AUGUST 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.

UnitedHealthcare®

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Avoid Clearinghouse EDI Claims Submissions Fees

You may experience additional costs to submit UnitedHealthcare claims electronically if we are considered a non-participating payer with your clearinghouse. Although this isn't common, we want to make sure you know how to avoid additional costs (or paper submissions) when you submit Electronic Data Interchange (EDI) 837 claims to us.

Submitting EDI Claims

If your clearinghouse classifies UnitedHealthcare as a non-participating payer and charges fees to submit claims electronically, please consider using the following options:

- **Optum Intelligent EDI:** Through Optum Intelligent EDI, most UnitedHealthcare claim submissions are free. Visit **UHCprovider.com/ediconnect** for more information.
- **Clearinghouses that consider UnitedHealthcare a participating payer:** These clearinghouses don't charge additional fees and may allow you to submit UnitedHealthcare claims without requiring you to move all your other transactions.

If you have questions, please contact the UnitedHealthcare EDI Support Team using the **EDI Transaction Support Form**, email **supportedi@uhc.com** or call **800-842-1109**.

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Use Our Online Tools to Submit Medical Prior Authorization

To help make it easier to do business with us, we're streamlining the process you use to request medical prior authorization. Instead of faxing these requests, please use the **Prior Authorization and Notification tool** on Link.

Benefits and Features of the Prior Authorization and Notification Tool

On average, it takes less than five minutes to submit a new request and less than three minutes to check the status of a request when you use the Prior Authorization and Notification tool. You can use the tool to:

- **Determine 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.

Reminder: Medical Prior Authorization Fax Numbers Retiring Soon

These fax numbers used for medical prior authorization requests will retire soon:

- UnitedHealthcare West fax numbers will retire on **Aug. 5, 2019**.
- Seven UnitedHealthcare Community Plan fax numbers will retire on **Sept. 3, 2019**.
- Certain UnitedHealthcare commercial fax numbers will retire on **Oct. 1, 2019**.

Go to **UHCprovider.com/fax** to see a list of retiring fax numbers and information about fax numbers used for inpatient admission notifications.

Questions?

If you haven't used the Prior Authorization and Notification tool before, we have 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 tool, call Provider Services at **877-842-3210** to submit your request by phone.

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New Controlled Substance e-Prescription Requirements for OptumRx

Starting Oct. 1, 2019, OptumRx® will only accept e-prescriptions for opioids and other controlled substances for home delivery pharmacy service. Non-electronic prescriptions will not be filled.

Why We're Making this Change

OptumRx, the pharmacy benefit provider for UnitedHealthcare, is part of a nationwide effort to require e-prescriptions for opioids and other controlled substances for its home delivery pharmacy. We're joining with care providers and communities to help prevent opioid misuse and addiction.

Prepare to Submit e-Prescriptions

You'll need to complete a two-step authentication and other extra security measures when e-prescribing controlled substances. Please make sure your electronic medical record (EMR) system is set up for e-prescriptions and that you have reviewed the online resources OptumRx has available about e-prescribing controlled substances.

Visit **professionals.optumrx.com/epcs** to watch a short video and read frequently asked questions about:

- The opioid crisis and how states are responding
- The shift to mandatory e-prescribing
- How to prepare your EMR for submitting e-prescriptions

Thank you for working with us to help make our communities safer.

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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: August 2019
Oxford Policy Update Bulletin: August 2019
UnitedHealthcare West Benefit Interpretation Policy Update Bulletin: August 2019
UnitedHealthcare West Medical Management Guideline Update Bulletin: August 2019
UnitedHealthcare Community Plan
Community Plan Medical Policy Update Bulletin: August 2019
UnitedHealthcare Medicare Advantage
Medicare Advantage Coverage Summary Update Bulletin: August 2019
Medicare Advantage Policy Guideline Update Bulletin: August 2019

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Updates to Requirements for Specialty Medical Injectable Drugs for UnitedHealthcare Commercial, UnitedHealthcare Community Plan and UnitedHealthcare Medicare Advantage 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, UnitedHealthcare Community Plan and UnitedHealthcare Medicare Advantage members. These requirements apply to members new to therapy and 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 that the Centers for Medicare & Medicaid Services (CMS) may assign.

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.

Scope of Changes for UnitedHealthcare Commercial Plans

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

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 the Mid-Atlantic, Inc., Neighborhood Health Partnership and UnitedHealthcare of the River Valley.

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

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

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

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

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. Examples of the medications that will be managed under the new process include:

Class or Use	Drug Examples
Alpha1-Proteinase Inhibitors	Aralast NP™, Glassia®, Prolastin-C® or Zemaira®
Asthma	Cinqair®, Fasenra™, Nucala® or Xolair®
Blood Modifiers	Soliris® or Ultomiris™
Botulinum Toxins A and B	Botox®, Dyport®, Myobloc® or Xeomin®
Central Nervous System Agents	Spinraza™, Exondys-51®, Onpattro™ or Radicava™
Endocrine	Crysvita® or H.P. Acthar gel®

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

Class or Use	Drug Examples
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™
Multiple Sclerosis Agents	Ocrevus® or Lemtrada®
Neutropenia	Neulasta®, Fulphila® or Udenyca®
Opioid Addiction	Sublocade™ or Probuphine®
Osteoarthritis	Sodium Hyaluronate such as Durolane®, Euflexxa® or Gelsyn™
RSV Prevention	Synagis®

If you have any questions, please call Provider Services at the number on the member's health plan ID card.

Specialty Medical Injectable Drugs Added to Review at Launch

Drug Name	UnitedHealthcare Commercial	UnitedHealthcare Community Plan	UnitedHealthcare Medicare Advantage	Treatment Uses
Xembify®	X	X		Treatment of primary humoral immunodeficiency (PI) in patients 2 years of age and older

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

To view 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**.

To view the **UnitedHealthcare Community Plan** Review at Launch Drug List Plan, 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**.

The **UnitedHealthcare 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. To view the 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.

Changes to Notification/Prior Authorization

Drug Name	Effective Date	UnitedHealthcare Commercial	UnitedHealthcare Community Plan	UnitedHealthcare Medicare Advantage	Treatment Uses	Summary of Changes
Synagis® (palivi-zumab)	Oct. 1, 2019	X			Respiratory syncytial virus (RSV) prophylaxis	Removing prior authorization requirement from affiliate plans UnitedHealthcare of the Mid-Atlantic, Inc., UnitedHealthcare of the River Valley and Neighborhood Health Partnership. Administrative guide drug sourcing requirements remain in place.

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

Drug Name	Effective Date	UnitedHealthcare Commercial	UnitedHealthcare Community Plan	UnitedHealthcare Medicare Advantage	Treatment Uses	Summary of Changes
Botulinum Toxins A and B (Dysport®, Xeomin®, Botox®, Myobloc®)	Oct. 1, 2019	X			Cervical dystonia, migraine, spasticity, blepharospasm, chronic sialorrhea, and certain other disorders of muscle tone	Removing prior authorization requirement from affiliate plans UnitedHealthcare of the Mid-Atlantic, Inc., UnitedHealthcare of the River Valley and Neighborhood Health Partnership. Administrative guide drug sourcing requirements remain in place.

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.

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

Changes to Administrative Guide Protocols

As of the date indicated in the following table, UnitedHealthcare will no longer reimburse for the following drugs listed when care providers or facilities purchase the drug directly and bill UnitedHealthcare. The drug must be acquired from the source noted for UnitedHealthcare commercial members.

The updated sourcing requirements don't apply to the New York State Empire Plan. For sourcing guideline details, go to UHCprovider.com > Resource Library > Drug Lists and Pharmacy > Specialty Pharmacy Program Commercial > Additional Specialty Pharmacy Resources > **UnitedHealthcare Administrative Guide Specialty Pharmacy Requirements for Certain Specialty Medications Commercial Members**.

Drug Name	Effective Date	Source	UnitedHealthcare Commercial
Zolgensma®	Oct. 1, 2019	Accredo Specialty Pharmacy Orsini Specialty Pharmacy	X
Botulinum Toxins A and B (Dysport, Xeomin, Botox, Myobloc)	Oct. 1, 2019	BriovaRx Specialty Pharmacy	X

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

Changes to our Drug Policies

Drug Policy Name	Effective Date	UnitedHealthcare Commercial	UnitedHealthcare Community Plan	UnitedHealthcare Medicare Advantage	Treatment Uses	Summary of Changes
Oncology Medication Clinical Coverage	Oct. 1, 2019	X	X		Used to treat oncology conditions as per the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium® (NCCN Compendium®)	Policy update Oct.1, 2019. The policy will be updated to include preferred product coverage criteria for Avastin® (bevacizumab) and Herceptin® (trastuzumab). Preferred product language will be added as follows: • Use of Mvasi (bevacizumab-awwb) prior to the use of Avastin and other bevacizumab biosimilar products.. • Use of Kanjinti (trastuzumab-anns) prior to the use of Herceptin and other trastuzumab biosimilar products.
White Blood Cell Colony Stimulating Factors	Oct. 1, 2019	X	X		Used to treat neutropenia	Policy update Oct.1, 2019. The policy will be updated to include preferred product coverage criteria. Preferred product language will be added as follows: Use of Zarxio® prior to the use of Granix®, Neupogen® and Nivestym™.

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

Upon prior authorization renewal, the updated policies will apply. UnitedHealthcare will honor all approved 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.

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Changes in Advance Notification and Prior Authorization Requirements

The following advance notification and prior authorization changes are 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 higher quality, improved health outcomes and better cost for our members.

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 Washington**:

Category	Codes
Continuous Glucose Monitor	A9276, A9277, A9278, K0553, K0554 (Continuous glucose monitors and supplies for members with **Type 2 diabetes diagnosis only**)
Durable Medical Equipment (DME)	E0118, E0731

For the most up-to-date advance notification and prior authorization requirements, go to **UHCprovider.com/priorauth**.

UnitedHealthcare Commercial

Learn about program revisions and requirement updates.

UnitedHealth Premium Program Version 12 Evaluation Details Now Available

UnitedHealth Premium® Program Version 12 evaluation details are now online. ›

Site of Service Reviews for Certain Musculoskeletal Surgical Procedures (Arthroscopic and Foot Surgery) — Revised Effective Date: Nov. 1, 2019

Medical necessity reviews for site of service for certain musculoskeletal surgical procedures (arthroscopic and foot surgery) will be delayed. ›

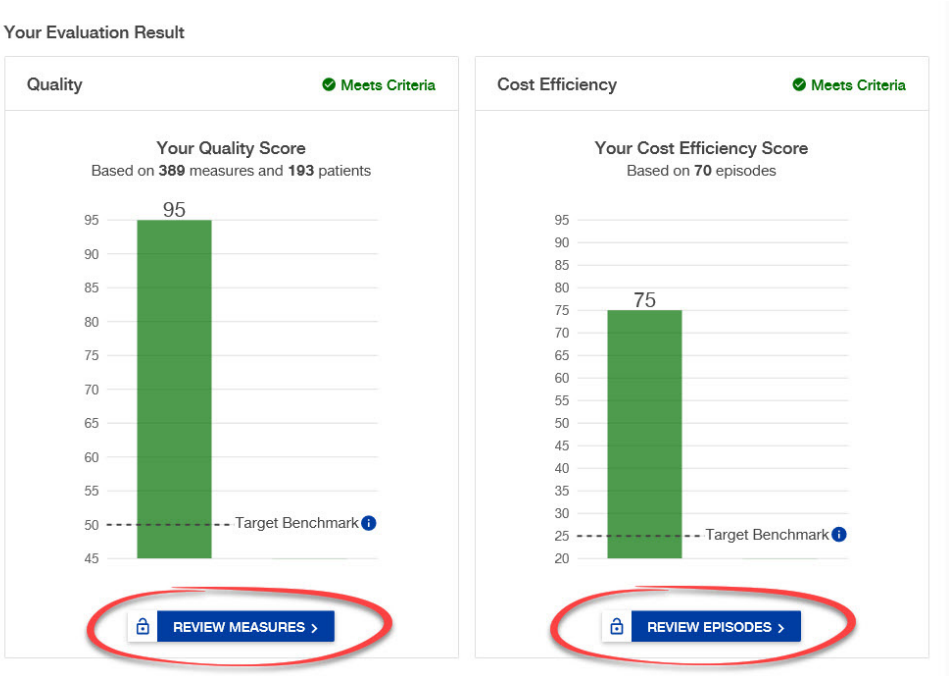
UnitedHealthcare Commercial

UnitedHealth Premium Program Version 12 Evaluation Details Now Available

Earlier this summer, we sent annual evaluation notices to physicians and practice administrators to let them know that their UnitedHealth Premium® program designation details were available to review online. We included registration instructions for physicians and administrators who hadn't previously validated their personal identification number on UnitedHealthPremium.UHC.com.

How to Request a Reconsideration

Physicians or their delegates may request reconsideration for a physician's designation by submitting a request on UnitedHealthPremium.UHC.com. Begin a review of the designation details by clicking "Review Measures" (for quality) or "Review Episodes" (for cost efficiency) in the evaluation results section of your designation overview as shown in the following example. For more detailed instructions on how to submit a reconsideration request, please see our **Reconsideration Overview**.



Learn More

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

UnitedHealthcare Commercial

Site of Service Reviews for Certain Musculoskeletal Surgical Procedures (Arthroscopic and Foot Surgery) — Revised Effective Date: Nov. 1, 2019

The June 2019 Network Bulletin announced that as of Aug. 2, 2019, for certain musculoskeletal surgical procedures (arthroscopic and foot surgery), a medical necessity review for the site of service will occur for UnitedHealthcare commercial members. To allow time for additional communication and optimal rollout, site of service medical necessity reviews for certain musculoskeletal procedures will be delayed.

The new launch date will be Nov. 1, 2019. For more information, please review these **frequently asked questions**.

Site of service reviews will apply to commercial benefit plans, including health exchange benefit plans and:

- UnitedHealthcare
- Neighborhood Health Partnership
- UnitedHealthcare of the River Valley
- UnitedHealthcare of the Mid-Atlantic, Inc.
- MAMSI Life and Health Insurance Company
- Optimum Choice, Inc.
- MD Individual Practice Association, Inc.

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**. If there's 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

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 contains an overview of the policy changes and their effective dates:

Policy	Effective Date	Summary of Change
Procedure to Modifier Policy, Professional	Sept. 1, 2019	• 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 the Centers for Medicare & Medicaid Services (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.
New Molecular Pathology Policy, Professional	Sept. 1, 2019	• The new Molecular Pathology Policy will be effective beginning with dates of service on and after Sept. 1, 2019. • Corrections from the June 2019 Network Bulletin: o The AMA Claim Designation code or Abbreviated Gene Name should be reported in Loop 2400 or SV101-7 field for electronic claims or Box 24 for paper claims. For identification, the ZZ qualifier is required in front of the Claim Designation code or Abbreviated Gene Name (ex: ZZCLRN1). o The Genetic Test Registry (GTR) unique ID should be reported in loop 2400 or SV101-7 field for electronic claims or in Box 24 for paper claims (ex: GTR123456789). • Claims that have complied with notification or prior authorization requirements in UnitedHealthcare's Genetic Testing and Molecular Prior Authorization Program satisfy the policy's requirements without further provider action if they meet UnitedHealthcare's Genetic Test Lab Registry requirements.

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UnitedHealthcare Community Plan

Learn about Medicaid coverage changes and updates.

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 speech, occupational and/or physical therapy services in select states. ›

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 Louisiana, Nebraska and Tennessee. Please review the following details:

State	Requires Site of Service Review	Services Requiring Prior Authorization	Effective Dates
Louisiana	No	Speech therapy	Sept. 1, 2019
Nebraska	Yes	Speech, occupational, physical therapy	Sept. 15, 2019
Tennessee	Yes	Speech, occupational, physical therapy	Oct. 1, 2019

Site of Service Medical Necessity Reviews

Site of service reviews will be conducted only if the requested services will be performed in an outpatient hospital clinic. The coverage determination guideline we use for 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 > **Advance Notification and Plan Requirement Resources** > UnitedHealthcare Community Plan (Medicaid and Long Term Care) Prior Authorization Requirements.

Prior Authorization Requirement Changes

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

- The referring physician's prior authorization request 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.

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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

- 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**.

For states that are implementing site of service (Nebraska and Tennessee)

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 can't be balance billed for the service.

For states that are adding prior authorization, but not implementing site of service (Louisiana)

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.

Additional Documentation Required

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 that will be needed 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.

CMS Preclusion List Policy

The Centers for Medicare & Medicaid Services (CMS) recently provided additional guidance about the CMS Preclusion List. ›

Change to National Drug Code Reimbursement Policy for Outpatient Facilities

The National Drug Code policy will be revised for drug-related codes in outpatient facilities for UnitedHealthcare Medicare Advantage plans, including all UnitedHealthcare Dual Complete® plans. ›

UnitedHealthcare Medicare Advantage

CMS Preclusion List Policy

On April 1, 2019, Medicare Advantage plans and Part D sponsors were required by the Centers for Medicare & Medicaid Services (CMS) to begin rejecting or denying claims submitted for drugs, services and items prescribed or furnished by care providers and entities who are listed on the CMS Preclusion List.

Per CMS, care providers on the Preclusion List:

- Aren't eligible for payment from Medicare Advantage plans and Part D sponsors
- Aren't able to bill Medicare Advantage and Part D members for the services or items provided
- Are financially liable for services or items provided to Medicare Advantage and Part D members

CMS Preclusion List Categories

As referenced in the October 2018 Network Bulletin, the CMS Preclusion List includes care providers and entities that CMS has determined fall into one of the following categories:

- Are currently revoked from Medicare, are under an active reenrollment bar and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. Such conduct includes, but is not limited to, felony convictions and Office of Inspector General exclusions.

To read more about the CMS Preclusion List in October 2018 Network Bulletin, go to UHCprovider.com > Menu > Resource Library > News and Network Bulletin > **October 2018 Network Bulletin**. See page 42.

The first CMS Preclusion List was provided to Medicare Advantage plans and Part D sponsors on Dec. 31, 2018, and included approximately 1,300 providers, prescribers and entities. Medicare Advantage plans and Part D sponsors began denying and rejecting claims submitted by care providers on the Preclusion List on April 1, 2019.

The Preclusion List, which CMS updates monthly, includes the date that providers' claims must be rejected or denied by plans and sponsors due to precluded status. As of the date identified on the Preclusion List, a precluded care provider's claims will no longer be paid, pharmacy claims will be rejected and the provider will be removed from UnitedHealthcare provider networks.

Additional Information

For more information about the Preclusion List, go to cms.gov > Medicare > Medicare Provider-Supplier Enrollment > **Preclusion List**.

UnitedHealthcare Medicare Advantage

Change to National Drug Code Reimbursement Policy for Outpatient Facilities

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.

Why We're Making this Change

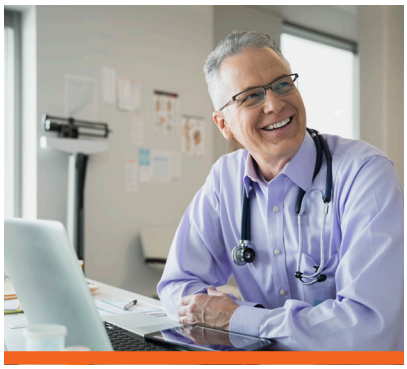
As the industry standard identifier for drugs, NDCs provide full transparency to the medication administered. They accurately identify the manufacturer, drug name, dosage, strength, package size and quantity.

Questions?

A frequently asked questions document with additional information, including a list of applicable codes, will be available on UHCprovider.com in September. If you have questions, please contact your Network Management Representative or call Provider Services at the number on the back of the member's health plan ID card.

UnitedHealthcare Affiliates

Learn about updates with our company partners.



Reminder for Your Patients in UnitedHealthcare Oxford Commercial Plans

We're continuing to streamline the administrative experience for UnitedHealthcare Oxford commercial plans as employer groups renew health coverage for their employees. ›

UnitedHealthcare Affiliates

Reminder for Your Patients in UnitedHealthcare Oxford Commercial Plans

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

If you have patients whose employers are renewing their health coverage with a UnitedHealthcare Oxford commercial plan, you'll see some differences in their new member ID card:

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

The ERA Payer ID number 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 care provider website listed on the back of the member's ID card for secure transactions.

For more information about these changes, use this **quick reference guide** and share it with your staff. Or you may call Provider Services at **800-666-1353**. When you call, please be prepared to share your National Provider Identifier (NPI) number.

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 of Washington. ›