

JULY 2019

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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We're streamlining the process you use to request medical prior authorization. This fall, we'll retire two more UnitedHealthcare commercial medical prior authorization fax numbers. >

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A pharmacy bulletin outlining upcoming new or revised clinical programs and implementation dates is now available online for UnitedHealthcare commercial plans. >

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OptumRx will begin retiring fax numbers this fall that are used for pharmacy prior authorization requests for all plans managed by OptumRx. This change will help simplify administrative activities for care providers and increase accuracy with prior authorization requests. >

[Letters Available in Document Vault](#)

Find UnitedHealthcare commercial and Medicare Advantage claim letters, notification/prior authorization letters and provider remittance advice in Document Vault. UnitedHealthcare West electronic funds transfer (EFT) payment packages are also available. >

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We're implementing a new required notification/prior authorization process for lower extremity vascular angiograms for UnitedHealthcare commercial, Medicare Advantage and Community Plan members. >



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We make regular updates to our requirements for certain specialty medications to help give UnitedHealthcare members access to quality, medically appropriate medications at the lowest possible cost. >

[Changes in Advance Notification and Prior Authorization Requirements](#)

We're making changes to certain advance notification and prior authorization requirements for UnitedHealthcare Community Plan in Maryland and Texas. >

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We're changing the name of a reimbursement policy that applies to UnitedHealthcare Medicare Advantage and Community Plan and updating the policy to address reimbursement for certain hospital discharge codes. >

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UnitedHealthcare Preferred Lab Network Launches in July

We're pleased to announce the following labs were selected to be part of the Preferred Lab Network effective **July 1, 2019**:

- [AmeriPath /DermPath Diagnostics](#)
- [BioReference](#)
- [GeneDX](#)
- [Invitae Corporation](#)
- [LabCorp](#)
- [Mayo Clinic Laboratories*](#)
- [Quest Diagnostics Inc.](#)

The Preferred Lab Network consists of currently contracted independent, free-standing lab care providers that have met higher standards for access, cost, data, quality and service — based on a rigorous application and review process. We'll work with these distinguished labs to continue our efforts to improve the care provider and member experience.

To make it easy for members and care providers to identify Preferred Lab Network providers, an indicator will appear next to the laboratory in our online directories starting July 1, 2019.



For more information, please visit Preferred Lab Network on [UHCprovider.com](#) > [Reports and Quality Programs](#). You can locate a preferred lab provider using the online directory available on connect.werally.com/plans/uhc.

**Laboratory services billed by Mayo Clinic and Mayo Health System are not included under the Mayo Clinic Laboratories agreement.*

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Medical Policy Updates

Select a **Policy Update Bulletin** from the following list to view complete details of the latest updates.

UnitedHealthcare Commercial & Affiliates

[UnitedHealthcare Medical Policy Update Bulletin: July 2019](#)

[Oxford Policy Update Bulletin: July 2019](#)

[UnitedHealthcare West Benefit Interpretation Policy Update Bulletin: July 2019](#)

[UnitedHealthcare West Medical Management Guideline Update Bulletin: July 2019](#)

UnitedHealthcare Community Plan

[Community Plan Medical Policy Update Bulletin: July 2019](#)

UnitedHealthcare Medicare Advantage

[Medicare Advantage Coverage Summary Update Bulletin: July 2019](#)

[Medicare Advantage Policy Guideline Update Bulletin: July 2019](#)

UnitedHealthcare Dental

[Dental Policy Update Bulletin: July 2019](#)

Medical Policy Update Bulletin Streamlined

We **heard your feedback** and have taken steps to simplify our monthly medical policy updates. To help you find the information you need, the Medical Policy Update Bulletin was reformatted and will now only highlight those policies with changes to coverage guidelines, clinical criteria, and procedure or diagnosis codes.

We're linking to the Medical Policy Update Bulletin in a new, streamlined format beginning with this issue of the Network Bulletin.

We value your comments and are committed to making improvements to our communications.

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Final Phase of Medical Prior Authorization Fax Numbers Will Retire on Oct. 1, 2019

To help make it easier to do business with us, we're streamlining the process you use to request medical prior authorization. The following fax numbers used for medical prior authorization requests for **UnitedHealthcare commercial* plans** will be retired on **Oct. 1, 2019**:

- 877-382-2193
- 866-756-9733

**Massachusetts, Nevada and Texas commercial plans are excluded due to state requirements. A dedicated fax number will be provided for these states at UHCprovider.com/priorauth.*

Submit Your Requests Online

To prepare for this change, please start using the **Prior Authorization and Notification tool** on Link today to submit your requests. The tool on Link is part of the same website you may already use to check eligibility and benefits, manage claims and update your demographic information.

Benefits and Features of Self Service

With the Prior Authorization and Notification tool **you can**:

- **See if prior authorization or notification is required** and **submit a new request** online.
- **Get a reference number**, even when prior authorization or notification isn't required.
- **View medical records requirements** for common services, **add an attachment or medical notes** to a new or existing submission and **make changes** to case information.
- **Check the status** of your requests — even those made over the phone.

Questions?



Go to UHCprovider.com/fax for a list of all retired fax numbers and information about fax numbers used for inpatient admission notifications.

If you haven't used the tool before, we have lots of resources to make it easy for you to get started. Go to UHCprovider.com/paan to get a quick reference guide, watch a short video tutorial or register for a training webinar.



If you're unable to use the Prior Authorization and Notification tool on Link, call Provider Services at **877-842-3210** to submit your medical prior authorization request.

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Final Phase of Medical Prior Authorization Fax Numbers Will Retire on Oct. 1, 2019

Reminder — More Fax Numbers Retiring Soon

Fax numbers used for medical prior authorization requests for UnitedHealthcare West will retire on **Aug. 5, 2019**. In addition, medical prior authorization fax numbers used for seven UnitedHealthcare Community Plans will retire on **Sept. 3, 2019**. Go to UHCprovider.com/fax to see a list of retiring fax numbers.

See How Our Online Tools Are Better Than Faxing

Fax numbers used for prior authorization requests will retire throughout 2019 as we continue looking for ways to put the power of self service in your hands and make it easier to do business with us. Start using our online tools today to submit your requests and see how they're better than faxing.

Learn more about other fax number retiring this fall. [>](#)

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 plans. Go to UHCprovider.com/pharmacy.

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OptumRx to Retire Fax Numbers Used for Pharmacy Prior Authorization

To help simplify administrative activities for care providers and increase the accuracy of prior authorization requests, OptumRx is going digital. Starting Oct. 1, 2019, OptumRx will begin retiring fax numbers used for pharmacy prior authorization requests for all plans managed by OptumRx. We'll send you a faxed notification before the fax number(s) you use are retired.

These fax numbers will be retiring in stages starting Oct. 1:

800-527-0531	855-806-3526
855-806-3524	800-203-1664
855-806-3525	800-382-8135

How to Submit Requests to Us

Instead of faxing, you'll use electronic Prior Authorization (ePA) to submit your pharmacy prior authorization requests. It's easy! Visit professionals.optumrx.com and click on Prior Authorizations to get started. We have online training and phone support to help you.

Questions?

 For more information, call the OptumRx Prior Authorization team at **800-711-4555**.

Letters Available in Document Vault

Did you know that many letters are posted to Document Vault on Link as soon as they're generated? Viewing them online can cut down on mail time and keep your claims moving.

UnitedHealthcare commercial and Medicare Advantage claim letters, notification/prior authorization letters and care provider remittance advice are in Document Vault. UnitedHealthcare West electronic funds transfer (EFT) payment packages are also available. We're looking to add UnitedHealthcare Community Plan letters in the future.

For details about the more than 20 letters that are available now, visit UHCprovider.com/documentvault. Haven't signed up to use Link? Go to UHCprovider.com/newuser to get started. If you have questions, call the UnitedHealthcare Connectivity Help Desk at **866-842-3278**, option 1, Monday through Friday, 7 a.m. to 9 p.m. Central Time.

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Notification/Prior Authorization for Lower Extremity Vascular Angiograms

To help provide UnitedHealthcare members with access to quality care and manage the appropriate use of certain services, we periodically make updates to notification/prior authorization requirements. Effective **Oct. 1, 2019**, we'll have a new required notification/prior authorization process for lower extremity vascular angiograms for UnitedHealthcare commercial, Medicare Advantage and Community Plan members. In Iowa, this change will be effective **Dec. 1, 2019**.

You'll need to complete the notification/prior authorization process when requesting a lower extremity angiogram or intervention for new and existing members for the following CPT® codes:

- **75710:** Angiography, extremity, unilateral, radiological supervision and interpretation
- **75716:** Angiography, extremity, bilateral, radiological supervision and interpretation

Why We're Making this Change

We're making this change to simplify care options for members. Our claims data shows that some care providers are using lower extremity vascular angiograms before using less-invasive diagnostic approaches. According to our policy, lower extremity vascular angiograms may be clinically needed when other forms of imaging lower extremity arteries haven't yielded adequate results.

How to Request Notification/Prior Authorization

Complete the notification/prior authorization process online or by phone:



Online: Go to UHCprovider.com/paan.

This preferred option gives you the option of attaching clinical information and may have the fastest response.



By Phone: Call the Provider Services number on your patient's member health care ID card.

After we receive your request and the required clinical records, we'll review the request and contact both the requesting care provider and member by mail and/or phone with our coverage decision within 15 calendar days from the date of submission, or sooner based on regulation. If coverage is denied, we'll include details in the denial letter on how to appeal.

If a notification/prior authorization isn't completed before performing a procedure, the claim will be denied. Care providers aren't able to bill members for services that are denied due to lack of prior authorization.

Additional Information



For more information about this notification/prior authorization requirement, please review these [frequently asked questions](#). If you have questions, please call Provider Services at the number on the back of the member's ID card.

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Updated Requirements for Specialty Medical Injectable Drugs for UnitedHealthcare Commercial, Medicare Advantage and Community Members

We're committed to providing UnitedHealthcare members with access to quality, medically appropriate medications at the lowest possible cost. As part of this commitment, we make regular updates to our requirements for certain specialty medications for many of our UnitedHealthcare commercial, Medicare Advantage and Community Plan members. These requirements apply to members new to therapy as well as members already receiving these medications. The requirements stated below apply to all applicable billing codes assigned to these drugs, including any Q or C codes assigned by the Centers for Medicare & Medicaid Services (CMS).

We encourage you to check whether a medication is covered before providing services. If you request notification/prior authorization, please wait for our determination before providing services.

UnitedHealthcare Commercial Plan Outpatient Medical Benefit Injectable Medication Prior Authorization Process Change for Certain Specialty Drugs

Effective Oct. 1, 2019, Optum — an affiliate company of UnitedHealthcare — will start managing prior authorization requests for certain medical benefit injectable medications for UnitedHealthcare commercial plan members. This includes the affiliate plans UnitedHealthcare of Mid-Atlantic, Inc., Neighborhood Health Partnership and UnitedHealthcare of the River Valley.

You should continue to request notification/prior authorization for UnitedHealthcare Oxford, UMR, UnitedHealthcare Community Plan and UnitedHealthcare Medicare Advantage members through the existing processes until future notice.

You'll need to use a new process to request a prior authorization once the existing authorization expires or if you change the therapy. Changes in therapy include place of therapy, dose or frequency of administration. Active prior authorizations that were obtained through the current process will remain in place.

The new process is designed to reduce the turnaround time for a determination. The system will document clinical requirements during the intake process and prompt you to provide responses to the clinical criteria questions. Please attach medical records, if requested.

How the New Process Works

You'll submit prior authorization requests online using the Specialty Pharmacy Transactions tool on Link.

- Sign in to Link by going to UHCprovider.com and clicking on the Link button in the top right corner.
- Select the Specialty Pharmacy Transactions tile on your Link dashboard. You will be directed to the new website we're using to process these authorization requests.
- Be sure to attach medical records, if requested.



Learn more at UHCprovider.com/paan.

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

UnitedHealthcare Commercial Plan Outpatient Medical Benefit Injectable Medication Prior Authorization Process Change for Certain Specialty Drugs

Please use the new process when requesting notification/prior authorization for a specialty medication listed under the injectable medications section on the [Enterprise Prior Authorization List](#), or a medication that is required to be provided by BriovaRX® specialty pharmacy according to the UnitedHealthcare Administrative Guide. To view the guide, go to [UHCprovider.com](#) > Menu > Administrative Guides and Manuals > Administrative Guide for Commercial, Medicare Advantage and DSNP > [2019 UnitedHealthcare Administrative Guide](#). You may also contact BriovaRX directly at **855-427-4682** to get help with prior authorization.

Class or Use	Some Drug Examples (Not an All-Inclusive List)
Alpha1-Proteinase Inhibitors	Aralast NP™, Glassia®, Prolastin-C® or Zemaira®
Asthma	Cinqair®, Fasentra™, Nucala® or Xolair®
Blood Modifiers	Soliris® or Ultomiris™
Botulinum Toxins A and B	Botox®, Dysport®, Myobloc® or Xeomin®
Central Nervous System Agents	Spinraza™, Exondys-51®, Onpattro™ or Radicava®
Endocrine	Crysvita® or H.P. Acthar gel®
Enzyme Deficiency	Brineura, Fabrazyme®, Lumizyme® and Revcovi™
Enzyme Replacement Therapy for Gaucher's Disease	Vpriv®, Cerezyme® or Elelyso®
Gonadotropin Releasing Hormone Analogs	Lupron Depot®, Triptodur® and Zoladex®
Gene Therapy	Luxturna™
HIV Agents	Trogarzo™
Immune Globulin	Bivigam®, Gamunex®-C, Gammagard®, HyQvia® and Privigen®
Immunomodulatory Agents	Ilaris®, Benlysta® or Gamifant®
Inflammatory Agents	Remicade®, Entyvio®, Orencia® IV and Ilumya™

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

UnitedHealthcare Commercial Plan Outpatient Medical Benefit Injectable Medication Prior Authorization Process Change for Certain Specialty Drugs

Class or Use	Some Drug Examples (Not an All-Inclusive List)
Multiple Sclerosis Agents	Ocrevus® or Lemtrada®
Neutropenia	Neulasta®, Fulphila® or Udenyca®
Opioid Addiction	Sublocade™ or Probuphine®
Osteoarthritis	Sodium Hyaluronate such as Durolane®, Euflexxa® and Gelsyn-3™
Osteoporosis	Evenity®
RSV Prevention	Synagis®

 | If you have any questions, please call Provider Services at the number on the member’s ID card.

Scope of Changes for UnitedHealthcare Commercial Plans

The following changes and requirements that apply to UnitedHealthcare commercial plans, will include affiliate plans such as UnitedHealthcare of the Mid-Atlantic, Inc., UnitedHealthcare of the River Valley, UnitedHealthcare Oxford, UMR and Neighborhood Health Partnership.

Specialty Medical Injectable Drugs Added to Review at Launch Program

Drug Name	UnitedHealthcare Commercial	UnitedHealthcare Community Plan	UnitedHealthcare Medicare Advantage	Treatment Uses
Zolgensma® (onasemnogene abeparvovec-xioi)	X	X	X	Spinal muscular atrophy
Cutaquig® (Immune Globulin Subcutaneous (Human) - hipp)	X	X		Primary Humoral Immunodeficiency in patients ages 18 and older

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

Specialty Medical Injectable Drugs Added to Review at Launch Program

For the **UnitedHealthcare Commercial Plan** Review at Launch Medication List, go to UHCprovider.com > Policies and Protocols > Commercial Policies > Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans > Review at Launch for New to Market Medications > [Review at Launch Medication List](#).

For the **UnitedHealthcare Community Plan** Review at Launch Medication List, go to UHCprovider.com > Policies and Protocols > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan > Review at Launch for New to Market Medications > [Review at Launch Medication List](#).

For **Medicare Advantage**, Review at Launch drugs are added as a Review at Launch Part B Medication in the Medications/Drugs (Outpatient/Part B) Coverage Summary. Go to UHCprovider.com > Policies and Protocols > Medicare Advantage Policies > Coverage Summaries for Medicare Advantage Plans > [Medications/Drugs \(Outpatient/Part B\) – Medicare Advantage Coverage Summary](#) > Attachment A: Guideline 5 – Other Examples of Specific Drugs/Medications.

Drugs Requiring Notification/Prior Authorization

Drug Name	Effective Date	UnitedHealthcare Commercial	UnitedHealthcare Community Plan	UnitedHealthcare Medicare Advantage	Treatment Uses	Summary of Changes
Asceniv™ (Immune Globulin Intravenous, Human – slra) 10% Liquid	Oct. 1, 2019	X	X		Used to treat Primary Humoral Immunodeficiency in patients ages 12 and older	Code J1599 already requires notification/prior authorization. Asceniv is new to market.
Cutaquig (Immune Globulin Subcutaneous (Human) - hipp). 16.5% solution	Oct. 1, 2019	X			Used to treat osteoporosis in patients with a high risk of fracture	Notification/prior authorization required.
Evenity (romosozumab-aqqg)	Oct. 1, 2019	X	X		Used to treat osteoporosis in patients with a high risk of fracture	Notification/prior authorization required.

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

Drugs Requiring Notification/Prior Authorization

Drug Name	Effective Date	UnitedHealthcare Commercial	UnitedHealthcare Community Plan	UnitedHealthcare Medicare Advantage	Treatment Uses	Summary of Changes
Jivi® (antihemophilic factor (recombinant) PEGylated-aucl)	Oct. 1, 2019	X			Used in previously treated adults and adolescents with hemophilia A for the on-demand treatment of acute bleeding episodes, perioperative management of bleeding and for the routine prophylaxis	Notification /prior authorization required.
Sodium Hyaluronate Derivatives	Oct. 1, 2019	X	X	X - Refer to current Prior Authorization Requirements for Medicare Advantage	Used for treatment of pain due to osteoarthritis of the knee	Notification/prior authorization required for the non-preferred products. The preferred products that don't require prior authorization are: Durolane, Euflexxa, Gelsyn. See medical policy for more information.

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

Drugs Requiring Notification/Prior Authorization

Drug Name	Effective Date	UnitedHealthcare Commercial	UnitedHealthcare Community Plan	UnitedHealthcare Medicare Advantage	Treatment Uses	Summary of Changes
Spravato™ (esketamine)	Oct. 1, 2019	X	X		Used for treatment resistant depression	Notification /prior authorization required.
White Blood Cell Colony Stimulating Factors – Long Acting Products Fulphila, Neulasta, Udenyca	Oct. 1, 2019		X		Used to treat neutropenia	Notification/prior authorization for both cancer and non-cancer related conditions effective Oct. 1, 2019.
White Blood Cell Colony Stimulating Factors – Short Acting Products Granix®, Neupogen®, Nivestym™, Zarxio®	Oct. 1, 2019	X	X		Used to treat neutropenia	Notification/prior authorization for both cancer and non-cancer related conditions effective Oct. 1, 2019.
Zolgensma (onasemnogene abeparvovec-xioi)	Oct. 1, 2019	X	X	X	Used to treat spinal muscular atrophy	Notification/prior authorization required.

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

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.

For UnitedHealthcare Community Plan members, coverage 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.

New Procedure Codes for Injectable Medications – Effective July 1, 2019

Based on updates from CMS, new procedure codes will become effective July 1, 2019, for certain injectable medications. 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:

- Gamifant® – C9050
- Ultomiris – C9052

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

Changes to our Drug Policies

Drug Name	Effective Date	UnitedHealthcare Commercial	UnitedHealthcare Community Plan	UnitedHealthcare Medicare Advantage	Treatment Uses	Summary of Changes
Infliximab (Remicade®, Inflectra®, Renflexis®)	Oct. 1, 2019	X			Used to treat Crohns disease, ulcerative colitis, rheumatoid arthritis, ankylosing spondylitis, psoriatic arthritis and plaque psoriasis	Policy update Oct. 1, 2019. We'll no longer require the use of Remicade prior to coverage for Inflectra. As part of the notification/prior authorization review, we'll require documentation to support the clinical requirement that members must try both Inflectra and Remicade, experience an adverse reaction, or have a contradiction to Inflectra and Remicade in order to receive coverage approval for Renflexis.

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

Changes to our Drug Policies

Drug Name	Effective Date	UnitedHealthcare Commercial	UnitedHealthcare Community Plan	UnitedHealthcare Medicare Advantage	Treatment Uses	Summary of Changes
Infliximab (Remicade®) , Inflectra® , Renflexis®) (continued)	Oct. 1, 2019	X			Used to treat Crohns disease, ulcerative colitis, rheumatoid arthritis, ankylosing spondylitis, psoriatic arthritis and plaque psoriasis	Notification/prior authorization for Remicade is required when administered in an outpatient hospital setting. Notification/prior authorization for Inflectra is required when administered in an outpatient hospital, office or home setting.
White Blood Cell Colony Stimulating Factors – Short Acting Products Granix, Neupogen, Nivestym, Zarxio	Oct. 1, 2019	X	X		Used to treat neutropenia	Policy update Oct. 1, 2019. Policy includes preferred product coverage criteria. Zarxio must be used prior to the use of Neupogen, Granix or Nyvestim.

Upon prior authorization renewal, the updated policy will apply. UnitedHealthcare will honor all approved prior authorizations on file until the end date on the authorization or the date the member’s eligibility changes. You don’t need to submit a new notification/prior authorization request for members who already have an authorization for these medications on Oct. 1, 2019.

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Changes in Advance Notification and Prior Authorization Requirements

We’re making changes to advance notification and prior authorization requirements for certain plans as part of our ongoing responsibility to evaluate our medical policies, clinical programs and health benefits compared to the latest scientific evidence and specialty society guidance. Using evidence-based medicine to guide coverage decisions supports quality patient care and reflects our shared commitment to the Triple Aim of better care, better health outcomes and lower costs.

Code Additions to Prior Authorization Categories

Effective for dates of service on or after **Oct. 1, 2019**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Maryland (Medicaid Plan)**:

Category	Codes
Cochlear and Other Auditory Implants	L8627, L8628, L8693, L8694
Hearing Aid Services	V5171, V5172, V5181, V5211, V5212, V5213, V5214, V5215, V5221, V5267

Effective for dates of service on or after **Oct. 1, 2019**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan Texas (STAR+PLUS)**:

Category	Codes
Outpatient Therapy	S9128, S9129, S9131

Effective for dates of service on or after **Oct. 1, 2019**, the following procedure codes will require prior authorization for **UnitedHealthcare Community Plan of Texas**. This includes Children’s Health Insurance Plan (CHIP), STAR, STAR Kids and STAR+PLUS plans:

Category	Codes
Psychological Testing	96116, 96121, 96132, 96133, 96130, 96131, 96136, 96137

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Changes in Advance Notification and Prior Authorization Requirements

Code Removals from Existing Prior Authorization Categories

Although prior authorization requirements are being removed for certain codes, post-service determinations may still be applicable based on criteria published in medical policies, local/national coverage determination criteria and/or state fee schedule coverage.

Effective for dates of service on or after **Oct. 1, 2019**, the following codes will **not** require prior authorization for **UnitedHealthcare Community Plan of Maryland (Medicaid)**:

Category	Codes
Hearing Aid Services	V5170, V5180, V5210, V5220

Effective for dates of service on or after **Oct. 1, 2019**, the following procedure codes will **not** require prior authorization for **UnitedHealthcare Community Plan of Texas (STAR+PLUS)**:

Category	Codes
Outpatient Therapy	97537, G0515
Home Health Care	S9124

Effective for dates of service on or after **Oct. 1, 2019**, the following codes will **not** require prior authorization for **UnitedHealthcare Community Plan of Texas (STAR Kids)**:

Category	Codes
Home Health Care	G0162



For the most updated advance notification lists and prior authorization requirements, go to UHCProvider.com/priorauth.

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Name Change and Code Update for Change for Evaluation and Management (E/M) Policy, Professional

Effective Aug. 1, 2019, we're changing the name of a reimbursement policy that applies to UnitedHealthcare Medicare Advantage and UnitedHealthcare Community Plan — **Evaluation and Management (E/M) Policy, Professional** — to align with the Centers for Medicare & Medicaid Services (CMS).

Name Change

The new policy name will be **M&R Observation and Discharge Policy, Professional**.

Discharge Code Update

This policy will also be changed to address reimbursement for discharge codes 99238 and 99239. According to CMS guidelines, "The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified non-physician practitioner even if the patient is discharged from the facility on a different calendar date. Only one hospital discharge day management service is payable per patient per hospital stay."

To be consistent with CMS guidelines, we are updating our policy to allow only one hospital discharge day management service per patient per hospital stay regardless of tax ID number. This policy change applies to services reported using the CMS-1500 paper form, its successor form or the CMS-1500 form electronic equivalent.

Learn More



For more information about hospital discharge day management, go to [cms.gov](https://www.cms.gov) > Regulations & Guidance > Manuals > [Medicare Claims Processing Manual, Chapter 12 – Physicians/Nonphysician Practitioners](#).



UnitedHealthcare Commercial

Learn about program revisions
and requirement updates.

[Online and Mobile Tool Enhancements to Find Care & Costs](#)

We've updated myuhc.com® to integrate cost-estimating tools into the Find Care & Costs section. >

[Site of Service Reviews for Certain Musculoskeletal Surgical Procedures \(Arthroscopic and Foot Surgery\) – Revised Effective Date for Certain States](#)

The new launch date for site of service medical necessity reviews for certain musculoskeletal surgical procedures (arthroscopic and foot surgery) in Colorado, Connecticut, New Jersey and New York is now Oct. 1, 2019. >

[Notification/Prior Authorization for Cardiac Event Monitoring](#)

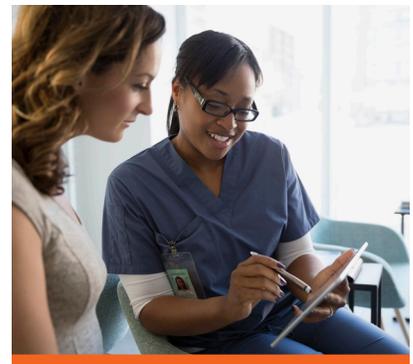
We're introducing a required notification/prior authorization process for implantable cardiac monitors. >

[Updates to Optum Neonatal Resource Services Guidelines](#)

The Neonatal Resource Services Clinical Guidelines is being updated based on current clinical evidence-based medicine. >

[Risk Adjustment Data Validation Audit Program for UnitedHealthcare Commercial Members](#)

We're requesting medical records for specific 2018 service dates to comply with the Risk Adjustment Data Validation audit program under the Affordable Care Act. >



[UnitedHealth Premium® Program Version 12 Evaluation Notices](#)

UnitedHealth Premium annual evaluation notices will begin arriving in early July. >

[UnitedHealthcare Commercial](#)

Online and Mobile Tool Enhancements to Find Care & Costs

To help UnitedHealthcare commercial members make informed choices about their health care, we've updated [myuhc.com](#)[®] to integrate cost estimating tools into the Find Care & Costs section. This integration simplifies searching for network care providers and viewing health care cost estimates on myuhc.com. The Find Care & Costs tool helps our members work with you to make confident, informed decisions about their care using cost and quality information.

Member cost estimates are care provider specific. To review your cost estimate data and a description of the methodology used for the Find Care & Costs member tools, please contact your UnitedHealthcare Network Management representative or your Provider Advocate.

Also, please notify your local Network Management team promptly with updates about care providers leaving the practice, demographic changes and change of ownership for your organization, as required by your contract.

California Care Providers

Pursuant to Section 1367.49 of the California Health and Safety Code and Section 10133.64 of the California Insurance Code, you have the opportunity to receive your cost estimate data and a description of the UnitedHealthcare methodology for the Find Care & Costs section. Please contact your UnitedHealthcare Network Management Representative or Provider Advocate for that information or to notify us if you'd like to add a link to a response to the Find Care & Costs display.

[UnitedHealthcare Commercial](#)

Site of Service Reviews for Certain Musculoskeletal Surgical Procedures (Arthroscopic and Foot Surgery) — Revised Effective Date for Certain States

In the June 2019 Network Bulletin, we announced that for certain musculoskeletal surgical procedures (arthroscopic and foot surgery), there will be a medical necessity review for the site of service for UnitedHealthcare commercial plans, which includes UnitedHealthcare Oxford, UnitedHealthcare of the Mid-Atlantic, Inc., MAMSI Life and Health Insurance Company, Optimum Choice, Inc. and MD Individual Practice Association, Inc. The new launch date for Colorado, Connecticut, New Jersey and New York will be **Oct. 1, 2019**.



For frequently asked questions about the reviews, go to [UHCprovider.com > Prior Authorization and Notification > Additional Resources > **Site of Service for Certain Musculoskeletal Surgical Procedures \(Arthroscopic and Foot Surgery\)**](#). For additional details about the reviews, go to the June 2019 Network Bulletin article on [UHCprovider.com > Menu > Resource Library > News and Network Bulletin > **June 2019 Network Bulletin**](#).

[UnitedHealthcare Commercial](#)

Notification/Prior Authorization for Cardiac Event Monitoring

Effective **Oct. 1, 2019**, we're introducing a required notification/prior authorization process for implantable cardiac monitors for UnitedHealthcare commercial members. In Iowa, this change will be effective Dec. 1, 2019.

You'll need to complete the notification/prior authorization process when requesting an implantable cardiac monitor for new and existing UnitedHealthcare commercial members for the following CPT codes:

- **33285:** Insertion, subcutaneous cardiac rhythm monitor
- **E0616:** Implantable cardiac event recorder

External cardiac monitoring will be required **before** an implantable monitor is approved. If a notification/prior authorization isn't completed before performing a procedure, the claim will be denied. Members can't be billed for services denied due to lack of prior authorization.

Why We're Making this Change

We're making this change as part of an ongoing effort to improve health care quality and affordability for members while managing the appropriate use of certain services. Our claims data shows that some care providers are using the implantable monitoring devices before using less-invasive external monitors. According to our policy, an implantable monitor may be clinically needed when other forms of external monitors haven't yielded adequate results.

How to Request Notification/Prior Authorization

You can complete the notification/prior authorization process:

- **Online:** Go to UHCprovider.com/paan. This preferred option gives you the option of attaching clinical information and may help give you and your patient the fastest results.
- **By Phone:** Call the Provider Services number on your patient's member health care ID card.

After we receive your request and the required clinical records, we'll review the request and contact both the requesting care provider and member by mail and phone with our coverage decision within 15 calendar days from the date of submission or sooner based on regulations. If coverage is denied, details on how to appeal will be provided in the letter.

Additional Information



For more information about this notification/prior authorization requirement, please review these [frequently asked questions](#). If you have questions, please call Provider Services at the number on the back of the member's ID card.

[UnitedHealthcare Commercial](#)

Updates to Optum Neonatal Resource Services Guidelines

To help ensure our guidelines remain up-to-date with current clinical evidence-based medicine, we regularly review them with a panel of medical experts. Based on our most recent review, we're making the following changes to the Neonatal Resource Services (NRS) Clinical Guidelines effective Sept. 29, 2019:

- **Apnea and Bradycardia:** The observation period following discontinuation of caffeine was revised from five to seven days, to five days for the majority of preterm infants. The statement regarding a seven-day apnea countdown for infants born at less than 30 weeks gestation was removed from the guidelines. The statement regarding methylxanthines for central apnea was removed.
- **Discharge Planning:** We revised the amount of acceptable weight loss and thresholds for glucose levels related to hypoglycemia. Information regarding a fasting glucose challenge test was added. The statement regarding a seven-day apnea countdown for infants born at less than 30 weeks gestation was removed.
- **Early-Onset Neonatal Sepsis:** The criteria for Early-Onset Neonatal Sepsis was revised to correlate with recent recommendations from the American Academy of Pediatrics. Previous Centers for Disease Control and Prevention (CDC) recommendations were removed from the guidelines. The criteria allowing extended antibiotic treatment based on persistently abnormal lab data was removed. Statements about infants at highest risk for Early-Onset Neonatal Sepsis, close outpatient follow-up after early discharge and discontinuation of antibiotics for negative blood cultures at 36 hours of incubation were added to the guidelines.
- **Feeding the Neonate:** First feeding timing guidelines were revised from 24-48 hours after birth to as early as possible within the first 24 hours of birth. Additional information regarding the positive benefits of maternal milk for preterm infants is provided. Please see the Discharge Planning guidelines for updated information about glucose levels related to hypoglycemia.
- **Neonatal Abstinence Syndrome (NAS):** Neonatal Abstinence Syndrome is now also called Neonatal Opioid Withdrawal Syndrome. Information about the Eating, Sleeping, Consoling protocol, use of standardized analgesic protocols and studies that show the positive benefits of methadone over morphine were added to the guidelines. Guidance on selective serotonin reuptake inhibitors use was consolidated with this update.



To review the updated guidelines, go to [UHCprovider.com](https://www.uhcprovider.com) > Policies and Protocols > [Clinical Guidelines](#).

[UnitedHealthcare Commercial](#)

Risk Adjustment Data Validation Audit Program for UnitedHealthcare Commercial Members

To comply with the Risk Adjustment Data Validation (RADV) audit program under the Affordable Care Act (ACA), we are required by the Department of Health and Human Services (HHS) to provide supporting medical documentation that will be used for the annual medical claims review audit for commercial members.

We started requesting medical records in June 2019 for specific 2018 service dates. Since a sample of enrollees will be randomly selected for the audit, not all care providers will receive this request.

UnitedHealthcare is using CIOX Health, a health care information management company, to conduct the request for medical records. CIOX Health can be reached at 877-445-9293. CIOX has a new fast, easy and secure way to electronically submit medical records. Go to cioxlink.com for a short video tutorial.

If you received the medical record request from CIOX Health, please include only the minimum necessary documentation in accordance with the Health Insurance Portability and Accountability Act (HIPAA). This includes the following:

- Demographics sheet
- Progress notes from face-to-face office visits
- Consultation reports and notes
- Discharge summary
- Emergency room records
- History and physical exam
- Medication list
- Operative and procedure notes
- Prescription(s) for laboratory services
- Problem list
- Radiology and Pathology Services
- Radiology reports

[UnitedHealthcare Commercial](#)

UnitedHealth Premium[®] Program Version 12 Evaluation Notices

UnitedHealth Premium annual evaluation notices will begin arriving in early July. The letters include instructions for viewing designation details at UnitedHealthPremium.UHC.com. You can also access the Premium program site on Link by going to UHCprovider.com and clicking on the Link button in the top right corner. If you aren't registered for Link, visit UHCprovider.com and select New User in the top right corner.

Learn More



For more information about the Premium program, go to UnitedHealthPremium.UHC.com or call **866-270-5588**.





UnitedHealthcare Reimbursement Policies

Learn about policy changes and updates.

[UnitedHealthcare
Commercial
Reimbursement Policy
Updates >](#)

[UnitedHealthcare
Community Plan
Reimbursement Policy:](#)

Reimbursement policies that apply to UnitedHealthcare Community Plan members are located here: [UHCprovider.com > Menu > Health Plans by State > \[Select State\]](#) > “View Offered Plan Information” under the Medicaid (Community Plan) section > Bulletins and Newsletters. We encourage you to regularly visit this site to view reimbursement policy updates.

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 Reimbursement Policies](#)

UnitedHealthcare Commercial Reimbursement Policy Updates

UnitedHealthcare Commercial Reimbursement Policy Updates

The following chart contains an overview of the policy changes and their effective dates for the following policies:

Policy	Effective Date	Summary of Change
Consultation Services Policy, Professional	Oct. 1, 2019	<ul style="list-style-type: none"> • UnitedHealthcare continues to move forward with the reimbursement change affecting consultation CPT codes 99241-99255 when billed by any health care professional or medical practice. • The first phase of deployment of the Consultation Services Policy enhancement was effective with dates of service on and after June 1, 2019, for care providers with stated year fee schedules of 2010 or later using Centers for Medicare & Medicaid Services (CMS) Relative Value Units (RVU) basis. • Care providers with questions or those on older fee schedules (2009 and prior) who wish to move to more current fee schedules may reach out to their UnitedHealth Network representative. • Consultation services may still be reimbursed when billed in accordance with the Preventive Care Services Coverage Determination Guideline for services such as lactation counseling. • With respect to telehealth and telemedicine services, the Telehealth and Telemedicine Policy will continue to apply, and Healthcare Common Procedure Coding System (HCPCS) codes G0406 -G0408, G0425-G0427, G0508 and G0509 will be payable pursuant to that policy, the participation agreement and the member’s benefit plan.

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[UnitedHealthcare Reimbursement Policies](#)

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UnitedHealthcare Commercial Reimbursement Policy Updates

Policy	Effective Date	Summary of Change
Intraoperative Neuromonitoring Policy (IONM)	Oct. 1, 2019	<ul style="list-style-type: none"> On or after Oct. 1, 2019, dates of processing, the following update to the Intraoperative Neuromonitoring Policy will be effective. Technologists will no longer be reimbursed for intraoperative neurophysiologic monitoring and baseline neurophysiologic study services reported in place of service (POS) 24, Ambulatory Surgical Center (ASC). Consistent with CMS, payment for the services of a monitoring technologist is included in the payment to the ASC. To view the applicable codes, please refer to the Intraoperative Neurophysiology section in the American Medical Association CPT manual, beginning with code 95940, and the HCPCS Level II manual, code G0453. As a reminder, per UnitedHealthcare’s Replacement Codes policy, IONM code 95941 is considered invalid for reimbursement purposes.
Procedure to Modifier Policy, Professional	Sept. 1, 2019	<ul style="list-style-type: none"> Effective with dates of service on or after Sept. 1, 2019, the GN, GO or GP modifiers will be required on “Always Therapy” codes to align with CMS. According to CMS, certain codes are “Always Therapy” services regardless of who performs them, and always require a therapy modifier (GP, GO, or GN) to indicate that they are provided under a physical therapy, occupational therapy or speech-language pathology plan of care. Always Therapy” modifiers are necessary to enable accurate reimbursement for each distinct type of therapy in accordance with member group benefits.



UnitedHealthcare Community Plan

Learn about Medicaid coverage changes and updates.

[UnitedHealthcare Community Plan 3rd Quarter 2019 Preferred Drug List](#)

The Preferred Drug List (PDL) is updated quarterly by our Pharmacy and Therapeutics Committee. >

[Concurrent Drug Utilization Review](#)

We're making additional Concurrent Drug Utilization Review safety edits to help increase patient safety with medications, and prevent abuse and fraudulent activity. >

[Updates to Requirements for Prior Authorization for Post-Acute Inpatient Care](#)

Facilities providing post-acute inpatient services will need to request prior authorization and receive an approval before a member can be admitted to a post-acute care facility or a post-acute care bed in a facility. >

[Update to UnitedHealthcare Genetic and Molecular Lab Testing Notification/Prior Authorization Requirement in Pennsylvania](#)

Prior authorization/notification for genetic and molecular lab testing is now effective Sept. 1, 2019, for UnitedHealthcare Community Plan members in Pennsylvania. >

[Outpatient Injectable Drug Prior Authorization Requirements for Michigan](#)

Prior authorization requirements for certain injectable drugs are being updated for UnitedHealthcare Community Plan members in Michigan. >

[Prior Authorization Change for Referrals and Services at Out-of-State and Out-of-Network Care Providers for New Jersey](#)

UnitedHealthcare Community Plan of New Jersey will require prior authorization for referrals and services at out-of-state and out-of-network care providers. >

[Sleep Study Prior Authorization Requirement Effective Oct. 1, 2019](#)

There will be a new required notification/prior authorization process for sleep studies performed in an outpatient hospital setting in certain states. >

[Speech, Occupational and Physical Therapy Services – Site of Service Review and Prior Authorization Updates for Select States](#)

We're going to require prior authorization for either speech, occupational and/or physical therapy services in select states. >

[UnitedHealthcare Community Plan](#)

UnitedHealthcare Community Plan 3rd Quarter 2019 Preferred Drug List

UnitedHealthcare Community Plan's Preferred Drug List (PDL) is updated quarterly by our Pharmacy and Therapeutics Committee. Please review the changes and update your references as necessary. Not all medications will be added, modified or deleted in each state, so please check the state's PDL for a state-specific list of preferred drugs. You may also view the changes at UHCprovider.com > Menu > [Health Plans by State](#) and then select your state.

We provided a list of available alternatives to UnitedHealthcare Community Plan members whose current treatment includes a medication removed from the PDL. Please provide affected members a prescription for a preferred alternative in one of the following ways:

- Call or fax the pharmacy.
- Use e-Script.
- Write a new prescription and give it to the member.

If a preferred alternative is not appropriate, call **800-310-6826** for prior authorization for the UnitedHealthcare Community Plan member to remain on their current medication.

Changes will be effective July 1, 2019, for Arizona, California, Florida – Florida Healthy Kids, Hawaii, Maryland, Mississippi, Nebraska, Nevada, New Jersey, New York, Ohio, Pennsylvania, Rhode Island and Virginia.

These changes don't apply to UnitedHealthcare Community Plans in Florida Managed Medicaid, Iowa, Kansas, Louisiana, Michigan, Texas and Washington.

PDL Additions

Brand Name	Generic Name	Comments
AquADEKs™	Multiple vitamin chewable tablet and drops	Indicated for the treatment or prevention of low levels of fat soluble nutrients and antioxidants in patients with cystic fibrosis; diagnosis required.
Daurismo™	Glasdegib tablet	Indicated for the treatment of newly diagnosed acute myeloid leukemia; prior authorization required. Available through specialty pharmacy.
Delstrigo™	Doravirine/lamivudine/tenofovir disoproxil tablet	Indicated for the treatment of HIV-1 infection; diagnosis required.
Krintafel®	Tafenoquine tablet	Indicated for the radical cure (prevention of relapse) of <i>Plasmodium vivax</i> malaria.
Perseris™	Risperidone injection	Indicated for the treatment of schizophrenia; prior authorization required.

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[UnitedHealthcare Community Plan](#)

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UnitedHealthcare Community Plan 3rd Quarter 2019 Preferred Drug List

Brand Name	Generic Name	Comments
Retacrit™	Epoetin alfa-epbx injection	Indicated for the treatment of anemia; prior authorization required. Available through specialty pharmacy.
Tegsedi™	Inotersen injection	Indicated for the treatment of polyneuropathy of hereditary transthyretin-mediated amyloidosis (hATTR); prior authorization required. Available through specialty pharmacy.
Vitakvi®	Larotrectinib capsule and oral solution	Indicated for the treatment of solid tumors with a neurotrophic receptor tyrosine kinase (NTRK) gene fusion; prior authorization required. Available through specialty pharmacy.

Removed from PDL

Brand Name	Generic Name	Comments
Absorica®	Isotretinoin capsule	Amnesteem®, Claravis™ and Myorisan™ are alternate options; members currently using medication will be allowed to continue therapy until their existing prior authorization expires.
N/A	Alclometasone dipropionate 0.05% cream	Alclometasone dipropionate ointment 0.05% and triamcinolone acetonide cream 0.025% are alternate options; members currently using medication will not be grandfathered.
N/A	Betamethasone dipropionate 0.05% cream	Betamethasone valerate ointment 0.1%, fluocinonide emulsified base cream 0.05%, fluticasone propionate ointment 0.005%, mometasone furoate ointment 0.1% and triamcinolone acetonide cream 0.5% are alternate options; members currently using medication will not be grandfathered.
Epogen®	Epoetin alfa injection	Retacrit is an alternate option; members currently using medication will not be grandfathered.
N/A	Fluocinolone acetonide 0.01% cream	Alclometasone dipropionate ointment 0.05% and triamcinolone acetonide cream 0.025% are alternate options; members currently using medication will not be grandfathered.
N/A	Fluocinonide 0.05% cream	Betamethasone augmented dipropionate cream 0.05%, betamethasone dipropionate ointment 0.05% and fluocinonide solution 0.05%; members currently using medication will not be grandfathered.

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[UnitedHealthcare Community Plan](#)

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UnitedHealthcare Community Plan 3rd Quarter 2019 Preferred Drug List

Brand Name	Generic Name	Comments
N/A	Fluocinonide 0.05% ointment	Betamethasone augmented dipropionate cream 0.05%, betamethasone dipropionate ointment 0.05% and fluocinonide solution 0.05%; members currently using medication will not be grandfathered.
N/A	Fluocinonide 0.05% gel	Betamethasone augmented dipropionate cream 0.05%, betamethasone dipropionate ointment 0.05% and fluocinonide solution 0.05%; members currently using medication will not be grandfathered.
N/A	Hydrocortisone butyrate 0.1% cream	Betamethasone valerate cream 0.1%, fluticasone propionate cream 0.05%, hydrocortisone butyrate ointment 0.1%, hydrocortisone butyrate solution 0.1% and triamcinolone acetonide lotion 0.1%; members currently using medication will not be grandfathered.
N/A	Hydrocortisone valerate 0.2% cream	Betamethasone valerate cream 0.1%, fluticasone propionate cream 0.05%, hydrocortisone butyrate ointment 0.1%, hydrocortisone butyrate solution 0.1% and triamcinolone acetonide lotion 0.1%; members currently using medication will not be grandfathered.
Miralax® single dose packet	Polyethylene glycol (PEG 3350) packets	Polyethylene glycol (PEG 3350) powder bottle is an alternate option; members currently using medication will not be grandfathered.
Premarin®	Conjugated estrogen vaginal cream	Estradiol vaginal cream is an alternate option; members currently using medication will not be grandfathered.
Procrit®	Epoetin alfa injection	Retacrit is an alternate option; members currently using medication will not be grandfathered.
Udenyca™	Pegfligrastim-cbqv injection	Neulasta is an alternate option; members currently using medication will be grandfathered.

Modifications will be effective July 1, 2019, for Arizona, California, Florida – Florida Healthy Kids, Hawaii, Maryland, Michigan, Nevada, New Jersey, New York, Ohio, Pennsylvania, Rhode Island and Washington.

These changes don't apply to UnitedHealthcare Community Plans in Florida Managed Medicaid, Iowa, Kansas, Louisiana, Mississippi, Nebraska, Texas and Virginia.

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[UnitedHealthcare Community Plan](#)

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UnitedHealthcare Community Plan 3rd Quarter 2019 Preferred Drug List

PDL Modifications

Brand Name	Generic Name	Comments
Duexis®	Ibuprofen and famotidine tablet	Prior authorization required; diclofenac, etodolac, ibuprofen, meloxicam, nabumetone, naproxen, famotidine or ranitidine are alternate options covered as separate agents. Members currently using medication in California, Rhode Island and Pennsylvania will be allowed to continue until their existing prior authorization expires.
Vimovo®	Naproxen and esomeprazole tablet	Prior authorization required; diclofenac, etodolac, ibuprofen, meloxicam, nabumetone, naproxen, lansoprazole, omeprazole capsules or pantoprazole are alternate options covered as separate agents. Members currently using medication in California, Rhode Island and Pennsylvania will be allowed to continue therapy until their existing prior authorization expires.

PDL Update Training on UHC On Air



Learn more about PDL updates by watching a UHC On Air video highlighting this quarter's significant PDL changes. You can access the video by going to UHCprovider.com and clicking on the Link button in the top right corner. Then, choose the UHC On Air tile from your Link dashboard. If you don't have access to Link, select the New User button on UHCprovider.com.



If you have questions, please call our Pharmacy Department at **800-310-6826**.

[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, the pharmacist will be alerted of a drug-drug interaction, therapeutic duplication or high dose for certain drug classes. 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.

Safety edits will be implemented on **Aug. 1, 2019**, in the pharmacy systems to review the member's current medications for the following:

- **Therapeutic Duplication:** Identifies potential duplications to prevent members from taking more than one drug in the same drug class.
- **Theradose (High Dose):** Identifies potential instances where a member could be exceeding the Food and Drug Administration's approved maximum dose.
- **Drug-Drug Interaction:** Identifies potential instances where a member could be utilizing two drugs with an identified drug-interaction flag in Medispan.

The following drug classes and cDUR edits will also be added:

cDUR Edit	Drug Class	States in Scope
Drug-Drug Interaction	Amiodarone + Warfarin	Arizona, California, Florida Healthy Kids (FHK), Florida Managed Medicaid Assistance (MMA), Hawaii, Kansas, Louisiana, Maryland, Michigan, Mississippi, Nebraska, New Jersey, Nevada, New York, New York Essential Plan Program (EPP), Ohio, Pennsylvania, Rhode Island, Texas, Virginia, Washington
Theradose	Citalopram	Arizona, California, Florida FHK, Florida MMA, Hawaii, Kansas, Louisiana, Nebraska (ages 18 and older), New Jersey, Nevada, New York, New York EPP, Ohio, Pennsylvania, Rhode Island, Texas, Virginia, Washington (ages 18 and older)
Theradose	Modafinil Armodafinil	Arizona, California, Florida FHK, Florida MMA, Hawaii, Kansas, Louisiana, Mississippi, Nebraska, New Jersey, Nevada, New York, New York EPP, Ohio, Pennsylvania, Rhode Island, Texas, Virginia, Washington
Therapeutic Duplication	Chantix®	Arizona, California, Florida FHK, Florida MMA, Hawaii, Kansas, Louisiana, Maryland, Michigan, Mississippi, Nebraska, New Jersey, Nevada, New York, New York EPP, Ohio, Pennsylvania, Rhode Island, Texas, Virginia, Washington

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[UnitedHealthcare Community Plan](#)

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Concurrent Drug Utilization Review

cDUR Edit	Drug Class	States in Scope
Therapeutic Duplication	Nonsteroidal Anti-inflammatory Drugs (NSAIDs)	Arizona, California, Florida FHK, Florida MMA, Hawaii, Kansas, Louisiana, Maryland, Michigan, Mississippi, Nebraska, New Jersey, Nevada, New York, New York EPP, Ohio, Pennsylvania, Rhode Island, Texas, Virginia, Washington
Therapeutic Duplication	Triptans	Arizona, California, Florida FHK, Florida MMA, Hawaii, Kansas, Louisiana, Maryland, Michigan, Mississippi, Nebraska, New Jersey, Nevada, New York, New York EPP, Ohio, Pennsylvania, Rhode Island, Texas, Washington

[UnitedHealthcare Community Plan](#)

Updates to Requirements for Prior Authorization for Post-Acute Inpatient Care

We regularly make changes to prior authorization requirements as part of UnitedHealthcare's ongoing responsibility to evaluate our medical policies, clinical programs and health benefits compared to the latest scientific evidence and specialty society guidance. These regular evaluations are part of our commitment to the Triple Aim of better quality, improved health outcomes and lower cost for our members. Following the prior authorization process can also help ensure continuity of care for your patients who are our members.

What's Changing for UnitedHealthcare Community Plan Members

Notice of Changes to Notification/Prior Authorization Requirements

Starting **Oct. 1, 2019**, facilities that provide post-acute inpatient services will now need to request prior authorization and receive an approval before a UnitedHealthcare Community Plan member in **Arizona, Ohio, Rhode Island or Washington** can be admitted to a post-acute care facility or a post-acute care bed in one of these facility types:

- Acute inpatient rehabilitation (AIR)
- Long-term acute care hospitals (LTAC)
- Skilled nursing facilities (SNF)
- Critical access hospitals
- Acute care hospitals

Prior authorization for these services continues to be a requirement for UnitedHealthcare Community Plan members in:

- Florida
- Hawaii
- Kansas
- Louisiana

- Maryland
- Michigan
- Nebraska
- New Jersey
- New York
- Pennsylvania
- Tennessee
- Wisconsin
- Virginia

If a facility doesn't get the required prior authorization, payment for in-patient services may be denied. Remember, members can't be billed for services denied due to failure to complete the prior authorization process.

Post-Admission Review

To help set a consistent concurrent review timeline for facilities, starting Oct. 1, 2019, we'll conduct an initial review between days 7 and 10 of the UnitedHealthcare Community Plan member's admission. After that, our concurrent reviews will be every seven days until discharge. Our SNF registered nurse will work with you during these reviews.

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[UnitedHealthcare Community Plan](#)

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Updates to Requirements for Prior Authorization for Post-Acute Inpatient Care

How to Submit a Prior Authorization Request

It's easy to request prior authorization using the Prior Authorization and Notification tool on Link. Go to UHCprovider.com/paan to get started. Clinical information can be uploaded through the tool.

If you use the Prior Authorization and Notification tool, you may be asked a series of questions that can help streamline the review process. You'll also receive a reference number that you use to track the status of your request. This reference number is not a determination of coverage or a guarantee of payment.

If you're unable to use the Prior Authorization and Notification tool on Link, you can call **877-842-3210**. If you call in your request, we'll let you know if clinical information is required.

Coverage Determination

Once you've submitted a prior authorization request, our nurses and medical directors will review the information and make a coverage determination. We'll notify you once we've made a decision.

Admission Notification

Please note that this change doesn't affect any existing admission notification requirements. You're still required to provide admission notification according to our admission notification protocol.

We're Here to Help



If you have questions, please call Provider Services at **877-842-3210**.

Update to UnitedHealthcare Genetic and Molecular Lab Testing Notification/Prior Authorization Requirement in Pennsylvania

In the April Network Bulletin, we shared that prior authorization/notification for genetic and molecular lab testing would be effective **July 1, 2019**, for UnitedHealthcare Community Plan members in Pennsylvania.

This requirement will now take effect Sept. 1, 2019. The requirement does not apply to Medicare Advantage.

For additional information, go to UHCprovider.com > Prior Authorization and Notification > [Genetic and Molecular Lab Testing Notification/Prior Authorization](#).

[UnitedHealthcare Community Plan](#)

Outpatient Injectable Drug Prior Authorization Requirements for Michigan

We’re committed to providing UnitedHealthcare members with access to quality, medically appropriate medications at the lowest possible cost. As part of this commitment, we make regular updates to our requirements for certain medications.

Effective **Oct. 1, 2019**, we’re making updates to prior authorization requirements for certain injectable drugs billed on the **medical benefit** for UnitedHealthcare Community Plan members in Michigan. These requirements will apply whether members are new to therapy or have already been receiving these medications.

Prior authorization will be required for the following drugs. If you administer any of these medications without first completing the prior authorization process, the claim may be denied. Care providers aren’t able to bill members for services that are denied due to lack of prior authorization.

Provider Administered Drugs Requiring Prior Authorization

Brineura®	Fasenra™	Radicava®
Cerezyme®	HP Acthar® Gel	Soliris®
Crysvita®	Ilaris®	Trogarzo™
Elelyso®	Ilumya™	

You can submit prior authorization requests online or by phone or fax:

- **Online:** Use the Prior Authorization and Notification tool on Link. Go to UHCprovider.com/priorauth for more information.
- **By Phone:** Call the Provider Services phone number on the member’s health care ID card.
- **By Fax:** Prior authorization paper forms are on UHCprovider.com > Menu > Health Plans by State > Michigan > Medicaid (Community Plan) > Prior Authorization and Notification. Please complete the form and fax to the number provided on the form.

[UnitedHealthcare Community Plan](#)

Prior Authorization Change for Referrals and Services at Out-of-State and Out-of-Network Care Providers

Effective July 1, 2019, UnitedHealthcare Community Plan of New Jersey will require prior authorization for referrals and services at out-of-state and out-of-network care providers.

This applies to:

- New referrals and members who are already receiving services at an out-of-state and/or out-of-network care provider
 - For those already receiving services at an out-of-state or out-of-network care provider, the prior authorization requirement will begin 90 days after the policy's effective date.
- All out-of-state and out-of-network acute care hospitals, sub-acute care facilities, ambulatory care (outpatient hospital) and physicians referring members and consultations to out-of-state and out-of-network care providers

If you don't submit a prior authorization request, we'll deny the claim and the out-of-state or out-of-network care provider won't be able to balance bill the member.

Why We're Making the Change

This change will help ensure:

- Our plan members receive the appropriate quantity and quality of health care services
- Services are delivered at the appropriate time
- The setting in which the service is delivered meets with the medical and social care needs of the member

This policy, which has already been reviewed and approved by the state of New Jersey, helps us fulfill our obligations under federal and state law as a New Jersey Medicaid health plan with regard to appropriately authorizing and paying for medically necessary services.

What You Need to Do

If a patient received services that ended before July 1, 2019, you don't need to do anything.

If a patient is currently receiving services that will continue beyond July 1, 2019, we'll allow continuity of care for up to 90 days after the policy's effective date without requiring prior authorization. To help avoid service disruption for the member, we strongly encourage you to request a coverage review before the end of the 90 days. The coverage review will determine if we'll continue to cover further care by or at the out-of-state or out-of-network physician, facility or other health care provider.

We don't require prior authorization for emergency or urgent care services.

How to Submit Your Coverage Review or Prior Authorization Request

Please submit your coverage review or prior authorization request in one of the following ways:

- **Online:** Use the Prior Authorization and Notification tool on Link. Go to UHCprovider.com and click on the Link button in the top right corner. Then, select the Prior Authorization and Notification tile on your Link
- **By Phone:** 866-604-3267

Resources



If you have questions, or would like a copy of the Out-of-State/Out-of-Network Policy, please call UnitedHealthcare Community Plan of New Jersey at **888-362-3368**.

[UnitedHealthcare Community Plan](#)

Sleep Study Prior Authorization Requirement Effective Oct. 1, 2019

Effective **Oct. 1, 2019**, there will be a new required notification/prior authorization process for sleep studies performed in an outpatient hospital setting for UnitedHealthcare Community Plan members in certain states.

Notification/Prior Authorization for CPT Codes in Maryland, New Jersey and Rhode Island

In Maryland, New Jersey and Rhode Island, you'll need to complete the notification/prior authorization process when requesting a sleep study for new and existing members for the following CPT codes:

95782	95800	95806	G0399
95783	95801	G0398	G0400

Notification/Prior Authorization for CPT Codes in Missouri

For Missouri, you'll need to complete the notification/prior authorization process when requesting a sleep study for new and existing members for the following CPT codes:

95782	95801	95807	G0398
95783	95805	95810	G0399
95800	95806	95811	G0400

How to Request Notification/Prior Authorization

Complete the notification/prior authorization process online or by phone:

- **Online:** Go to UHCprovider.com/paan. This preferred option gives you the option of attaching clinical information and may have the fastest response.
- **By Phone:** Call the Provider Services number on your patient's member health care ID card.

After we receive your request and the required clinical records, we'll review the request and contact both the requesting care provider and member by mail and phone with our coverage decision within 15 calendar days from the date of submission, or sooner based on regulations. If coverage is denied, we'll include details in the denial letter on how to appeal.

If a notification/prior authorization isn't completed before performing a procedure, the claim will be denied. Care providers aren't able to bill members for services that are denied due to lack of prior authorization.

Questions?



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

[UnitedHealthcare Community Plan](#)

Speech, Occupational and Physical Therapy Services – Site of Service Review and Prior Authorization Updates for Select States

UnitedHealthcare Community Plan aims to improve cost efficiencies for the overall health care system. One way we’ll do that is by conducting site of service medical necessity reviews for all speech, occupational and physical therapy services. We’re also revising our existing prior authorization requirements.

We’ll require prior authorization for either speech, occupational and/or physical therapy services in select states. We may also determine whether the site of service is medically necessary, consistent with national standards.

Affected States

Please review the requirements for site of service reviews and prior authorization for the following states:

State	Requires Site of Service Review	Services Requiring Prior Authorization	Effective Dates
Arizona	No	Speech therapy	Oct. 1, 2019
New Jersey	Yes	Speech (expanded codes: 92507, 92508, 92526, 92521, 92522, 92523), occupational, physical therapy	Aug. 1, 2019
New York	Yes	Speech, occupational, physical therapy	Oct. 1, 2019
Ohio	Yes	Speech, occupational, physical therapy	Aug. 1, 2019

Site of Service Medical Necessity Reviews

Site of service reviews will be conducted only if the services requested will be performed in an outpatient hospital clinic. The coverage determination guideline we use to help facilitate our site of care medical necessity determinations for these therapy services will be available at UHCprovider.com/policies > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan.

Site of service reviews may apply to speech, occupational and/or physical therapy procedure codes that are currently subject to prior authorization requirements. You can find the list of services that are subject to prior authorization requirements at UHCprovider.com > [Prior Authorization and Notification](#) > UnitedHealthcare Community Plan Prior Authorization Requirements.

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[UnitedHealthcare Community Plan](#)

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Speech, Occupational and Physical Therapy Services – Site of Service Review and Prior Authorization Updates for Select States

Prior Authorization Requirement Changes

We're making changes to our prior authorization requirements for speech, occupational and/or physical therapy services:

- **For states that are implementing site of service (New York and Ohio):** The member's referring physician will be required to submit prior authorization requests for evaluations and re-evaluations. Currently, these types of prior authorization requests for therapy services are often submitted by therapy care providers. If we don't have the prior authorization on file before providing therapy, we'll deny the claim and members cannot be balance billed for the service.
- The referring physician's prior authorization requests must be submitted online using the Prior Authorization and Notification tool on Link at UHCprovider.com/paan. Once the referring physician has received approval for the evaluation or re-evaluation, therapy visits can be requested by therapy care providers. If the evaluation or re-evaluation wasn't submitted and approved by the referring physician then the referring physician will have to submit the request to initiate or continue therapy services.
- **For states that are adding prior authorization but not implementing site of service (Arizona):** All therapy services may be initiated by the requesting therapist but the referring physician will still need to provide the required supporting documentation and sign off on the plan of care for each episode of care.
- **All states** will be required to follow the updated Coverage Determination Guidelines > UHCprovider.com/policies > Community Plan Policies > [Medical & Drug Policies and Coverage Determination Guidelines for Community Plan](#) > Speech Language Pathology.
- All therapy requests must be submitted online using the Prior Authorization and Notification tool on Link at UHCprovider.com/paan.

You'll need to submit additional documentation to us as part of the prior authorization process for evaluations and re-evaluations. You can find the documents in the coverage determination guidelines at UHCprovider.com/policies > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan > Speech Language Pathology Services or Outpatient Physical and Occupational Therapy.

Questions?



If you have questions, please call Provider Services at **866-604-3267**.



UnitedHealthcare Medicare Advantage

Learn about Medicare policy and guideline changes.

[Enhancements for Durable Medical Equipment, Prosthetics, Orthotics & Supplies Codes and Categories](#)

To better align with CMS guidelines, we're making two enhancements related to the CMS Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) Fee Schedule. >

[Updates to Requirements for Prior Authorization for Post-Acute Inpatient Care](#)

We're making a change to claims submitted when certain Medicare Advantage members are admitted to a post-acute care inpatient facility without an approved prior authorization request. >

[Home Health Services Claim Requirement](#)

We recently introduced an automated process that helps ensure care providers meet a claim requirement for Medicare Advantage members receiving home health services. >

[UnitedHealthcare Outpatient Injectable Cancer Therapy Prior Authorization Requirement](#)

Prior authorization for certain outpatient injectable chemotherapy and related cancer therapies will be required for all UnitedHealthcare Medicare Advantage health plan members. >

[Reimbursement Policy Name Change for Medicare Advantage](#)

We're renaming one of our Medicare Advantage reimbursement policies to align with the Centers for Medicare & Medicaid Services (CMS) naming conventions and simplify your search for the policy. >

[Discontinuing Reimbursement for Certain Home Care Service Codes](#)

UnitedHealthcare Medicare Advantage will no longer reimburse for home care services with certain Healthcare Common Procedure Coding System (HCPCS) codes. >

[UnitedHealthcare Medicare Advantage](#)

Enhancements for Durable Medical Equipment, Prosthetics, Orthotics & Supplies Codes and Categories

To better align with Centers for Medicare & Medicaid Services (CMS) guidelines, we are making two enhancements related to the CMS Durable Medical Equipment, Prosthetics, Orthotics & Supplies (DMEPOS) Editing.

DMEPOS Code Enhancement

As previously communicated in July 2018, durable medical equipment (DME) suppliers submitting claims are required to report place of service codes for DME services. Reimbursement is limited to codes that represent a patient's residence. The applicable codes are: 01, 04, 09, 12, 13, 14, 16, 31, 32, 33, 54, 55, 56 and 65. DME services provided in a location other than the patient's home are not reimbursable.

Effective for claims processed on or after **July 24, 2019**, we're making an enhancement to include codes from the DMEPOS Fee Schedule. This enhancement doesn't change the policy intent.

DMEPOS Capped Rental and Oxygen Categories Enhancement

According to CMS guidelines, DME suppliers who submit claims for oxygen or oxygen-related equipment must enroll in the National Supplier Clearinghouse (NSC) to be eligible for reimbursement. Enrolling in this database helps ensure suppliers have the appropriate provider specialty classification to be eligible for reimbursement. For more information about enrolling in the NSC, go to [cms.gov > Regulations & Guidance > Manuals > **Medicare Program Integrity Manual Chapter 15 - Medicare Enrollment.**](https://www.cms.gov/Regulations&Guidance/Manuals/medicare-program-integrity-manual-chapter-15-medicare-enrollment)

In alignment with CMS guidelines, we require that DME suppliers also be enrolled and listed in the UnitedHealthcare national database.

To further support CMS guidelines, we will be enhancing our claims processing system for services that fall into two DMEPOS categories – Capped Rental (CR) and Oxygen (OX). This enhancement will help identify suppliers who don't have the appropriate provider specialty classification and have submitted claims for these categories of services. This enhancement will be effective retroactive from dates of service on or after Jan. 1, 2019. This update doesn't change the policy intent.

Additional Information



For additional information, review the DMEPOS Fee Schedule. Go to [cms.gov > Medicare > Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule > **DMEPOS Fee Schedule.**](https://www.cms.gov/Medicare/DurableMedicalEquipmentProstheticsOrthoticsandSupplies/FeeSchedule)

[UnitedHealthcare Medicare Advantage](#)

Updates to Requirements for Prior Authorization for Post-Acute Inpatient Care

Changes to prior authorization requirements are part of UnitedHealthcare's ongoing responsibility to evaluate our medical policies, clinical programs and health benefits compared to the latest scientific evidence and specialty society guidance. These regular evaluations are part of our commitment to the Triple Aim of better quality, improved health outcomes and lower cost for our members. Following the prior authorization process will also help ensure continuity of care for your patients who are our members.

What's Changing for UnitedHealthcare Medicare Advantage Benefit Plan Members

Facilities providing post-acute inpatient services have been required since Jan. 1, 2019, to request prior authorization and receive a pre-service determination, before UnitedHealthcare Medicare Advantage plan members can be admitted to a post-acute care facility or a post-acute care bed in one of the following types of facilities:

- Acute care hospitals that provide post-acute services
- Acute inpatient rehabilitation (AIR)
- Critical access hospitals that provide post-acute services
- Long-term acute care hospitals (LTAC)
- Skilled nursing facilities (SNF)

These UnitedHealthcare Medicare Advantage benefit plans include UnitedHealthcare Dual Complete®, UnitedHealthcare Community Plan Massachusetts Senior Care Options, UnitedHealthcare Connected – TX (Medicare-Medicaid plan) and UnitedHealthcare Connected for MyCareOhio (Medicare-Medicaid plan).

Beginning **Oct. 1, 2019**, we'll deny claims for all post-acute inpatient services if one of these members is admitted to a post-acute care facility without an approved prior authorization request. Remember, members can't be billed for services denied due to the care provider's failure to complete the prior authorization process.

How to Submit a Prior Authorization Request

It's easy to request prior authorization using the Prior Authorization and Notification tool on Link. Go to UHCprovider.com/paan to get started. Clinical information can be uploaded through the tool.

If you use the Prior Authorization and Notification tool, you'll be asked a series of questions that can help streamline the review process. You'll also receive a reference number that you can use to track the status of your request. This reference number is not a determination of coverage or a guarantee of payment.



If you're unable to use the Prior Authorization and Notification tool on Link, you can call **877-842-3210**. If you call in your request, we'll let you know if clinical information is required.

Coverage Determination

Once you've submitted a prior authorization request, our nurses and medical directors will review the information and make a coverage determination. We'll notify you once we've made a decision.

Admission Notification

You're still required to provide admission notification once you admit the UnitedHealthcare Medicare Advantage plan member to the facility because timely admission notification is a key element of providing coordinated care for UnitedHealthcare members. However, for facilities providing post-acute inpatient services that will require an approved prior authorization request, we're removing reimbursement reductions when there is a lack of timely admission notification starting Oct. 1 2019.



If you have questions, please call Provider Services at **877-842-3210**, 24 hours a day, seven days a week.

[UnitedHealthcare Medicare Advantage](#)

Home Health Services Claim Requirement for Medicare Advantage Members

We recently introduced an automated process to help ensure care providers are meeting a claim requirement for Medicare Advantage members receiving home health services. Under this requirement, members need to have a face-to-face encounter with a qualified clinician during the 90-day period **before** home health services started or within 30 days **after** the start of home health care. This requirement is based on rules from the Centers for Medicare & Medicaid Services (CMS).

This qualified clinician must be either:

- A physician who cared for the patient in the acute or post-acute care facility from which the patient was directly admitted to home health services
- An allowed non-physician practitioner

For information about the face-to-face encounter requirements and non-physician practitioners who are allowed to perform face-to-face visits, go to [cms.gov](https://www.cms.gov) > Regulations & Guidelines > Internet-Only Manuals (IOMs) > [Medicare Benefit Policy Manual, Chapter 7, §30.5.1.1 - 30.5.1.2 – Face-to-Face Encounter](#).



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

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[UnitedHealthcare Medicare Advantage](#)

UnitedHealthcare Outpatient Injectable Cancer Therapy Prior Authorization Requirement

Effective **Oct. 1, 2019**, prior authorization for certain outpatient injectable chemotherapy and related cancer therapies will be required for all UnitedHealthcare Medicare Advantage health plan members. This includes AARP® MedicareComplete, Care Improvement Plus, UnitedHealthcare Dual Complete® and UnitedHealthcare Group Medicare Advantage plans. Optum, an affiliate company of UnitedHealthcare, will manage these prior authorization requests.

UnitedHealthcare Medicare Advantage health plan members in Florida, Georgia and Wisconsin who previously required notification for outpatient injectable chemotherapy through the vendor eviCore will now be required to obtain prior authorization through Optum.

How to Submit a Prior Authorization Request

To submit an online request for prior authorization, go to UHCprovider.com and sign in to Link to access the Prior Authorization and Notification tool. Select the “Radiology, Cardiology + Oncology” box. After selecting Medicare as the product type, you will be directed to another website to process the authorization requests.

Prior authorization will be required when adding a new injectable chemotherapy drug or cancer therapy to an existing regimen.

Prior Authorization for Outpatient Injectable Chemotherapy and Related Cancer Therapies

Prior authorization will be required for:

- Chemotherapy and biologic therapy injectable drugs (J9000-J9999), Leucovorin (J0640) and Levoleucovorin (J0641)
- Chemotherapy and biologic therapy injectable drugs that have a Q code
- Chemotherapy and biologic therapy injectable drugs that have not yet received an assigned code and will be billed under a miscellaneous Healthcare Common Procedure Coding System (HCPCS) code
- Colony Stimulating Factors:
 - Filgrastim (Neupogen) – J1442
 - Filgrastim-aafi (Nivestym) – Q5110
 - Filgrastim-sndz (Zarxio) – Q5101
 - Pegfilgrastim (Neulasta) – J2505
 - Pegfilgrastim-jmdb (Fulphila) – Q5108
 - Sargramostim (Leukine®) – J2820
 - Tbo-filgrastim (Granix) – J1447
- Denosumab (Brand names Xgeva® and Prolia®) – J0897

Prior Authorization for Therapeutic Radiopharmaceuticals

In addition, prior authorization will be required for the following therapeutic radiopharmaceuticals:

- Lutetium Lu 177 (Lutathera®)
- Radium RA-223 dichloride (Xofigo®)
- All therapeutic radiopharmaceuticals that have not yet received an assigned code and will be billed under a miscellaneous HCPCS code

Therapeutic radiopharmaceuticals billed under the following HCPCS codes require prior authorization:

- A9513 Lutetium Lu 177, dotatate, therapeutic, 1 mCi
- A9606 Radium RA-223 dichloride, therapeutic, per microcurie
- A9699 Radiopharmaceutical, therapeutic, not otherwise classified

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[UnitedHealthcare Medicare Advantage](#)

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UnitedHealthcare Outpatient Injectable Cancer Therapy Prior Authorization Requirement

If a member receives injectable chemotherapy drugs or related cancer therapies in an outpatient setting between July 1, 2019 and Sept. 30, 2019, you don't need to request prior authorization until you administer a new chemotherapy drug or related cancer therapy. We will authorize the chemotherapy regimen the member was receiving prior to Oct. 1, 2019. The authorization will be effective until Sept. 30, 2020.

Reimbursement Policy Name Change for Medicare Advantage

To simplify your search for policies and better align our reimbursement policy names with the Centers for Medicare & Medicaid Services (CMS) naming conventions, we periodically change the names of certain policies. Effective **Aug. 1, 2019**, we'll make the following policy name change:

- **Current Policy Name:** Durable Medical Equipment, Orthotics and Prosthetics Multiple Frequency
- **New Policy Name:** Durable Medical Equipment, Orthotics and Prosthetics Policy

The name change will not affect the policy intent or the procedure codes eligible for reimbursement. This reimbursement policy applies to all network physicians, non-network physicians and other qualified health care professionals. This announcement is applicable to reimbursement policies for services reported using the 1500 Health Insurance Claim Form (CMS-1500), its electronic equivalent or its successor form.

[UnitedHealthcare Medicare Advantage](#)

Discontinuing Reimbursement for Certain Home Care Service Codes

As a reminder for professional claims on or after March 22, 2018, UnitedHealthcare Medicare Advantage stopped reimbursing for home care services with the following Healthcare Common Procedure Coding System (HCPCS) codes:

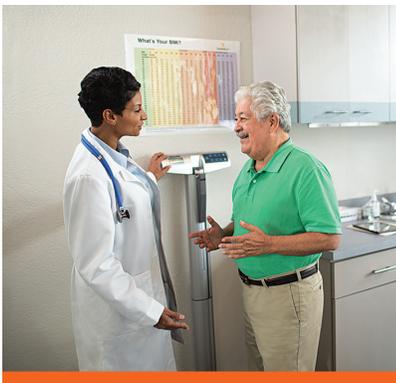
- G0151-G0162
- G0299
- G0300
- G0493-G0496

We made this change to better align with the Centers for Medicare & Medicaid Services (CMS) correct coding guidelines. According to CMS guidelines, these codes are included in the payment to the facility under the home health care episode of care and shouldn't be reported separately by individual physicians or health care providers on a CMS-1500 form.



Doing Business Better

Learn about how we make improved health care decisions.



[Helping Coordinate Patient Care](#)

We offer programs and services to help care providers coordinate care. >

[Remind Members About Their Rights and Responsibilities](#)

The Member Rights and Responsibilities were created to help members understand what they can expect from their health care and how they can improve that experience. >

[Doing Business Better](#)

Helping Coordinate Patient Care

Effective health care coordination between health care providers helps ensure that patients receive safe, high-quality care. To help you coordinate care so patients can live healthier lives, we monitor continuity and coordination of medical care for members across settings and transitions of care, including changes in:

- Management of care between practitioners
- Health care settings, including inpatient and ambulatory locations
- Practitioners partnering to provide ongoing care for a member

Here are some examples of the care coordination activities we provide.

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

Timely Postpartum Care Timely postpartum care can contribute to healthier outcomes for women after delivery and is a measure of quality care. UnitedHealthcare uses Healthcare Effectiveness Data and Information Set (HEDIS®) measurement guidelines to measure postpartum visit compliance. The standard is a postpartum visit on or between 21 and 56 days after delivery. UnitedHealthcare offers the Healthy First Steps Program, which is a maternity case management program, and automated calls from Silverlink, to remind members to schedule their postpartum appointments after delivery.

End-Stage Renal Disease Program This program is designed to improve clinical outcomes for members with end-stage renal disease (ESRD) by coordinating care between practitioners to manage members' comorbid conditions, as well as dialysis therapy to improve continuity and clinical outcomes. The program focuses on reducing inpatient hospitalizations, emergency room visits and mortality, while improving quality of life.

Diabetic Eye Exam Regular eye exam screenings for members with diabetes may help detect diabetic retinal disease. UnitedHealthcare uses HEDIS® measurement guidelines to measure retinal eye exams for members ages 18-75 with type 1 and type 2 diabetes. Continuity and coordination of medical care is monitored through communication between the member's primary care physician and the eye care professional performing the dilated retinal exam.

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[Doing Business Better](#)

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Helping Coordinate Patient Care

Member and Practitioner Coordination of Care Survey Questions

We ask members and practitioners to provide their thoughts on coordination of care through regular surveys. The surveys give us valuable information about their experience with communication of timely and useful information between multiple treating practitioners and care providers.

Post-Hospital Discharge

Follow-up visits after a patient is discharged from the hospital should be timely, especially for members with complex care needs who are at risk for relapse and re-hospitalization, and lack a clear transition of care. Studies show that “early consultations with a practitioner after discharge can reduce the 28-day readmission risk by almost 50 percent.”*

*Bricard, D. & Or, Z. Eur J Health Econ (2019). Retrieved from <https://doi.org/10.1007/s10198-018-1022-y>



Availability of these care coordination activities vary by health care plan. If you have questions, call Provider Services at **877-842-3210**.

Why is it important to focus on care coordination?

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.

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

[Doing Business Better](#)

Remind Members About Their Rights and Responsibilities

We created Member Rights and Responsibilities to help members understand what they can expect from their health care and how they can improve that experience.

Please share this information with your patients who are UnitedHealthcare members. If they have questions or need help communicating, such as assistance from a language interpreter, please ask them to call the customer service number on the back of their member health care 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 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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Remind Members About Their Rights and Responsibilities

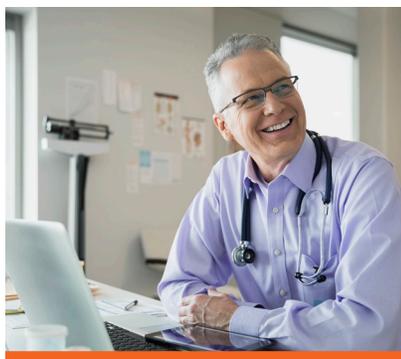
Members have the responsibility to:

- 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.*
- Sign in to myuhc.com, or call us when you have a question about eligibility, benefits, claims and more.
- Sign in to myuhc.com, or call us before receiving services to verify that the doctor or health care professional participates in the UnitedHealthcare network.



UnitedHealthcare Affiliates

Learn about updates with our company partners.



[Connecting Your Optum ID to oxfordhealth.com](#)

If you haven't created an Optum ID or connected it to oxfordhealth.com yet, now is the time to do it. We're getting closer to the time when your Oxford credentials will no longer work. >

[UnitedHealthcare Affiliates](#)

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For help with oxfordhealth.com, call our Technical Support at **800-811-0881**, from 8 a.m. to 5 p.m. Eastern Time, Monday through Friday.



State News

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

[Changes in Advance Notification and Prior Authorization Requirements](#)

We're making changes to certain advance notification and prior authorization requirements for UnitedHealthcare Community Plan in Maryland and Texas. >

[Outpatient Injectable Drug Prior Authorization Requirements for Michigan](#)

Prior authorization requirements for certain injectable drugs are being updated for UnitedHealthcare Community Plan members in Michigan. >

[Update to UnitedHealthcare Genetic and Molecular Lab Testing Notification/Prior Authorization Requirement in Pennsylvania](#)

Prior authorization/notification for genetic and molecular lab testing is now effective Sept. 1, 2019, for UnitedHealthcare Community Plan members in Pennsylvania. >

[Prior Authorization Change for Referrals and Services at Out-of-State and Out-of-Network Care Providers for New Jersey](#)

Starting in July, UnitedHealthcare Community Plan of New Jersey will require prior authorization for referrals and services at out-of-state and out-of-network care providers. >

Doc#: PCA-1-016071-06022019_07012019

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