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.

UnitedHealthcare®

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Enhanced Features for Prior Authorization and Notification Tool on Link

In October 2019, we launched new enhanced functionality in our Prior Authorization and Notification tool on Link. This functionality was released for many service categories requiring prior authorization

This is part of our efforts to help simplify your administrative responsibility and the prior authorization process. By gathering relevant clinical information with your submission, UnitedHealthcare can use the information to evaluate your request, allowing for quicker decisions and improving the efficiency of the prior authorization process. This functionality will continue to be released to additional service categories in November and December 2019 and January 2020.

In the coming months, we'll also unveil a new look and feel of the prior authorization user interface tool to help simplify the process and enhance the overall prior authorization submission experience.

For the latest system enhancements, specific service category launch dates and training, please visit the Interactive Guide for Prior Authorization and Notification Tool at **UHCprovider.com/paan**. The tool includes:

- Affected service categories
- Clinical information necessary for submission
- Information on what's the same and what's different
- Frequently Asked Questions

Getting Started with the Prior Authorization and Notification Tool

If you haven't used our Prior Authorization and Notification tool before, you can learn more at **UHCprovider.com/paan**. To access the tool, you'll need an Optum ID. Go to **UHCprovider.com/newuser** to get started. If you need help, please call the UnitedHealthcare Connectivity Help Desk at **866-842-3278**, option 1, from 7 a.m. to 9 p.m. Central Time, Monday through Friday.

Get Ready for 2020 Open Enrollment by Verifying the Plans You Serve

Right now Medicare beneficiaries are evaluating their plan options. Because of this, they might contact you to check your participation. You can prepare for this outreach by verifying your UnitedHealthcare plan participation using My Practice Profile on Link or call us.

My Practice Profile

If you have access to My Practice Profile on Link, **sign in** and click the View Provider Details icon next to a care provider's name. When the Provider Details window opens to the right, click the Provider Products tab. Go to **UHCprovider.com** for more information.

If you don't have access to My Practice Profile, call **877-842-3210** and enter your tax ID number. Say "other professional services" then "credentialing". Then choose "chiropractic," "medical" or "behavioral health professional" and "get status". The last step is to enter the care provider's social security number.

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Advancing Health Equity Activity Now Available for Continuing Education Credit

With the U.S. population becoming increasingly diverse, it's important to consider how diversity can affect the way that health care services need to be adapted to meet various social, cultural and linguistic needs. Recognizing and appreciating those differences allows care providers to effectively and empathetically provide the best care to a diverse population.

A multi-credit education series was developed to help increase care provider understanding of how culture impacts health care use and outcomes, and how to apply that knowledge to interactions with patients who have diverse backgrounds.

Activity Overview

This activity will provide an overview of health equity and present ways that care providers can apply the knowledge and skills necessary to most effectively tailor health care delivery to all. It consists of two overview modules and four case studies.

Earn Continuing Education (CE) Credits

This accredited education activity is made available, free of charge, for all health care professionals.

Get Started Today

Visit **optumhealtheducation.com/advancing-health-equity** to learn more and complete the Advancing Health Equity activity.

Prescription Drug List Updates

The Jan. 1, 2020 Prescription Drug List and pharmacy benefit updates for UnitedHealthcare commercial plans are now available at UHCprovider.com > Menu > Resource Library > **Drug Lists and Pharmacy**.

BriovaRx Becomes Optum

To provide a more streamlined, simplified brand experience for patients and care providers, **BriovaRx® is changing its name to Optum**. See the following chart for the specific name changes:

Former Pharmacy Name	New Pharmacy Name Care Providers Will Begin Seeing
BriovaRx	Optum® Pharmacy
BriovaRx Infusion Services	Optum® Infusion Services
	Examples of where you will see the new name:

	• UnitedHealthcare systems/documents:
	   o Specialty Guidance Program (SGP)
	   o Prior authorization letters
	   o Explanations of benefits
	   o UnitedHealthcare directory
	• Infusion and specialty EMR systems

The rebranding effort began in early October 2019 and is expected to take some time to fully transition to the Optum brand in all patient and care provider materials. During this time, you may see both the former and new names being used, but our care and support will remain the same. **No action is required from care providers or patients currently utilizing BriovaRx services.**

What Care Providers Can Expect

This transition will take time and you may see both names through late-2020. In the meantime, you can expect:

- A change in pharmacy identification in your referral process, including drop-down menu selections and directory references
- No change in actual processes, as this is a name change only
- Additional details including FAQs in an upcoming Network Bulletin article

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BriovaRx Becomes Optum

What Patients Can Expect

- **There will be no disruption of service or change in process for patients.**
- Patients will be informed of the following name change starting October 2019:

Former Brand Name	New Pharmacy Name Patients Will Begin Seeing
BriovaRx Specialty Pharmacy	Optum® Specialty Pharmacy
BriovaRx Infusion Services	Optum® Infusion Pharmacy
	Examples of where patients will see the new name:
	• Welcome kits • Condition support materials • Optum websites

- Patients will continue to enjoy the excellent services they have come to expect from BriovaRx and will see increased benefit and services as Optum continues to invest in new and innovative solutions designed to meet the needs of those we serve.

Why We Are Making This Change

At Optum, we are focused on fully leveraging our capabilities to best serve the millions of people who count on us every day. This means more closely connecting services across our businesses, including our specialty and infusion pharmacies. Unifying under the Optum brand will be an important step in further simplifying the patient and provider experience, integrating clinical capabilities for better outcomes and providing exceptional support.

Thank you for your understanding as we work through this transition period.

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

A pharmacy bulletin outlining upcoming new or revised clinical programs and implementation dates is now available online for UnitedHealthcare commercial and UnitedHealth Oxford commercial plans. To view it, go to **UHCprovider.com/pharmacy**.

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Preferred Lab Tiering Benefits on Eligibility and Benefit 270/271 EDI Transactions

Preferred Lab tiering benefits allow members to receive a lower cost share when services are delivered by a Preferred Lab Network. It's important care providers understand how to recognize these benefits on their Electronic Data Interchange (EDI) 271 responses.

Message Segment

When a member has the Preferred Lab tiering benefit on their medical plan, it will be indicated in the message segment:

MSG*PLAN INCLUDES PREFERRED LAB BENEFITS~

If you're a Preferred Lab Network provider and the member's plan includes the Preferred Lab tiering benefit, the following message will display:

MSG*PROVIDER IS PREFERRED LAB FOR MEMBER~

Service Type Code 5

STC 5 for diagnostic lab will denote the cost share for the Preferred Lab tiering benefit. If the member has the Preferred Lab tiering benefit on their plan, the copay or coinsurance amount will display:

EB*A*IND*5***27**0*****Y~
MSG*HIGHEST BENEFIT PREFERRED LAB~

Share this information with your software vendor, clearinghouse or IT department to help ensure these benefits are being returned to you.

We're Here to Help

Go online to learn more about our **Preferred Lab Network** and participating labs. Complete our online **EDI Support Form** or go to **UHCprovider.com/edicontacts** for help using EDI.

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OptumRx Retiring Fax Numbers Used for Pharmacy Prior Authorizations

OptumRx is going digital and retiring fax numbers used to submit pharmacy prior authorization requests. This is part of our ongoing efforts to simplify administrative activities, increase accuracy of prior authorization requests and enable faster coverage determinations.

If you use one of the fax numbers that's retiring, we've sent you a fax notice with the retirement date.

These fax numbers will be retiring in stages through Dec. 31, 2019:

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

How to Submit Prior Authorization Requests to OptumRx

Please submit your prior authorization requests through electronic prior authorization (ePA). You can get started with ePA by going to **professionals.optumrx.com > Prior authorizations > Submit a prior authorization**.

If you're unable to submit requests online, call the OptumRx prior authorization team at **800-755-4555** to submit a request by phone.

To comply with federal and state requirements, we'll accept fax prior authorizations for Medicare Part D, for states with their own mandated prior authorization forms and for Massachusetts, Rhode Island, South Carolina and Texas. To get a fax form, visit our website or call the OptumRx prior authorization team at **800-711-4555**.

Changes to Advance Notification and Prior Authorization Requirements

View the Upcoming Changes to Advance Notification and Prior Authorization Requirements bulletin to get the latest updates to our advance notification and prior authorization requirements. The bulletin is available at UHCprovider.com/priorauth > Advance Notification and Plan Requirement Resources > **2019 Summary of Changes**.

We make these changes as part of our ongoing responsibility to evaluate medical policies, clinical programs and health benefits compared to the latest scientific evidence and medical 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, improved health outcomes and lower costs.

To see current prior authorization requirements for all plans, please visit UHCprovider.com/priorauth > **Advance Notification and Plan Requirement Resources** > Select a Plan Type.

Front & Center

Medical Policy Updates

Access a **Policy Update Bulletin** from the following list for complete details on the latest updates:

UnitedHealthcare Commercial & Affiliates
UnitedHealthcare Commercial Medical Policy Update Bulletin: November 2019
UnitedHealthcare Oxford Policy Update Bulletin: November 2019
UnitedHealthcare West Benefit Interpretation Policy Update Bulletin: November 2019
UnitedHealthcare West Medical Management Guideline Update Bulletin: November 2019

UnitedHealthcare Community Plan
UnitedHealthcare Community Plan Medical Policy Update Bulletin: November 2019

UnitedHealthcare Medicare Advantage
Medicare Advantage Coverage Summary Update Bulletin: November 2019
Medicare Advantage Policy Guideline Update Bulletin: November 2019

UnitedHealthcare Dental
Dental Policy Update Bulletin: November 2019

Backup Postcard Notification for Paperless Claims Letters

When a Link Password Owner enrolls in Paperless Delivery Options, they include an email address so someone is notified when new letters are posted. If we're alerted that a notification email is undeliverable, we currently send the claims letters by mail. Soon, we'll change the process to send postcard notifications instead of the letters.

If you receive these postcards, please sign in to Document Vault to view the letters, and also ask your Password Owner to make sure we have the right email address entered in the Paperless Delivery Options tool.

Accessing Document Vault

Go to **UHCprovider.com** and click on the Link button in the upper right corner to sign in. Then, open the Document Vault tile on your dashboard.

Resources

- **Find your Password Owner**
- Quick Reference Guide: **Document Vault**
- Quick Reference Guide: **Paperless Delivery Options** (Password Owners only)

> If you need help using Link, call the UnitedHealthcare Connectivity Help Desk at **866-842–3278**, option 1, from 7 a.m. to 9 p.m. Central Time, Monday through Friday.

UnitedHealthcare Community Plan Significantly Expanding Dual Special Needs Plan — UnitedHealthcare Dual Complete

On Jan. 1, 2020, UnitedHealthcare will begin serving eligible members who enroll in our Dual Special Needs Plan (D-SNP) – UnitedHealthcare Dual Complete, a Medicare Advantage plan – in more than 250 new counties across the United States. This expansion will include one state – California – new to the UnitedHealthcare Dual Complete offering and 17 states that will be expanding coverage by entering new service areas.

Here's a list of states and counties launching the plan on Jan. 1, 2020:

- **Alabama** – Calhoun, Limestone, Marshall, and Morgan counties

- **California** – Alameda, Fresno, Kings and Madera counties

- **Colorado** – Teller County

- **Indiana** – Bartholomew, Benton, Blackford, Boone, Carroll, Cass, Clark, Clay, Clinton, Crawford, Daviess, Dearborn, Decatur, Delaware, Dubois, Fayette, Floyd, Fountain, Franklin, Fulton, Gibson, Greene, Hamilton, Harrison, Howard, Jackson, Jasper, Jefferson, Jennings, Knox, Lawrence, Madison, Marshall, Martin, Miami, Newton, Ohio, Orange, Owen, Parke, Perry, Pike, Pulaski, Putnam, Randolph, Ripley, Rush, Scott, Shelby, Spencer, Starke, Sullivan, Switzerland, Tippecanoe, Tipton, Union, Vermillion, Vigo, Wabash, Warren, Washington and White counties

- **Iowa** – Adair, Cass, Cerro Gordo, Plymouth, Sioux, and Woodbury counties

- **Kansas** – Atchison, Bourbon, Cherokee, Crawford and Labette counties

- **Kentucky** – Adair, Anderson, Bath, Bell, Bourbon, Boyd, Boyle, Bracken, Breathitt, Carroll, Carter, Casey, Clark, Clay, Daviess, Elliott, Estill, Fleming, Floyd, Gallatin, Garrard, Grant, Greenup, Hancock, Harlan, Harrison, Henderson, Henry, Jackson, Johnson, Knott, Knox, Laurel, Lawrence, Lee, Leslie, Letcher, Lewis, Lincoln, Magoffin, Martin, Mason, McCreary, McLean, Menifee, Mercer, Montgomery, Morgan, Nicholas, Ohio, Owen, Owsley, Pendleton, Pike, Powell, Pulaski, Robertson, Rockcastle, Rowan, Russell, Scott, Taylor, Trimble, Union, Washington, Webster, Whitley and Wolfe counties

- **Massachusetts** – Hampshire County

- **Michigan** – Antrim, Arenac, Benzie, Cass, Clare, Crawford, Grand Traverse, Kalkaska, Lake, Leelanau, Livingston, Manistee, Missaukee, Ogemaw, Osceola, Otsego, Roscommon, Wayne and Wexford counties

- **Mississippi** – Alcorn, Attala, Chickasaw, Clay, Coahoma, Covington, Greene, Jasper, Jones, Lauderdale, Leake, Lee, Leflore, Monroe, Neshoba, Newton, Oktibbeha, Pearl River, Perry, Pontotoc, Prentiss, Tippah, Tunica and Union counties

- **Nebraska** – Antelope, Boone, Butler, Clay, Colfax, Cuming, Custer, Dakota, Dixon, Fillmore, Hamilton, Howard, Jefferson, Johnson, Kearney, Knox, Merrick, Nuckolls, Pawnee, Pierce, Platte, Polk, Sherman, Stanton, Thayer, Thurston, Webster and York counties

UnitedHealthcare Community Plan Significantly Expanding Dual Special Needs Plan — UnitedHealthcare Dual Complete

- **New Jersey** – Warren County
- **New York** – Suffolk County
- **Ohio** – Athens, Belmont and Lawrence counties
- **Oklahoma** – Mayes, Okmulgee and Rogers counties
- **Pennsylvania** – Adams, Bradford, Cameron, Clearfield, Delaware, Elk, Fulton, Indiana, McKean, Mifflin, Montgomery, Montour, Potter, Schuylkill, Sullivan, Tioga and Wayne counties
- **West Virginia** – Hampshire, Harrison, Mineral and Morgan counties
- **Wisconsin** – Ashland, Barron, Bayfield, Buffalo, Burnett, Chippewa, Douglas, Dunn, Pepin, Pierce, Polk, Rusk, Sawyer, St. Croix and Washburn counties

This is a Medicare Advantage plan for members who qualify for both Medicare and Medicaid. DSNPs are a special type of Medicare Advantage Prescription Drug Plan (MAPD) and must follow existing Centers for Medicare & Medicaid Services (CMS) rules. The UnitedHealthcare Dual Complete Program will reimburse claims according to your UnitedHealthcare contractual Medicare Advantage payment appendix.

For more information, visit **UHCprovider.com**.

UnitedHealthcare Commercial

Learn about program revisions and requirement updates.

Important Changes, Including Jan. 1, 2020 Code Additions, to Notification/ Prior Authorization Requirements and Site of Service Medical Necessity Reviews for Certain Surgical Procedures for UnitedHealthcare Commercial Plans

We're making updates to previously communicated expanded notification/prior authorization requirements and site of service medical necessity reviews. ❯

Training to Treat Post-Traumatic Stress Disorder

UnitedHealthcare, Optum, and the STRONG STAR Training Initiative are working together to provide access to training on evidence-based treatment for Post-Traumatic Stress Disorder. ❯

Update on Out-of-Network Laboratory Referral Protocol for 2019

We're delaying the launch of the out-of-network laboratory referral request process. We expect to have the tools available to help you complete the request process by Nov. 8, 2019. ❯

UnitedHealthcare Commercial Reimbursement Policy Updates ❯

Peer Comparison Reports to be Released for Select Specialists in Early November

In early November 2019, we'll mail select specialty physicians a letter directing them to the Document Vault on Link to view their Peer Comparison report. ❯

More Fax Numbers Being Retired

As part of our ongoing commitment to paperless processes and workflows, fax number(s) you may have used will be retiring on Jan. 1, 2020. ❯

UnitedHealth Premium Reconsideration Submission Deadline is Nov. 29, 2019

Physicians and their delegates may request reconsideration of a physician's designation details by submitting a request on UnitedHealthPremium.UHC.com on or before Nov. 29, 2019. ❯

UnitedHealthcare Commercial

Important Changes, Including Jan. 1, 2020 Code Additions, to Notification/Prior Authorization Requirements and Site of Service Medical Necessity Reviews for Certain Surgical Procedures for UnitedHealthcare Commercial Plans

In the September edition of the Network Bulletin, we announced that we'd be expanding our notification/prior authorization requirements and site of service medical necessity reviews to include certain surgical codes. This was part of our efforts towards achieving better health outcomes, improving patient experience and lowering the cost of care.

We'd like to make you aware of some important changes we've made to the original September announcement. Additionally, we're continuing this important work by expanding our prior authorization requirements and site of service medical necessity reviews to include additional surgical codes, effective **Jan. 1, 2020**.

1. **Updates to Previous Surgical Code Announcement:** In the September 2019 edition of the Network Bulletin, we announced the expansion of our notification/prior authorization requirements and site of service medical necessity reviews to include certain surgical codes effective for dates of service on or after Nov. 1, 2019 in most states. You can find the original announcement at **UHCprovider.com/news** > Network Bulletin Archive > **September 2019 Network Bulletin > Pages 18 & 19**.

Please note the following updates to the original announcement:

- We've **removed** some surgical codes from the code list such that notification/prior authorization will not be required for certain surgical codes. You can find the expanded list of surgical codes that are subject to notification/prior authorization requirements **here**.

- Effective dates and excluded states are below. Please note some effective dates and excluded states have changed.

    – **Effective for dates of service on or after Nov. 1, 2019** in most states

    – **Effective for dates of service on or after Dec. 1, 2019** in California, Connecticut, New Jersey and New York

    – **Effective for dates of service on or after Jan. 1, 2020** in Colorado, Rhode Island and Maryland (note that Maryland is no longer excluded as of this date)

    – **Effective for dates of service on or after March 1, 2020** for Georgia, Iowa, Kansas, Nebraska, New Hampshire, North Carolina, Maine, South Carolina and Vermont.

    – **Excluded states:** Alaska, Kentucky, Massachusetts, Texas, Utah and Wisconsin

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Important Changes, Including Jan. 1, 2020 Code Additions, to Notification/Prior Authorization Requirements and Site of Service Medical Necessity Reviews for Certain Surgical Procedures for UnitedHealthcare Commercial Plans

- Surgical codes that are subject to site of service medical necessity reviews as of the effective dates above are listed in the *Outpatient Surgical Procedures – Site of Service Utilization Review Guideline* at UHCprovider.com > Policies and Protocols > Commercial Policies > Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans.

- Effective for dates of service on or after **Feb. 1, 2020**, we'll conduct site of service medical necessity reviews for **UnitedHealthcare Oxford commercial benefit plans** for those surgical codes listed in UnitedHealthcare Oxford's clinical policy titled *Outpatient Surgical Procedures – Site of Service*. We will use this clinical policy to facilitate our site of service medical necessity reviews for surgical procedures. On Feb. 1, 2020, you can find the policy at UHCprovider.com/policies > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies**. Until then, you can find the policy, including a complete list of the codes, in the **Oxford Policy Update Bulletin: November 2019**.

2. **Further Expansion of Surgical Codes:** For dates of service on or after **Jan. 1, 2020**, we'll further expand our notification/prior authorization requirements to include the surgical codes listed **here**. *We'll only require notification/prior authorization if these procedures/CPT codes will be performed in an outpatient hospital setting*.

   If the surgical procedure will be performed in an outpatient hospital setting, we'll conduct a review to determine whether the site of service is medically necessary for the surgical codes listed in our **Outpatient Surgical Procedures – Site of Service Utilization Review Guideline**.

Please note that some states have different effective dates or are excluded, as follows:

- **Effective for dates of service on or after Feb. 1, 2020**: California, Colorado, Connecticut, New Jersey and New York (note that Colorado has a different effective date for these codes than the codes listed in #1 above)

- **Effective for dates of service on or after March 1, 2020**: Georgia, Iowa, Kansas, Nebraska, New Hampshire, North Carolina, Maine, South Carolina and Vermont

- **Excluded States:** Alaska, Kentucky, Massachusetts, Texas, Utah and Wisconsin

Affected Plans: UnitedHealthcare commercial benefit plans, including exchange benefit plans and the following benefit plans:

- UnitedHealthcare
- Neighborhood Health Partnership
- UnitedHealthcare of the River Valley

Excluded Plans: UnitedHealthcare Oxford, UnitedHealthcare West and Sierra

Important Points

- We conduct medical necessity reviews under the terms of the member's benefit plan, which requires services to be medically necessary, including cost-effective, to be covered.

- Consistent with existing prior authorization requirements, if we determine that the requested service or site isn't medically necessary, you'll need to submit a new prior authorization request if you make a change to the service or site.

UnitedHealthcare Commercial

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Important Changes, Including Jan. 1, 2020 Code Additions, to Notification/Prior Authorization Requirements and Site of Service Medical Necessity Reviews for Certain Surgical Procedures for UnitedHealthcare Commercial Plans

- For any procedures/CPT codes that are already subject to notification/prior authorization requirements, we'll continue to review the procedures to determine medical necessity.

- We only require notification/prior authorization for planned procedures.

- If you don't notify us or complete the notification/prior authorization process before the planned procedure is rendered, we may deny the claims and you won't be able to bill the member for the service.

Completing the Notification/Prior Authorization Process

The process for completing the notification/prior authorization request and timeframes remains the same. You can learn more about how to use the prior authorization advanced notification (PAAN) link through training, complete the notification/prior authorization process or confirm a coverage decision as follows:

- **Online:** Go to **UHCprovider.com/paan**

- **Phone:** Call **877-842-3210** from 7 a.m. to 7 p.m. local time, Monday through Friday

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Site of Service Medical Necessity Reviews for MR/CT Imaging Procedures for UnitedHealthcare Oxford Commercial Benefit Plans – Effective Feb, 1, 2020

Effective for dates of service on or after **Feb. 1, 2020**, MR/CT imaging procedures that are already subject to prior authorization and medical necessity requirements will be subject to site of service medical necessity reviews for UnitedHealthcare Oxford commercial benefit plans. Site of service medical necessity reviews will be conducted if the imaging procedure will be performed in an outpatient hospital setting.

We will use the criteria set forth in our *Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service* clinical policy to facilitate site of service medical necessity reviews. On Feb. 1, 2020, you can find the policy at UHCprovider.com/policies > Commercial Policies > **UnitedHealthcare Oxford Clinical, Administrative and Reimbursement Policies**. Until then, you can find the policy in the **Oxford Policy Update Bulletin: November 2019**.

Completing the Notification/Prior Authorization Process

For UnitedHealthcare Oxford, all pre-certification requests are handled by eviCore healthcare. To pre-certify a radiology procedure, please contact eviCore healthcare using one of the two options listed below:

- Call eviCore healthcare at 877-773-2884

- Log on to the eviCore healthcare web page using the Prior Authorization and Notification App.

Questions

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

UnitedHealthcare Commercial

Training to Treat Post-Traumatic Stress Disorder

UnitedHealthcare, Optum, and the STRONG STAR Training Initiative are working together to provide access to training on evidence-based treatment for Post-Traumatic Stress Disorder (PTSD).

UnitedHealthcare, Optum and the STRONG STAR Training Initiative, with leadership provided by the University of Texas Health Science Center at San Antonio, is offering training to health care service delivery personnel to learn more about PTSD prevalence, screening and two types of evidence-based treatment: prolonged exposure and cognitive processing therapy.

The presentation, Evidence-Based Treatments for PTSD: An Introduction to Cognitive Processing Therapy and Prolonged Exposure Therapy, was broadcast on Oct. 29, 2019. It's available for viewing on demand at UHC On Air to help you identify, assess and refer patients for quality interventions for PTSD. It was awarded 1 Continuing Medical Education (CME) by the American Academy of Family Physicians.

Topics include:

- Prevalence rates of trauma exposure and PTSD in the U.S.
- Identifying/Screening for PTSD using PTSD screening tools

- Evidence-based treatments for PTSD (Components and Outcomes)
    - Cognitive processing therapy
    - Prolonged exposure therapy
- Information on the STRONG STAR Training Initiative

This program provides you with information on the importance of identification, screening and intervention using evidence-based treatment options to improve the overall health and wellness of your patients.

Follow these steps to access the presentation on demand:

- Click **here**
- Enter your Optum ID and the program will begin to play

At the end of the program, you'll need to answer a series of questions and pass with at least 80% to earn the educational credit certificate. You can download the certificate from your UHC On Air profile, and we'll automatically email a copy to you after completion.

If you have questions, send an email to **uhconair@uhc.com**. We'll respond within 48 to 72 hours.

UnitedHealthcare Commercial

Update on Out-of-Network Laboratory Referral Protocol for 2019

After careful consideration and to help provide a positive overall experience for our members and participating care providers, we've decided to delay the launch of the out-of-network laboratory referral request process. We expect to have the tools available to help you complete the request process by Nov. 8, 2019.

Out-of-network laboratory referrals can create excess costs in the health care system and may pose a potential quality risk to your patients. To help protect your patients, you're required to refer lab services to a participating lab provider. The following requirement applies only to UnitedHealthcare commercial plans.

For an exception to this requirement, you must have both:

- Written consent from the member to use an out-of-network laboratory for that member's lab service for that date of service. The consent indicates the member has discussed the option to use an in-network lab with their care provider and they have made an informed decision to receive services from an out-of-network laboratory despite the potential increased out-of-pocket costs associated with that decision.
- UnitedHealthcare approval to refer the member to use an out-of-network laboratory for that member's lab service for that date of service.

Beginning Nov. 8, 2019, UnitedHealthcare will require an online process to satisfy the exception requirements before referring UnitedHealthcare commercial plan members to out-of-network labs for testing services. This requirement does not apply to in-network laboratory referrals or when the referring provider has obtained a network exception to refer the member to a non-participating laboratory.

You can prepare for this requirement by visiting **UHCprovider.com** and view the Prepping for Out of Network Laboratory Referral Protocol. You'll learn about requesting IDs and get to view the upcoming consent form that will be required for all non-participating referrals.

Your UnitedHealthcare Participation Agreement requires that when you refer members to other care providers, you refer them to UnitedHealthcare in-network care providers, unless an exception applies. If an exception applies, beginning Nov. 8, 2019, you'll need to follow our online process to demonstrate that to us before referring members of UnitedHealthcare commercial plans to out-of-network labs for testing services.

For more information and for the latest updates on out-of-network laboratory referral protocols for 2019, go to **UHCprovider.com**.

UnitedHealthcare Commercial

UnitedHealthcare Commercial Reimbursement Policy Updates

We regularly make changes to policies as part of an ongoing effort to improve health care quality and affordability for members while managing the appropriate use of certain services. The following chart shows new policy changes and their effective dates:

Policy	Effective Date	Summary of Change
Respiratory Viral Panel Testing Policy, Professional	Feb. 1, 2020	• Effective with dates of service on or after Feb. 1, 2020, multiplex polymerase chain reaction (RT-PCR) respiratory viral panel testing — CPT® codes 87631, 87632 and 87633 will not be reimbursable when billed by any care provider on a HCFA-1500 claim form in any place of service. • There are other respiratory viral panel tests available for use in a non-facility place of service. • When multiplex polymerase chain reaction (RT-PCR) respiratory viral panel testing — CPT codes 87631, 87632 and 87633 are billed on a UB facility claim form, in an inpatient facility, observation or emergency room setting; reimbursement is currently and will continue to be considered included in or part of the overall facility payment. • The Centers for Disease Control and Prevention (CDC) recognizes the Infectious Disease Society of America (IDSA) guidelines, which are available at **academic.oup.com/cid/article/68/6/e1/5251935**.
Professional/ Technical Component Policy, Professional	Feb. 1, 2020	• Effective with dates of process on or after Feb. 1, 2020, in alignment with the Centers for Medicare & Medicaid Services (CMS), reimbursement for the technical component of CPT codes 92585, 92587 and 92588, when reported in a facility place of service (POS), will be denied. • Currently the policy includes an exception to bypass denial of the technical component for these services, allowing reimbursement when reported in a facility POS. • Payment for the technical component of these services is considered included in the payment to the facility and not reimbursable on a CMS 1500 claim form.

CPT® is a registered trademark of the American Medical Association.

UnitedHealthcare Commercial Reimbursement Policy Updates

Policy	Effective Date	Summary of Change
Outpatient Hospital Maximum Frequency Per Day Policy, Facility	Feb. 1, 2020	• Effective with dates of service on or after Feb. 1, 2020, UnitedHealthcare will align with the CMS National Correct Coding Initiative (NCCI) Facility Outpatient Hospital Services Medically Unlikely Edits (MUE) values for certain procedures for outpatient claims submitted on the CMS UB04 claim form or its electronic equivalent. • The purpose of this new policy is to provide coding guidance for outpatient facilities billing one unit or multiple units of a CPT or HCPCS code. Claims submitted with Type of Bill 13X and where the facility is reimbursed at a discount and/or by the fee schedule, including non-par providers, will be processed according to the maximum number of units allowed for each service.

UnitedHealthcare Commercial

Peer Comparison Reports to be Released for Select Specialists in Early November

In early November 2019, we'll mail select specialty physicians a letter directing them to the Document Vault on Link to view their peer comparison report. The report shows how a physician's practice compares to other physicians in our network and identifies areas where they're doing well and where there may be room for improvement.

UnitedHealthcare Peer Comparison Reports give physicians actionable information to help deliver better care, better health outcomes and better costs to patients by:

- Analyzing claims data to identify variations from peer benchmarks and alerting physicians whose paid claims data for UnitedHealthcare members over a given period varies from expected practice patterns

- Leveraging utilization measures or specialty-specific procedural measures

- Working collaboratively to improve value for UnitedHealthcare members by helping ensure that services they receive align with evidence-based standards of care

- Identifying focused areas for improvement with suggested actions to reduce variations

You can find more information about peer comparison reports at **UHCprovider.com/peer**. You can also email us at **physician_engagement@uhc.com** or call our Health Care Measurement Resource Center at **866-270-5588**. If you have questions about Document Vault, please call the UnitedHealthcare Connectivity Help Desk at **866-842-3278**, option 1, from 7 a.m. to 9 p.m. Central Time, Monday through Friday.

UnitedHealthcare Commercial

More Fax Numbers Being Retired

As part of our ongoing commitment to paperless processes and workflows, fax number(s) you may have used will be retiring on Jan. 1, 2020. The retiring numbers are:

801-994-1077	801-994-1080	801-994-1106
801-994-1207	801-994-1343	801-994-1347
801-994-1398		

For fast delivery and confirmation of receipt, submit electronically by going to **UHCprovider.com/Link** – your gateway to UnitedHealthcare's online tools. With Link tools, you can get eligibility and benefit details, submit referrals, manage claims and prior authorizations, submit claims reconsideration, and even manage your demographic information in our provider directory. It can help you save time, improve efficiency and reduce errors caused by conventional submission practices.

Questions

If you haven't used our tools before, we have resources to make it easy for you to get started. Go to **UHCprovider.com** to get a quick reference guide, watch a short video tutorial or register for a training webinar. If you're unable to use the online tools, visit **UHCprovider.com** or call Provider Services.

UnitedHealth Premium Reconsideration Submission Deadline is Nov. 29, 2019.

The deadline to request reconsideration of physician Version 12 UnitedHealth Premium designation details is approaching. The Premium program's reconsideration process gives physicians and their approved delegate(s) an opportunity to request a change or correction to certain quality and/or cost efficiency information included in their Premium program evaluation.

Physicians and their delegates may request reconsideration of a physician's designation details by submitting a request on UnitedHealthPremium.UHC.com on or before Nov. 29, 2019. Begin a review of the designation details by signing in to **UnitedHealthPremium.UHC.com** and clicking "Review Measures" for quality or, for cost efficiency, by clicking "Review Episodes" or "Review Patients" in the evaluation results section of the designation overview. For more detailed instructions on how to submit a reconsideration request, see our **Reconsideration Overview**. Requests submitted after Nov. 29, 2019 will not be processed.

Learn More

For more information about the Premium program, including methodology and reconsideration requests, visit **UnitedHealthPremium.UHC.com** or call **866-270-5588**.

UnitedHealthcare Community Plan

Learn about Medicaid coverage changes and updates.

UnitedHealthcare Community Plan of Missouri — Changes to Previously Communicated Notification/Prior Authorization Requirements for Sleep Studies, and Site of Service Medical Necessity Reviews for Certain Sleep Studies — Effective Oct. 1, 2019

We're making updates to previously communicated expanded notification/prior authorization requirements and site of service medical necessity reviews. ❯

UnitedHealthcare Community Plan Reimbursement Policy ❯

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan of Missouri — Changes to Previously Communicated Notification/Prior Authorization Requirements for Sleep Studies and Site of Service Medical Necessity Reviews for Certain Sleep Studies — Effective Oct. 1, 2019

We'd like to make you aware of some updates we're making to previously communicated notification/prior authorization requirements for sleep studies. We're conducting site of service medical necessity reviews for certain sleep studies.

Sleep Study Code Updates

In the July 2019 edition of the Network Bulletin, we announced notification/prior authorization requirements for sleep study codes. You can find the announcement at **UHCprovider.com/news** > Network Bulletin Archive > **July 2019 Network Bulletin** > Page 44.

We've made the following updates since the original announcement:

- We've **removed** 95782, 95783, G0398, G0399 and G0400 from the code list.
- We've added 95808 to the code list.
- The updated list of sleep study codes subject to notification/prior authorization requirements is:

95800	95807
95801	95808
95805	95810
95806	95811

Site of Service Medical Necessity Reviews for Sleep Studies

Together, we've been focused on helping to work toward achieving better health outcomes, improving patient experience and lowering the cost of care. To continue this important work, our newly expanded prior authorization requirement will help to improve cost efficiencies for the overall health care system while still providing access to safe, quality health care.

- For dates of service on or after Oct. 1, 2019, we'll conduct a review to determine whether the site of service is medically necessary for the following sleep study codes:

95805	95810
95807	95811
95808	

- *Site of service medical necessity reviews will be conducted if these codes will be performed in an outpatient hospital setting.*

We understand changes like these aren't always easy. We take that into serious consideration as we work together to achieve better health care outcomes and lower the cost of care. We're committed to helping you and your patients through these changes by providing you the information and support you may need.

UnitedHealthcare Community Plan

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UnitedHealthcare Community Plan of Missouri — Changes to Previously Communicated Notification/Prior Authorization Requirements for Sleep Studies and Site of Service Medical Necessity Reviews for Certain Sleep Studies — Effective Oct. 1, 2019

Important Points

- We conduct medical necessity reviews under the terms of the member's benefit plan, which requires services to be medically necessary, including cost-effective, to be covered.

- Consistent with existing prior authorization requirements, if we determine that the requested service or site isn't medically necessary, you'll need to submit a new prior authorization request if you make a change to the service or site.

- We only require notification/prior authorization for planned procedures.

- If you don't notify us or complete the notification/prior authorization process before the planned procedure is rendered, we may deny the claims and you won't be able to bill the member for the service.

Attended Polysomnography Medical Policy

Our **Attended Polysomnography for Evaluation of Sleep Disorders** Medical Policy includes the criteria we'll use to facilitate our site of service medical necessity reviews. The policy is available at UHCprovider.com > Policies and Protocols > Community Plan Policies > **Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Community Plans**.

Completing the Notification/Prior Authorization Process

The process for completing the notification/prior authorization request and timeframes remains the same. You can learn more about how to use the prior authorization advanced notification (PAAN) link through training, complete the notification/prior authorization process or confirm a coverage decision as follows:

- **Online:** Go to **UHCprovider.com/paan**
- **Phone:** Call **877-842-3210** from 7 a.m. to 7 p.m. local time, Monday through Friday

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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.

UnitedHealthcare Medicare Advantage

Learn about Medicare policy and guideline changes.

UnitedHealthcare Medicare Advantage 2020 Benefit Plan Expansion

UnitedHealthcare is expanding its Medicare Advantage plan offerings to more than 850 counties across 41 states for 2020. ❯

Update on Change to National Drug Code Reimbursement Policy for Outpatient Facilities

The implementation date has been delayed for the Change to National Drug Code Reimbursement Policy for Outpatient Facilities. ❯

UnitedHealthcare Medicare Advantage

UnitedHealthcare Medicare Advantage 2020 Benefit Plan Expansion

UnitedHealthcare is expanding its Medicare Advantage plan offerings to more than 850 counties across 41 states for 2020. We're excited to expand our existing plan offerings and offer new plans to Medicare members. Our plans are supported by the UnitedHealthcare Medicare Advantage provider network. The following states have Medicare Advantage plan expansions:

Northeast	Central	Southeast	West
Conn.	Iowa	Ala.	Ariz.
Mass.	Ill.	Ark.	Calif.
N.H.	Ind.	Fla.	Colo.
N.J.	Kan.	Ga.	Idaho
N.Y.	Ky.	Miss.	N.M.
Pa.	Mich.	N.C.	Nev.
Va.	Minn.	S.C.	Utah
W. Va.	Mo.	Tenn.	Wash.
Maine	N.D.		
R.I.	Neb.		
	Ohio		
	Okla.		
	S.D.		
	Texas		
	Wis.		

Beginning Jan. 1, 2020, **many but not all** UnitedHealthcare and AARP® branded PPO plan members will have access to a broader national network of contracted care providers. That means these PPO members will have nationwide access to care at in-network costs.

To learn more about all Medicare Advantage plans in your state, please visit UHCprovider.com > Menu > **Health Plans by State** > *Choose your state* > Medicare Advantage Health Plans. Participating care providers may review the Medicare Advantage plans they're contracted to accept by visiting the My Practitioner Profile tool at **UHCprovider.con/link** and explore the Provider Products section within the Provider Demographic Details.

UnitedHealthcare Medicare Advantage

Update on Change to National Drug Code Reimbursement Policy for Outpatient Facilities

The implementation date has been delayed for the Change to National Drug Code Reimbursement Policy for Outpatient Facilities.

On Aug. 1, 2019, we communicated the following requirement for contracted care providers:

For dates of service on or after Nov. 1, 2019, the National Drug Code (NDC) policy for UnitedHealthcare Medicare Advantage plans, including all UnitedHealthcare Dual Complete® plans, will be revised for drug-related codes in outpatient facilities. With this policy change, care providers who are contracted with us who submit claims for drug-related Healthcare Common Procedure Coding System (HCPCS) and CPT codes in an outpatient facility will be required to include the following information on the claim:

- A valid NDC number

- Quantity

- A unit of measure

If the required information isn't included, the claim may be denied. The NDC requirement will apply to all claims submitted on the CMS-1500, Electronic Data Interface (EDI) 837p, CMS UB-04 and EDI 837i claim forms.

We will provide an update when the new target release date is scheduled.

Doing Business Better

Learn about how we make improved health care decisions.

Medical Records Standards

A comprehensive, detailed medical record is a key to promoting quality medical care and improving patient safety. ❯

Appropriate Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder

A comprehensive medical evaluation is necessary to appropriately diagnose attention-deficit/hyperactivity disorder (ADHD) and rule out any potential medical causes for the symptoms. ❯

Screening for Common Behavioral Health Issues in Primary Care

The U.S. Preventive Services Task Force (USPSTF) recommends that PCPs screen patients for depression and alcohol/substance use in primary care settings. ❯

Treatment for Members with Substance Use Disorders

Improving treatment for individuals who are diagnosed with substance use disorder helps decrease drug-related illnesses and deaths and encourages appropriate use of health care services. ❯

Medical Records Standards

A comprehensive, detailed medical record is a key to promoting quality medical care and improving patient safety.

UnitedHealthcare recommends that you have signed, written policies to include:

1. Maintenance of a single, permanent medical record that is current, organized and comprehensive for each patient and available at each visit.

2. Protection of patient records against loss, destruction, tampering or unauthorized use. This includes having adequate security safeguards in electronic medical records to prevent unauthorized access or alteration of records. Such safeguards must not be able to be overridden or turned off.

3. Periodic staff training on confidentiality.

4. Records storage to help ensure privacy and security while allowing easy retrieval by authorized persons.

5. Mechanisms for monitoring and handling missed appointments.

6. Medical record documentation standards and performance goals to assess the quality of medical record keeping.

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

- Include patient's identifying information on each page.

- Help ensure that records reflect all services provided, ancillary services/tests ordered and all diagnostic/therapeutic services referred by the physician/health care professional. This includes hospital discharge summaries and consultations from other physicians/health care professionals.

- Document physician review of all lab, x-rays, consultation reports, behavioral health reports, ancillary providers' reports, hospital records and outpatient records.

- Make it easy to identify the medical history and include chronic illnesses, accidents, operations, family and social history, cite medical conditions and significant illnesses on a problem list, and document clinical findings, evaluation and treatment plan for each visit.

- Include evidence of periodic depression screening

- Provide evidence of appropriate preventive/risk screenings

- Document smoking, ETOH and substance use/abuse history beginning at age 11.

- Include name of medication and dosages for medical record. Also, list over-the-counter drugs taken by the member.

- Give prominence to notes on allergies and adverse reactions or note that the member has no known allergies or adverse reactions.

- Date all entries and identify the authors. Documentation of records generated by word processing or electronic medical records software should include all authors and their credentials. It should also be apparent from the documentation which individual performed a given service.

- Clearly label additions or corrections to a medical record entry with the author and date of change and maintain the original entry.

- Generate documentation at the time of service or soon after.

- Clearly label any documentation generated at a previous visit as previously obtained, if it's included in the current record.

- Prominently display information on advance directives.

Appropriate Diagnosis and Treatment of Attention Deficit Hyperactivity Disorder

A comprehensive medical evaluation is necessary to appropriately diagnose attention-deficit/hyperactivity disorder (ADHD) and rule out any potential medical causes for the symptoms.

The **American Academy of Pediatrics** and the **American Academy of Child and Adolescent Psychiatry** have developed evidence-based clinical practice guidelines to help care providers diagnose ADHD. These guidelines should be used with information from parents and teachers.

Here are helpful resources for care providers:

- The National Institute for Children's Health Quality's **Vanderbilt Assessment Scales** are used by health care professionals to help diagnose ADHD in children ages 6 - 12.

- **CHADD - The National Resource on ADHD** offers resources and tips about all aspects of ADHD and related conditions.

Treatment Plan and Follow-Up Visits

Once an ADHD diagnosis is confirmed, the treatment plan usually includes a combination of behavior modification, pharmacotherapy, parent training and education. You can learn more at:

- **liveandworkwell.com**. Use access code "united" to get started. For information on screening, available therapies and medications, go to Mind and Body > Mental Health > ADHD.

- **providerexpress.com** > Clinical Resources > Behavioral Health Toolkit for Medical Providers and also > Clinical Tools and Quality Initiatives.

The National Committee for Quality Assurance uses Healthcare Effectiveness Data and Information Set (HEDIS®) data to assess the frequency of follow-up visits for children taking ADHD medication. While some patients may require more frequent monitoring, the following is the minimum recommended follow-up schedule: *

- When children ages 6 –12 start medication for ADHD, a follow-up visit should occur within 30 days.

- Those same children should be seen for at least two additional follow-up visits within nine months of starting treatment.

HEDIS® 2018: Specifications for Survey Measures

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Doing Business Better

Screening for Common Behavioral Health Issues seen in Primary Care

The U.S. Preventive Services Task Force (USPSTF) recommends that PCPs screen patients for depression and alcohol/substance use in primary care settings. Screening for these disorders is critical to treatment since it can contribute to the patient's readiness to change. You can help by screening all patients, including adolescents. We recommend the following screening tools and resources:

Depression

Patient Heath Questionnaire (PHQ-9)*:The Patient Health Questionnaire (PHQ) screeners site includes downloadable PHQ screeners in several languages to help accurately diagnose and track improvement of the treatment of depression. The site also includes background information about the screeners and scoring instructions and proposed treatment actions.

Attention Deficit Hyperactivity Disorder (ADHD)

- **Vanderbilt Assessment Scales**: The National Institute for Children's Health Quality's (NICHQ) **Vanderbilt Assessment Scales** are used by care providers to help diagnose ADHD in children ages 6 – 12.

- **CHADD - the National Resource on ADHD**: **CHADD** offers resources and tips about all aspects of ADHD and related conditions.

Alcohol/Substance Use

National Institute on Alcohol Abuse and Alcoholism

- pubs.niaaa.nih.gov/publications/
- integration.samhsa.gov/clinical-practice/sbirt/CRAFFT_Screening_interview.pdf
- crafft.org

The National Institute on Alcohol Abuse and Alcoholism site includes several commonly used alcohol use screeners including the AUDIT-C and CAGE. The Substance Abuse and Mental Health Services Administration (SAMHSA) site includes the CRAFFT tool, which is a substance use screening tool for adolescents ages 12 – 21. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. The site includes information related to these conditions.

Optum Behavioral Health/United Behavioral Health and UnitedHealthcare have gathered information for you and your patients in treating depression, alcohol/substance use disorders and ADHD:

- **providerexpress.com** > Clinical Resources > Behavioral Health Toolkit for Medical Providers and also > Clinical Tools and Quality Initiatives
- **UHCprovider.com** > Menu > Resource Library > Behavioral Health Resources
- **liveandworkwell.com** (use access code 'clinician') > Mind & Body > Mental Health OR Substance Use Disorder/Addiction
- LiveandWorkWell Prevention Center: **prevention.liveandworkwell.com**

Referrals

Call the toll-free number on the back of the member health care ID card to refer a patient to an Optum network practitioner for assessment and/or treatment. A link to the Optum Clinician Directory is on **providerexpress.com** > **Our Network** > Directories.

*PHQ-9 was developed by Drs. Robert L. Spitzer, Janet B.W.Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.

Doing Business Better

Treatment for Members with Substance Use Disorders

Substance use disorder is a national problem. In 2017, the Substance Abuse and Mental Health Services Administration reported that 34.2 million Americans had a substance or alcohol use disorder.[1] Many millions more misuse alcohol or prescription medications or use illicit drugs each year.[1] Unfortunately, these conditions are vastly undertreated; only 4 million Americans received any form of substance use treatment in 2017.[1]

Improving treatment for individuals who are diagnosed with substance use disorder helps decrease drug-related illnesses and deaths, encourages appropriate use of health care services and reduces the economic and social costs associated with substance use.[2]

The first step is to properly identify a substance use disorder. There are several brief and easy-to-administer assessment tools available to help screen patients with potential substance use disorders, including: APA DSM5 Level 2 Substance Use Adult; APA DSM5 Level 2 Substance Use Parent of Child Age 6 to 17; AUDIT-C; CAGE; CAGE-AID; and CRAFFT. These screening tools are available online at **providerexpress.com** under "Clinical Resources" in the "Clinical Tools and Quality Initiatives" section.

Once a patient is diagnosed with a substance use disorder, it's important they get treatment right away. According to the Healthcare Effectiveness Data and Information Set (HEDIS®) standards, individuals who are newly diagnosed should be seen for a follow-up appointment within 14 days and then again two more times within 34 days.[3]

No single treatment is appropriate for all individuals. It's best to create a treatment plan that incorporates and builds on the individual's motivations and strengths. The length of time a person receives care is critical for treatment effectiveness.[4] Invite support persons' help in intervening with the patient diagnosed with a substance use disorder. Welcome calls from family members and other people with whom the patient approves to support

their care. Identifying and involving others concerned with the patient's well-being increases the patient's engagement and participation.

Treating substance use disorders requires an approach that reflects the complex nature of these chronic medical conditions.

Additional information on substance use disorders and patient resources are available on the Behavioral Health Toolkit for Medical Providers on providerexpress.com under "Clinical Resources." The toolkit now contains PsychHub videos, which are short videos on behavioral health topics, including videos on substance use disorders and opioid treatment. On liveandworkwell.com, look under the "Mind & Body" tab for the topic "Substance Use Disorder/Addiction."

[1] Substance Abuse and Mental Health Services Administration (2018). Key substance use and mental health indicators in the United States: Results from the 2017 National Survey on Drug Use and Health (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from **samhsa.gov/data/**.

[2] Substance Abuse and Mental Health Services Administration (US); Office of the Surgeon General (US). Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health [Internet]. Washington (D.C.): U.S. Department of Health and Human Services; 2016 Nov. CHAPTER 1, INTRODUCTION AND OVERVIEW OF THE REPORT. Available from: **ncbi.nlm.nih.gov/books/NBK424860/**
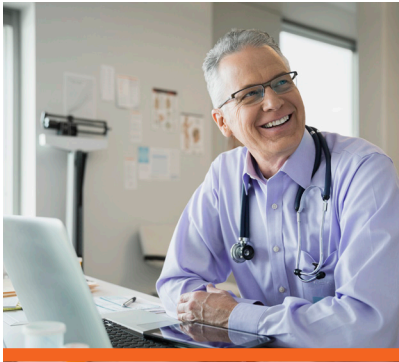
[3] National Committee for Quality Assurance (2019). Healthcare Effectiveness Data and Information Set (HEDIS®) Technical Specifications.

[4] National Institute on Drug Abuse (2018). Principles of Drug Addiction Treatment: A Research-Based Guide (3rd ed.). Retrieved from **drugabuse.gov**.

UnitedHealthcare Affiliates

Learn about updates with our company partners.

New Member ID Cards for Some UnitedHealthcare Oxford Commercial Plan Member

Some UnitedHealthcare Oxford commercial members are receiving new member ID cards as part of our continued effort to streamline the administrative experience. ❯

UnitedHealthcare Affiliates

New UnitedHealthcare Oxford Commercial Plan Member ID Cards

As part of our efforts to streamline the administrative experience for UnitedHealthcare Oxford commercial plans, we're providing members with new member ID cards that show:

- A new **11-digit** ID number
- A **numeric-only** Group number
- **UHCprovider.com** on the back of the card

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

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

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

Learn More

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

State News

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

UnitedHealthcare Community Plan of Missouri — Changes to Previously Communicated Notification/Prior Authorization Requirements for Sleep Studies, and Site of Service Medical Necessity Reviews for Certain Sleep Studies — Effective Oct. 1, 2019

We're making updates to previously communicated expanded notification/prior authorization requirements and site of service medical necessity reviews. ›