a hospital (19, 21 or 22) will be denied per guidance from the AAN.
Professional and Technical Component Policy for Duplicate or Repeat Services of Global Test Only (Policy Change)	Sept. 1, 2018	• Only one physician or other health care professional will be reimbursed when duplicate or repeat services are reported. • These services are defined as identical CPT or HCPCS codes assigned a Professional Component (PC)/Technical Component (TC) indicator 1, 2, 3, 4, 6 or 8 submitted for the same patient on the same date of service. • When the same care provider reports standalone service (PC/TC Indicator 2, 3, or 4) more than once, on the same date of service, the second and subsequent services will not be separately reimbursed. • Separate consideration will only be given to those services reported with the appropriate modifier. • When a Global Test Only code (PC/TC 4) is reported and the same or different provider reports a PC/TC 2 and/or PC/TC 3 code that is a component of the Global Test Only code, the PC/TC 2 and/or PC/TC 3 code will not be separately reimbursed.

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UnitedHealthcare Commercial Reimbursement Policies

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Coordinated Commercial Reimbursement Policy: Rollout Begins July 1, 2018

Policy	Effective Date	Summary of Change (New Policy or change to an Existing Policy)
New Patient Visit (Claim Processing Change)	Oct. 1, 2018	• Consistent with CMS, E/M services not meeting the CMS new patient definition will be denied. • To facilitate appropriate member cost share, we will no longer process claims with an assumptive replacement established E/M code. • Providers who experience denials may resubmit the appropriate level established E/M CPT or subsequent visit HCPCS code based on the service documented in the medical record. • To determine which procedure code accurately reflects the services rendered, care providers should refer to the CMS 1995 or 1997 Evaluation and Management Guidelines. Additionally, providers and/or their staff may take the "Evaluation and Management Coding; Back to Coding Basics" course available by clicking on "Link" via UHCprovider.com. The course is available without cost and eligible for 1 AAPC continuing education credit.
Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency	Oct. 1, 2018	• The title of the policy will be revised to the Durable Medical Equipment, Orthotics and Prosthetics Policy. • DME suppliers will be required to report the applicable place of service (POS). Reimbursement will be limited to settings that represent the patient's residence (01, 04, 09, 12, 13, 14, 16, 33, 54, 55, 56, and 65). For POS 31 and 32, please refer to the Supply Policy. • There are specific items that are not suitable for home use, for example, an implantable device used during a surgical procedure. Therefore, when reported with a POS that represents the patient's home, these items will not be reimbursed. • In addition, certain supplies/items are considered included in the rental period, initial purchase, or per the code description and will not be separately reimbursed.

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UnitedHealthcare Commercial Reimbursement Policies

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Coordinated Commercial Reimbursement Policy: Rollout Begins July 1, 2018

Policy	Effective Date	Summary of Change (New Policy or change to an Existing Policy)
Non-Patient Facility Laboratory Services	Oct. 1, 2018	• Consistent with guidance from CMS, facility claims submitted with Type of Bill 014X (14X) will be denied for providers that are reimbursed for non-patient lab services at a percent of charge rate. • As defined by CMS, a non-patient is a beneficiary that is neither an inpatient nor an outpatient of a hospital, but has a specimen that has been submitted for analysis to a hospital and the beneficiary is not physically present at the hospital. • This new policy applies to claims submitted on the CMS UB04 claim form or its electronic equivalent.

*Unless otherwise noted, the following reimbursement policies apply to services reported using the 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent or its successor form. UnitedHealthcare reimbursement policies do not address all factors that affect reimbursement for services rendered to UnitedHealthcare members, including legislative mandates, member benefit coverage documents, UnitedHealthcare medical or drug policies, and the UnitedHealthcare Care Provider Administrative Guide. Meeting the terms of a particular reimbursement policy is not a guarantee of payment.

Once implemented, the policies may be viewed in their entirety at UHCprovider.com > Menu > Policies and Protocols > Commercial Policies > Reimbursement Policies for Commercial Plans. In the event of an inconsistency between the information provided in the Network Bulletin and the posted policy, the posted policy prevails.

If you have any questions about the policy changes outlined above, please contact Provider Services at **877-842-3210**.

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UnitedHealthcare Community Plan

Learn about Medicaid coverage changes and updates.

Concurrent Drug Utilization Review

To help increase patient safety and prevent abuse and fraudulent activity, UnitedHealthcare Community Plan i s continuing to implement Concurrent Drug Utilization Review (cDUR) safety edits. New safety edits will be implemented on Aug. 1, 2018.

UnitedHealthcare Community Plan Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates

UnitedHealthcare Community Plan

Concurrent Drug Utilization Review

To help increase patient safety and prevent abuse and fraudulent activity, UnitedHealthcare Community Plan is continuing to implement Concurrent Drug Utilization Review (cDUR) safety edits.

At the Point of Sale (POS), the pharmacist will be alerted of a drug-drug interaction, therapeutic duplication or high dose. The pharmacist will then look at the member's profile and contact the prescriber or member to determine if the member should receive both prescriptions. If the pharmacist determines the prescription should be processed, they can override the alert by entering the appropriate reason codes. Pharmacies will receive a fax explaining these safety edits and what action needs to be taken to override them.

The following safety edits will be implemented on Aug. 1, 2018:

1. *Therapeutic Duplication:*
   This safety edit in the pharmacy system looks at the member's current medications and identifies potential duplications to prevent members from taking more than one drug in the same drug class.
2. *Drug-Drug Interaction:*
   This safety edit in the pharmacy system checks the member's current medications and identifies potential instances where a member could be taking two drugs with an identified drug-interaction flag in Medispan.
3. *Theradose (High Dose):*
   This safety edit in the pharmacy system looks at the member's current medications and identifies potential instances where a member could be exceeding the FDA's approved maximum dose.

The following drug classes and cDUR edits will be added to the program:

cDUR Edit	Drug Class	Health Plan	States in Scope
Drug Drug Interaction	Opioids + Carisoprodol	UnitedHealthcare Community Plan	AZ, CA, FL FHK, FL MMA, HI, KS, LA, MD, MI, MS, NE, NJ, NV, NM, NY, NY EPP, OH, PA, RI, TX, VA, WA
Drug Drug Interaction	Linezolid + Serotonin Modulators	UnitedHealthcare Community Plan	AZ, CA, FL FHK, FL MMA, HI, KS, LA, MD, MI, MS, NE, NJ, NV, NM, NY, NY EPP, OH, PA, RI, TX, VA, WA

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UnitedHealthcare Community Plan

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Concurrent Drug Utilization Review

cDUR Edit	Drug Class	Health Plan	States in Scope
Drug Drug Interaction	Ciprofloxacin + Tizanidine	UnitedHealthcare Community Plan	AZ, CA, FL FHK, FL MMA, HI, KS, LA, MD, MI, MS, NE, NJ, NV, NM, NY, NY EPP, OH, PA, RI, TX, VA, WA
Therapeutic Duplication	ACE Inhibitors	UnitedHealthcare Community Plan	AZ, CA, FL FHK, FL MMA, HI, KS, LA, MD, MI, MS, NE, NV, NJ, NM, NY, NY EPP, OH, PA, RI, TX, WA
Therapeutic Duplication	ARB products	UnitedHealthcare Community Plan	AZ, CA, FL FHK, FL MMA, HI, KS, LA, MD, MI, MS, NE, NV, NJ, NM, NY, NY EPP, OH, PA, RI, TX, WA
Therapeutic Duplication	ACE Inhibitors + ARB	UnitedHealthcare Community Plan	AZ, CA, FL FHK, FL MMA, HI, KS, LA, MD, MI, MS, NE, NV, NJ, NM, NY, NY EPP, OH, PA, RI, TX, VA, WA
Theradose	PPI	UnitedHealthcare Community Plan	AZ, CA, FL FHK, FL MMA, HI, KS, LA, MD, MI, MS, NE, NV, NJ, NY, NY EPP, NM, OH, PA, RI, TX, WA
Theradose	Sleep Aides	UnitedHealthcare Community Plan	AZ, CA, FL FHK, FL MMA, HI, KS, LA, MS, NE, NV, NJ, NY, NY EPP, NM, OH, PA, RI, TX, WA

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates

For complete details on the policy updates listed in the following table, please refer to the June 2018 Medical Policy Update Bulletin at UHCprovider.com > Menu > Policies and Protocols > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines > Medical Policy Update Bulletins.

Policy Title	Policy Type	Effective Date
NEW		
Crysvita® (Burosumab-Twza)	Drug	June 1, 2018
UPDATED/REVISED		
Ablative Treatment for Spinal Pain	Medical	Aug. 1, 2018
Athletic Pubalgia Surgery	Medical	June 1, 2018
Benlysta® (Belimumab)	Drug	June 1, 2018
Breast Imaging for Screening and Diagnosing Cancer	Medical	Aug. 1, 2018
Breast Reduction Surgery	CDG	June 1, 2018
Buprenorphine (Probuphine® & Sublocade™) (for Pennsylvania Only)	Drug	June 1, 2018
Clinical Trials	CDG	June 1, 2018
Corneal Hysteresis and Intraocular Pressure Measurement	Medical	Aug. 1, 2018
Extracorporeal Shock Wave Therapy (ESWT)	Medical	Aug. 1, 2018
Hip Resurfacing and Replacement Surgery (Arthroplasty)	Medical	Aug. 1, 2018
Intensity-Modulated Radiation Therapy	Medical	Aug. 1, 2018
Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC)	Medical	June 1, 2018
Motorized Spinal Traction	Medical	June 1, 2018
Neuropsychological Testing Under the Medical Benefit	Medical	June 1, 2018
Preterm Labor Management	Medical	June 1, 2018
Proton Beam Radiation Therapy	Medical	Aug. 1, 2018

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UnitedHealthcare Community Plan

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UnitedHealthcare Community Plan Medical Policy, Medical Benefit Drug Policy and Coverage Determination Guideline Updates

Policy Title	Policy Type	Effective Date
UPDATED/REVISED		
Repository Corticotropin Injection (H.P. Acthar Gel®)	Drug	June 1, 2018
Sodium Hyaluronate	Medical	Aug. 1, 2018
White Blood Cell Colony Stimulating Factors	Drug	June 1, 2018
RETIRED		
Gait Analysis	Medical	June 1, 2018

Note: The inclusion of a health service (e.g., test, drug, device or procedure) on this list does not imply that UnitedHealthcare provides coverage for the health service. In the event of an inconsistency or conflict between the information in this bulletin and the posted policy, the provisions of the posted policy prevail.

UnitedHealthcare Medicare Advantage

Learn about Medicare policy, reimbursement and guideline changes.

Reimbursement for 340B Drug Pricing Program

We're making some important changes that affect how we reimburse for payable drugs and biological agents purchased through the 340B Drug Pricing Program. These changes align with Centers for Medicare & Medicaid Services (CMS) payment policy.

Change to Supply Policy – Bundling Code L8680 with Code 63650 in All Places of Service

In the January 2016 Network Bulletin, UnitedHealthcare announced that effective May 1, 2016 for UnitedHealthcare Medicare Advantage members, the Supply Policy would be enhanced to deny HCPCS code L8680 (Implantable neurostimulator electrode) when billed with CPT code 63650 (Percutaneous implantation of neurostimulator electrode array, epidural) in an office or non-facility place of service. For claims with a date of service on or after Oct. 1, 2018, UnitedHealthcare Medicare Advantage will further align the Supply policy with CMS to deny HCPCS code L8680 when reported in a facility place of service.

New Policy - Intraoperative Neuromonitoring (IONM)

Effective for claims with a date of service on or after Sept. 1, 2018, UnitedHealthcare will implement the Intraoperative Neuromonitoring (IONM) reimbursement policy. The policy will apply to UnitedHealthcare Medicare Advantage and UnitedHealthcare Community Plan Medicare for services reported using the 1500 Health Insurance Claim Form (CMS 1500) its electronic equivalent or successor form.

UnitedHealthcare Medicare Advantage Policy Guideline Updates

UnitedHealthcare Medicare Advantage Coverage Summary Updates

UnitedHealthcare Medicare Advantage

Reimbursement for 340B Drug Pricing Program

We're making some important changes that affect how we reimburse for payable drugs and biological agents purchased through the 340B Drug Pricing Program. These changes align with Centers for Medicare & Medicaid Services (CMS) payment policy.

What You Need to Know

In accordance with CMS guidance:

- Effective Jan. 1, 2018, we're reimbursing separately payable drugs and biological agents purchased through the 340B program at an adjusted amount 22.5 percent less than the average sales price (ASP). These drugs and biologicals are assigned the status indicator "K."
- These changes apply to all eligible care providers who are paid under the Hospital Outpatient Prospective Payment System (OPPS), regardless of whether they participate in our network.
- Claims for separately payable OPPS drugs or biologicals purchased through the 340B program must include the appropriate modifier. CMS has established two HCPCS Level II modifiers to identify 340B-acquired drugs — modifiers "JG" and "TB."

CMS Guidance

CMS has advised that the terms and conditions for payment in provider participation agreements govern the reimbursement of 340B drugs. CMS has also advised that Medicare Advantage plans are required to pay non-contracted providers the rate for 340B drugs that the care provider would receive under Original Medicare. Thus, we've updated our reimbursement methodology to align with CMS' updated rates. In doing so, for our contracted 340B providers that are paid in accordance with CMS payment methodology and who are required by their participation agreements to code and bill in accordance with CMS guidance, as well as non-contracted 340B providers, we expect your claims to comply with CMS requirements by including the necessary modifiers to issue proper reimbursement.

If we receive a claim from a 340B care provider for a separately payable OPPS drug or biological agent appearing on the listing of 340B drugs with a status indicator "K" that doesn't include the appropriate "JG" or "TB" modifier, we'll assume that the claim should be treated as part of the 340B program and the claim will be adjusted as necessary to provide reimbursement at the adjusted, reduced 340B rate. Additionally, we'll pursue recoupment efforts to recover any funds that were paid erroneously for claims previously paid at the unadjusted rate of ASP plus 6 percent.

For more information, please contact your UnitedHealthcare network representative.

UnitedHealthcare Medicare Advantage Reimbursement Policy

Change to Supply Policy — Bundling Code L8680 with Code 63650 in All Places of Service

In the January 2016 Network Bulletin, UnitedHealthcare announced that effective May 1, 2016 for UnitedHealthcare Medicare Advantage members, the Supply Policy would be enhanced to deny HCPCS code L8680 (Implantable neurostimulator electrode) when billed with CPT code 63650 (Percutaneous implantation of neurostimulator electrode array, epidural) in an office or non-facility place of service. This aligned with the Centers for Medicare & Medicaid Services (CMS) incorporating reimbursement for electrodes into the implantation procedure by tripling the non-facility Relative Value Units for code 63650.

For claims with a date of service on or after Oct. 1, 2018, UnitedHealthcare Medicare Advantage and UnitedHealthcare Community Plan Medicare will further align the Supply policy with CMS to deny HCPCS code L8680 when reported in a facility place of service. In alignment with CMS Prospective Payment System, all costs associated with drugs and supplies are considered included in the global payment to the facility and not considered separately reimbursable when reported on a CMS-1500 claim form by a physician or other qualified health care professional in any place of service.

UnitedHealthcare Medicare Advantage Reimbursement Policy

New Policy — Intraoperative Neuromonitoring (IONM)

Effective for claims with a date of service on or after Sept. 1, 2018, UnitedHealthcare will implement the Intraoperative Neuromonitoring (IONM) reimbursement policy. This policy is based on guidance from the American Academy of Neurology (AAN) and the Centers for Medicare & Medicaid Services (CMS). Separate reimbursement for IONM services represented by CPT codes 95940, 95941 and G0453 will only be considered when performed in an inpatient or outpatient hospital place of service (POS) 19, 21 or 22. IONM services reported in any other place of service will be denied.

The IONM Policy will apply to UnitedHealthcare Medicare Advantage and UnitedHealthcare Community Plan Medicare for services reported using the 1500 Health Insurance Claim Form (CMS 1500) its electronic equivalent or successor form.

UnitedHealthcare Medicare Advantage Policy Guideline Updates

The following UnitedHealthcare Medicare Advantage Policy Guidelines have been updated to reflect the most current clinical coverage rules and guidelines developed by the Centers for Medicare & Medicaid Services (CMS). The updated policies are available for your reference at **UHCprovider.com > Menu > Policies and Protocols > Medicare Advantage Policies > Policy Guidelines**.

Policy Title
UPDATED/REVISED (Approved on May 9, 2018)
Air-Fluidized Bed (NCD 280.8)
Arthroscopic Lavage and Arthroscopic Debridement for the Osteoarthritic Knee (NCD 150.9)
Benson-Henry Institute Cardiac Wellness Program (NCD 20.31.3)
Blepharoplasty
Computer Enhanced Perimetry (NCD 80.9)
Cosmetic and Reconstructive Services and Procedures
Deep Brain Stimulation for Essential Tremor and Parkinson's Disease (NCD 160.24)
Endoscopy (NCD 100.2)
Endothelial Cell Photography (NCD 80.8)
Extracranial-Intracranial (EC-IC) Arterial Bypass Surgery (NCD 20.2)
Eylea® (Aflibercept)
Home Prothrombin Time/International Normalized Ratio (PT/INR) Monitoring for Anticoagulation Management (NCD 190.11)
Hospital Beds (NCD 280.7)
Hydrophilic Contact Lenses (NCD 80.4)
INDEPENDENCE iBOT 4000 Mobility System (NCD 280.15)

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UnitedHealthcare Medicare Advantage

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UnitedHealthcare Medicare Advantage Policy Guideline Updates

Policy Title
UPDATED/REVISED (Approved on May 9, 2018)
Intensive Cardiac Rehabilitation (ICR) Programs (NCD 20.31)
Intraocular Lenses (IOLs) (NCD 80.12)
Intraocular Photography (NCD 80.6)
Lucentis® (Ranibizumab)
Mammograms (NCD 220.4)
Ornish Program for Reversing Heart Disease (NCD 20.31.2)
Pressure Reducing Support Surfaces
Scleral Shell (NCD 80.5)
Screening for Cervical Cancer with Human Papillomavirus (HPV) (NCD 210.2.1)
Self-Contained Pacemaker Monitors (NCD 20.8.2)
The Pritikin Program (NCD 20.31.1)
Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (NCD 160.27)
Treatment of Kidney Stones (NCD 230.1)
Urological Supplies
White Cane for Use by a Blind Person (NCD 280.2)

Note: The inclusion of a health service (e.g., test, drug, device or procedure) on this list does not imply that UnitedHealthcare provides coverage for the health service. In the event of an inconsistency or conflict between the information in this bulletin and the posted policy, the provisions of the posted policy prevail.

UnitedHealthcare Medicare Advantage Coverage Summary Updates

For complete details on the policy updates listed in the following table, please refer to the **June 2018 Medicare Advantage Coverage Summary Update Bulletin** at **UHCprovider.com > Menu > Policies and Protocols > Medicare Advantage Policies > Coverage Summaries > Coverage Summary Update Bulletins**.

Policy Title
UPDATED/REVISED (Approved on May 11, 2018)
Ambulance Services
Cardiac Pacemakers and Defibrillators
Computed Tomographic Angiography (CTA)/Electron Beam Computed Tomography (EBCT) of the Chest
Deep Brain Stimulation for Essential Tremor and Parkinson's Disease
Extracorporeal Photopheresis
Gastroesophageal and Gastrointestinal (GI) Services and Procedures
Hospice Services
Laboratory Tests and Services
Lung Volume Reduction Surgery (LVRS)
Medications/Drugs (Outpatient/Part B)
Nutritional Therapy: Enteral and Parenteral Nutritional Therapy
Orthopedic Procedures, Devices and Products
Preventive Health Services and Procedures
Prostate: Services and Procedures
Radiologic Diagnostic Procedures
Varicose Veins Treatment and Other Vein Embolization Procedures

Note: The inclusion of a health service (e.g., test, drug, device or procedure) on this list does not imply that UnitedHealthcare provides coverage for the health service. In the event of an inconsistency or conflict between the information in this bulletin and the posted policy, the provisions of the posted policy prevail.

Doing Business Better

Learn about how we make improved health care decisions.

Member Rights and Responsibilities

Feel free to distribute the following information to your patients about their UnitedHealthcare member rights and responsibilities. If your patients have questions about their rights as UnitedHealthcare members, or need help communicating, such as assistance from a language interpreter, please ask them to call the customer service phone number on the back of their health plan member ID card.

Coordination of Care

Effective care coordination among health care providers requires teamwork based on the principle that all who interact with a patient must work together to help ensure delivery of safe, high-quality care. UnitedHealthcare monitors continuity and coordination of medical care for members across settings or transitions of care, including changes in management of care between practitioners, changes in settings, including inpatient and ambulatory locations, or other changes in which different practitioners partner to provide ongoing care for a member.

Doing Business Better

Member Rights and Responsibilities

Feel free to distribute the following information to your patients about their UnitedHealthcare member rights and responsibilities. If your patients have questions about their rights as UnitedHealthcare members, or need help communicating, such as assistance from a language interpreter, please ask them to call the customer service phone number on the back of their health plan member ID card.

Member Rights and Responsibilities

Members have the right to:

- Be treated with respect and dignity by UnitedHealthcare personnel, network doctors and other health care professionals.
- Privacy and confidentiality for treatments, tests and procedures you receive. See Notice of Privacy Practices in your benefit plan documents for a description of how UnitedHealthcare protects your personal health information.
- Voice concerns about the service and care you receive.
- Register complaints and appeals concerning your health plan and the care provided to you.
- Get timely responses to your concerns.
- Candidly discuss with your doctor the appropriate and medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Access to doctors, health care professionals and other health care facilities.
- Participate in decisions about your care with your doctor and other health care professionals.
- Get and make recommendations regarding the organization’s rights and responsibilities policies.
- Get information about UnitedHealthcare, our services, network doctors and other health care professionals.
- Be informed about, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards, when applicable.
- Choose an Advance Directive to designate the kind of care you wish to receive should you become unable to express your wishes.

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Doing Business Better

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Member Rights and Responsibilities

Members have the responsibility to:

- Know and confirm your benefits before receiving treatment.
- Contact an appropriate health care professional when you have a medical need or concern.
- Show your ID card before receiving health care services.
- Pay any necessary co-payment at the time you receive treatment.
- Use emergency room services only for injuries and illnesses that, in the judgment of a reasonable person, require immediate treatment to avoid jeopardy to life or health.
- Keep scheduled appointments.
- Provide information needed for your care.
- Follow the agreed-upon instructions and guidelines of doctors and health care professionals.
- Participate in understanding your health problems and developing mutually agreed-upon treatment goals.
- Notify your employer of any changes in your address or family status.*
- Log in to **myuhc.com**, or call us, when you have a question about eligibility, benefits, claims and more.
- Log in to myuhc.com, or call us before receiving services to verify that the doctor or health care professional participates in the UnitedHealthcare network.

*For UnitedHealthcare commercial plans only

Coordination of Care

Effective care coordination among health care providers requires teamwork based on the principle that all who interact with a patient must work together to help ensure delivery of safe, high-quality care. UnitedHealthcare monitors continuity and coordination of medical care for members across settings or transitions of care, including changes in management of care between practitioners, changes in settings, including inpatient and ambulatory locations, or other changes in which different practitioners partner to provide ongoing care for a member. Some examples of these care coordination activities, as applicable to line of business, are:

Controlled Substance Monitoring identifies patients who may benefit from having their opioid pain management regimens reviewed and evaluated by their health care provider. Care providers associated with patients identified through this program receive a comprehensive member-specific report that includes the clinical issue of concern, prescription utilization details for the medications involved and recommended action. Care providers are encouraged to contact identified members to discuss and re-evaluate their narcotic pain management regimens and to coordinate appropriate treatment, if indicated.

Timely Postpartum Care can contribute to healthier outcomes for women after delivery and is a measure of quality care. UnitedHealthcare uses HEDIS guidelines to measure postpartum visit compliance. The standard is a postpartum visit on or between 21 and 56 days after delivery. UnitedHealthcare offers interventions such as maternity case management program, Health First Steps program, along with Silverlink automated calls that remind members after delivery to schedule their postpartum appointment.

End Stage Renal Disease (ESRD) Program is designed to improve clinical outcomes for patients with ESRD through coordination between care providers to manage the patient's co-morbid conditions as well as dialysis therapy to improve continuity and clinical outcomes. The program focuses on reducing inpatient hospitalizations, reducing emergency room visits, reducing mortality and improving quality of life.

Diabetic Eye Exam is used to monitor performance for timely screening or monitoring for diabetic retinal disease. UnitedHealthcare uses HEDIS guidelines to measure retinal eye exam measure based on members ages 18–75 with diabetes (type 1 and type 2). Continuity and coordination of medical care is monitored through communication between the diabetic member's primary care physician and the eye care professional performing the dilated retinal exam.

Member and Practitioner Coordination of Care Survey Questions provide valuable information on experience with communication of timely and useful information between multiple treating practitioners and providers.

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Doing Business Better

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Coordination of Care

Why is it important to focus on care coordination?

The Institute of Medicine (IOM) identified care coordination as one of the national priorities for action to improve quality and make care safe, effective, patient centered, timely, efficient and equitable.[1]

UnitedHealthcare agrees — when a patient's health plan and all of their care providers work together closely, it can help increase the chances they're receiving the safest, highest quality of care possible.

Here are some simple ideas for you and your team to consider to help patients feel confident their health care needs are being met.

1. Get the complete picture. Ask your patients to sign an authorization form so you can get their medical records from other clinics or care providers. Remind them to bring in health care paperwork from other specialists, as well as all medications and over-the-counter drugs.

2. Explain recommended tests and pass along results promptly. Thoroughly explain any recommended tests your patient needs. Let them know when and how you'll share their results. When you discuss results, be sure to flag any follow-up care that's needed. If there are any delays in getting the results, proactively let your patient know.

3. Ask patients for their support. Tell your patients you want to be involved in all aspects of their care. Ask them to let you know about any off-site tests and/or visits to a specialist, urgent care or emergency room.

4. Schedule appointments. If required, print out a referral form to help your patients schedule their follow-up appointments. Offer to schedule their next check-up visit before they leave your office.

5. Encourage information sharing. Remind your patients to give your contact information to any other specialists they see. Give them a business card to make this even easier.

[1] Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies

ahrq.gov/downloads/pub/evidence/pdf/caregap/caregap.pdf

UnitedHealthcare Affiliates

Learn about updates with our company partners.

Specialty Pharmacy Requirements for Certain Specialty Medications (Oxford Health Plans Commercial Members) – Effective Oct. 1, 2018

Effective Oct. 1, 2018, for Oxford Health Plan members, participating hospitals in New York, New Jersey and Connecticut will be required to purchase certain multiple sclerosis and anti-inflammatory specialty medications from the specialty pharmacy, BriovaRx. BriovaRx will bill Oxford Health Plans directly for these medications. Hospitals will only need to bill Oxford Health Plans the appropriate code for administration of the medication and should not bill us for the medication itself. ›

OxfordHealth.com Migrating to Optum ID

Soon, we'll migrate provider and facility users of OxfordHealth.com to the Optum ID. The log in screen will temporarily allow you to sign in with either your Optum ID or your Oxford ID; eventually, the Oxford ID option will be removed. ›

Important Reminders for Your Patients in UnitedHealthcare Oxford Commercial Plans

In December 2017, we let care providers know that we would be taking steps to streamline the administrative experience for UnitedHealthcare Oxford commercial plans. These steps have begun and will continue over the next 24 to 36 months as employer groups renew health coverage for their employees. ›

Oxford® Medical and Administrative Policy Updates ›

SignatureValue/UnitedHealthcare Benefits Plan of California Benefit Interpretation Policy Updates ›

SignatureValue/UnitedHealthcare Benefits Plan of California Medical Management Guideline Updates ›

UnitedHealthcare Affiliates

Specialty Pharmacy Requirements for Certain Specialty Medications (Oxford Health Plans Commercial Members) – Effective Oct. 1, 2018

Effective Oct. 1, 2018, for Oxford Health Plan members, participating hospitals in New York, New Jersey and Connecticut will be required to purchase certain multiple sclerosis and anti-inflammatory specialty medications from the specialty pharmacy, BriovaRx. BriovaRx will bill Oxford Health Plans directly for these medications. Hospitals will only need to bill Oxford Health Plans the appropriate code for administration of the medication and should not bill us for the medication itself.

The multiple sclerosis and anti-inflammatory specialty medications impacted by this change are:

JCODE	Brand Name
J2323	Tysabri
J0202	Lemtrada
J2350	Ocrevus
J1745	Remicade
Q5103	Inflectra
Q5104	Renflexis
J3380	Entyvio
J3357/J3358	Stelara
J0129	Orencia
J3262	Actemra
J1602	Simponi Aria
J0717	Cimzia

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UnitedHealthcare Affiliates

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Specialty Pharmacy Requirements for Certain Specialty Medications (Oxford Health Plans Commercial Members) – Effective Oct. 1, 2018

This list of specialty medications is subject to change upon 90 days written notice. This protocol applies to the drugs listed above when dispensed in the outpatient hospital setting of participating hospitals for Oxford Health Plan members.

We anticipate that all hospitals will be able to procure the specialty medications to be administered in an outpatient hospital setting from BriovaRx. Oxford may issue a denial of payment for failure to follow the protocol. Hospitals may not bill members for these medications. A payment policy will prohibit payment to hospitals for these medications unless the hospital has contracted their separately reimbursable drugs at 165% of Centers for Medicare & Medicaid Services (CMS) or less. This protocol does not apply when Medicare or another health benefit plan is the primary payer and Oxford Health Plans is the secondary payer.

UnitedHealthcare Affiliates

OxfordHealth.com Migrating to Optum ID

Soon, we'll begin migrating provider and facility users of OxfordHealth.com to the Optum ID. The log in screen will temporarily allow you to sign in with either your Optum ID or your Oxford ID; eventually, the Oxford ID option will be removed.

If you use Link, you already have an Optum ID and will sign in with that. If you do not have an Optum ID yet, you can create one anytime by going to UHCprovider.com and clicking *Sign In* on the upper right corner of the home page. On the next screen, click on *Create an Optum ID* under *Additional Options*. Soon, you'll be able to start the Optum ID registration from the OxfordHealth.com login page as well.

What's an Optum ID and why do I need one?

Optum specializes in providing health care financial information, tools and solutions and maintains Link for UnitedHealthcare. We are moving toward a single ID and password (Optum ID) for all care provider web users, and Optum ID is already used to sign in to Link and Electronic Payments & Statements (EPS). All OxfordHealth.com users will transition to an Optum ID this year.

What's Link?

Link is UnitedHealthcare's flagship self-service website for care providers. Link tools can quickly provide the comprehensive information you need for most UnitedHealthcare benefit plans without the extra step of calling for information. Learn more about Link apps at UHCprovider.com/Link.

Can I use Link now for UnitedHealthcare Oxford members?

Yes, with some qualifications. UnitedHealthcare Oxford members whose plans renewed after Dec. 1, 2017, have www.uhcprovider.com listed on the back of their ID card. For these members, you'll use Link apps for the functions you used to complete on OxfordHealth.com. Some Link apps can be used for UnitedHealthcare Oxford members whose plans have not renewed yet. To learn more, please visit oxhp-facility.uhc.com/secure/materials/providers/OxfordLinkArticle.pdf.

We're here to help

For more information, call OxfordHealth.com Technical Support at 800-811–0881 from 8 a.m. – 5 p.m. Eastern Time, Monday – Friday.

UnitedHealthcare Affiliates

Important Reminders for Your Patients in UnitedHealthcare Oxford Commercial Plans

In December 2017, we let care providers know that we would be taking steps to streamline the administrative experience for UnitedHealthcare Oxford commercial plans. These steps have begun and will continue over the next 24 to 36 months as employer groups renew health coverage for their employees.

If you have patients whose employers are renewing their health coverage with a UnitedHealthcare Oxford commercial plan, you'll see some differences in their new member identification (ID) card that we want to remind you about:

- The member's ID number will be **11** digits
- The Group Number will change to be **numeric-only**.
- The website listed on the back of the card is www.myuhc.com.

The ERA Payer ID number will not change and will remain **06111**.

When your patients see you for care, ask your staff to:

- Check their eligibility each time they visit your office.
- Include their new member ID number on claims or requests for services that require authorization.
- Use the provider website listed on the back of the member's ID card for secure transactions.

For more information about these changes, use this Quick Reference Guide and share it with your staff. For more information, please call Provider Services at **800-666-1353**. When you call, provide your National Provider Identifier (NPI) number.

UnitedHealthcare Affiliates

Oxford® Medical and Administrative Policy Updates

For complete details on the policy updates listed in the following table, please refer to the June 2018 Policy Update Bulletin at OxfordHealth.com > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > Policy Update Bulletin.

Policy Title	Policy Type	Effective Date
UPDATED/REVISED		
Alpha$_1$-Proteinase Inhibitors	Clinical	July 1, 2018
Assignment of Benefits & Balance Billing	Administrative	July 1, 2018
Assisted Administration of Clotting Factors and Coagulant Blood Products	Clinical	July 1, 2018
Carrier Testing for Genetic Diseases	Clinical	July 1, 2018
Clotting Factors and Coagulant Blood Products	Clinical	July 1, 2018
Cosmetic and Reconstructive Procedures	Clinical	July 1, 2018
Denosumab (Prolia® & Xgeva®)	Clinical	June 1, 2018
Discontinued Procedure (CES)	Reimbursement	July 1, 2018
Drug Coverage Criteria - New and Therapeutic Equivalent Medications	Clinical	July 1, 2018
Drug Coverage Guidelines	Clinical	June 1, 2018
Drug Coverage Guidelines	Clinical	July 1, 2018
Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements	Administrative	July 1, 2018
Gastrointestinal Motility Disorders, Diagnosis and Treatment	Clinical	July 1, 2018
Gynecomastia Treatment	Clinical	June 1, 2018
Injectable Chemotherapy Drugs: Application of NCCN Clinical Practice Guidelines	Clinical	July 1, 2018
Injection and Infusion Services	Reimbursement	June 1, 2018
Intrauterine Fetal Surgery	Clinical	June 1, 2018
Intravenous Enzyme Replacement Therapy (ERT) for Gaucher Disease	Clinical	July 1, 2018
Macular Degeneration Treatment Procedures	Clinical	July 1, 2018
Manipulative Therapy	Clinical	July 1, 2018
Mifeprex® (Mifepristone)	Clinical	June 1, 2018

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UnitedHealthcare Affiliates

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Oxford® Medical and Administrative Policy Updates

Policy Title	Policy Type	Effective Date
Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions	Clinical	July 1, 2018
Occipital Neuralgia and Headache Treatment	Clinical	July 1, 2018
Physical Medicine & Rehabilitation: Multiple Therapy Procedure Reduction	Reimbursement	July 1, 2018
Precertification Exemptions for Outpatient Services	Administrative	July 1, 2018
Preventive Care Services	Clinical	July 1, 2018
Preventive Medicine and Screening	Reimbursement	July 1, 2018
Preventive Medicine and Screening (CES)	Reimbursement	July 1, 2018
Procedure and Place of Service	Reimbursement	June 1, 2018
Prolotherapy for Musculoskeletal Indications	Clinical	June 1, 2018
Radiation Therapy Procedures Requiring Precertification for eviCore healthcare Arrangement	Clinical	July 1, 2018
Radiopharmaceuticals and Contrast Media	Clinical	July 1, 2018
Reduced Services (CES)	Reimbursement	July 1, 2018
Repository Corticotropin Injection (H.P. Acthar Gel®)	Clinical	June 1, 2018
Routine Foot Care	Clinical	July 1, 2018
Specialty Medication Administration - Site of Care Review Guidelines	Clinical	July 1, 2018
Split Surgical Package (CES)	Reimbursement	July 1, 2018
Supply Policy	Reimbursement	July 1, 2018
Transpupillary Thermotherapy	Clinical	June 1, 2018
Trogarzo™ (Ibalizumab-Uiyk)	Clinical	July 1, 2018
White Blood Cell Colony Stimulating Factors	Clinical	July 1, 2018
RETIRED		
Gait Analysis	Clinical	June 1, 2018

Note: The inclusion of a health service (e.g., test, drug, device or procedure) on this list does not imply that Oxford provides coverage for the health service. In the event of an inconsistency or conflict between the information in this bulletin and the posted policy, the provisions of the posted policy prevail.

Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc., Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc.

UnitedHealthcare Affiliates

SignatureValue/UnitedHealthcare Benefits Plan of California Benefit Interpretation Policy Updates

For complete details on the policy updates listed in the following table, please refer to the **June 2018 SignatureValue/UnitedHealthcare Benefits Plan of California Benefit Interpretation Policy Update Bulletin** at **UHCprovider.com > Menu > Policies and Protocols > Commercial Policies > UnitedHealthcare SignatureValue/UnitedHealthcare Benefits Plan of California Benefit Interpretation Policies > Benefit Interpretation Policy Update Bulletins**.

Policy Title	Applicable State(s)	Effective Date
UPDATED/REVISED		
Acquired Brain Injury Services	Texas	June 1, 2018
Cognitive Rehabilitation	All (California, Oklahoma, Oregon, Texas, & Washington)	July 1, 2018
Physician Services: Primary Care and Specialist Visits	All	July 1, 2018
Treatment of Extreme Obesity	All	July 1, 2018
Treatment of Temporomandibular Joint (TMJ) Disorders	All	July 1, 2018
Vision Care and Services	All	July 1, 2018
Weight Gain or Weight Loss Programs	All	July 1, 2018

Note: The inclusion of a health service (e.g., test, drug, device or procedure) on this list does not imply that UnitedHealthcare provides coverage for the health service. In the event of an inconsistency or conflict between the information in this bulletin and the posted policy, the provisions of the posted policy prevail.

UnitedHealthcare Affiliates

SignatureValue/UnitedHealthcare Benefits Plan of California Medical Management Guideline Updates

For complete details on the policy updates listed in the following table, please refer to the June 2018 SignatureValue/UnitedHealthcare Benefits Plan of California Medical Management Guidelines Update Bulletin at UHCprovider.com > Menu > Policies and Protocols > Commercial Policies > UnitedHealthcare SignatureValue/UnitedHealthcare Benefits Plan of California Medical Management Guidelines > Medical Management Guideline Update Bulletins.

Policy Title	Effective Date
UPDATED/REVISED	
Ablative Treatment for Spinal Pain	July 1, 2018
Athletic Pubalgia Surgery	June 1, 2018
Breast Imaging for Screening and Diagnosing Cancer	July 1, 2018
Clinical Practice Guidelines	June 1, 2018
Corneal Hysteresis and Intraocular Pressure Measurement	July 1, 2018
Cosmetic and Reconstructive Procedures	July 1, 2018
Extracorporeal Shock Wave Therapy (ESWT)	July 1, 2018
Gene Expression Tests for Cardiac Indications	June 1, 2018
Gynecomastia Treatment	June 1, 2018
Hip Resurfacing and Replacement Surgery (Arthroplasty)	July 1, 2018
Intensity-Modulated Radiation Therapy	July 1, 2018
Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC)	June 1, 2018
Motorized Spinal Traction	June 1, 2018
Neuropsychological Testing Under the Medical Benefit	June 1, 2018
Preterm Labor Management	June 1, 2018
Preventive Care Services	July 1, 2018
Proton Beam Radiation Therapy	July 1, 2018

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UnitedHealthcare Affiliates

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SignatureValue/UnitedHealthcare Benefits Plan of California Medical Management Guideline Updates

Policy Title	Effective Date
Sodium Hyaluronate	July 1, 2018
Specialty Medication Administration – Site of Care Review Guidelines	July 1, 2018
RETIRED	
Gait Analysis	June 1, 2018

Note: The inclusion of a health service (e.g., test, drug, device or procedure) on this list does not imply that UnitedHealthcare provides coverage for the health service. In the event of an inconsistency or conflict between the information in this bulletin and the posted policy, the provisions of the posted policy prevail.

State News

Stay up to date with the latest state/regional news.

Specialty Pharmacy Requirements for Certain Specialty Medications (Oxford Health Plans Commercial Members) – Effective Oct. 1, 2018

Effective Oct. 1, 2018, for Oxford Health Plan members, participating hospitals in New York, New Jersey and Connecticut will be required to purchase certain multiple sclerosis and anti-inflammatory specialty medications from the specialty pharmacy, BriovaRx. BriovaRx will bill Oxford Health Plans directly for these medications. Hospitals will only need to bill Oxford Health Plans the appropriate code for administration of the medication and should not bill us for the medication itself. ›

Authorization Requirement for Kymriah — Chimeric Antigen Receptor T-Cell (CAR-T) Therapy

Effective Oct. 1, 2018, UnitedHealthcare Community Plan in Iowa will require prior authorization for Kymriah™ (tisagenleuleucel). We'll require prior authorization for Kymriah therapy or related services, including outpatient or inpatient evaluation and the Kymriah outpatient or inpatient episode. ›

State News

Authorization Requirement for Kymriah — Chimeric Antigen Receptor T-Cell (CAR-T) Therapy

Effective Oct. 1, 2018, UnitedHealthcare Community Plan in Iowa will require prior authorization for Kymriah™ (tisagenleuleucel).

For dates of service on or after Oct. 1, 2018, we'll require prior authorization for Kymriah therapy or related services, including outpatient or inpatient evaluation and the Kymriah outpatient or inpatient episode. For dates of service prior to Oct. 1, 2018, we strongly encourage care providers to seek a pre-determination to help ensure coverage.

Coverage reviews for Kymriah will be managed by Optum Transplant Resource Services through the same process as the transplant of tissue or organs. Care providers will be required to contract with Optum Transplant Resource Services to receive prior authorization and bill for Kymriah.

As with all prior authorization requirements, if you provide Kymriah or an any CAR-T related services without first completing the prior authorization process, the claim will be denied. Members can't be billed for services denied due to failure to complete the notification/prior authorization process.

Insurance coverage provided by or through UnitedHealthcare Insurance Company, All Savers Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc., UHC of California DBA UnitedHealthcare of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare of Texas, Inc., UnitedHealthcare Benefits of Texas, Inc., UnitedHealthcare of Utah, Inc. and UnitedHealthcare of Washington, Inc. or other affiliates. Administrative services provided by United HealthCare Services, Inc. OptumRx, OptumHealth Care Solutions, Inc. or its affiliates. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC), United Behavioral Health (UBH) or its affiliates.

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