2010 Provider Reference Manual

for physicians, health care professionals, facilities and ancillary providers

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Contact information at a glance

Electronic solutions

www.oxfordhealth.com

To access our website, please go to ***www.oxfordhealth.com***.

To log in to ***www.oxfordhealth.com***, you will need a username and password. If you do not have a username and password, please click on **Need to Register**, fill in the required information and submit your request. Physicians and other health care professionals should have immediate access; facilities will receive a username and password by telephone within two to three business days.

From the providers or facility home page, you can perform the following transactions:

- Submit and check referrals, claims and precertification requests
- Submit notification of inpatient admissions (facilities only)
- Check patient benefits and eligibility
- Change your address, e-mail, username, password, and referral fax number
- Request materials
- Perform a physician search
- Learn about new business arrangements
- View radiology and laboratory program information
- View our prescription drug information
- View our medical and administrative policies
- View our clinical and preventive practice guidelines
- View our disease management initiatives

Oxford Express® (1-800-666-1353)

Use our automated telephone system to:

- Check patient eligibility
- Check the status of referrals and precertification requests
- Submit referrals and precertification requests
- Check the status of claims and request copies of remittance advices

eSolutions support team

We have a team of professionals dedicated to assisting you with electronic solutions for your administrative needs. They can also provide you with helpful information and assist you with a variety of topics related to Electronic Data Interchange (EDI), including:

- Understanding the benefits of electronic claims
- Resolving problems with your practice management vendor
- Addressing issues with your clearinghouse
- Reading your electronic claims tracking reports
- Setting up electronic claim payments and remittances
- Submitting electronic referrals
- Selecting hardware and software
- Topics related to ***www.oxfordhealth.com***

For more information on electronic claims, please call the eSolutions support team at **1-800-599-4334**.

Addresses, telephone and fax numbers

To access Provider Services, which includes medical management services, please call **1-800-666-1353** (Mon. – Fri., 8 a.m. – 6 p.m. ET).

Medical management

Call for precertification

- Inpatient admissions
- Outpatient procedures

See Section Six on **Ancillary Services** for details on precertification for alternative medicine, physical therapy, radiology, radiation therapy or behavioral health; or see Section Four on **Precertification** for more information.

Oxford On-Call®

The Oxford On-Call program offers flexible choice in health care guidance service available by phone to Oxford members 24 hours a day, 365 days a year. Oxford On-Call registered nurse staff assist members with urgent and non-urgent medical problems using state-of-the-art clinical guidelines. Members can speak to a registered nurse who can offer suggestions and guidance on the most appropriate source of care, chat online with a nurse about general health questions, or listen to recorded messages on more than 1,100 health topics by calling 1-800-201-4911.

Our registered nurses provide practical self-care tips to help members manage their condition at home, if appropriate, and educate them about signs and symptoms that may indicate the need for a higher level of care.

In addition, Oxford On-Call provides members with helpful information about many topics such as H1N1 influenza, illness, injury, chronic conditions, prevention, healthy living, and men's, women's and children's health.

Services and resources contact information

Behavioral Health department – (for precertification only)	1-800-201-6991
Fax	1-800-760-4041
Clinical Appeals department fax	1-203-459-7351
Complementary & Alternative Medicine fax (care plans)	1-800-201-7025
Electronic solutions support	1-800-599-4334
Fraud Hotline	1-800-915-1909
Fraud Hotline – Medicare Part D only (may be shared with patients)	1-877-637-5595
Laboratory information – Laboratory Corporation of America (LabCorp) Client services:	
Patient service center locator number for members	1-888-LABCORP
North New Jersey	1-800-223-0631
South New Jersey	1-800-633-5221
New York	1-800-223-0631
Connecticut	1-800-631-5250
Or visit ***www.oxfordhealth.com*** for a complete list of participating laboratories.	

See Section Six on **Ancillary Services** for a complete list of outpatient laboratories.

Medicare Appeals department fax	1-866-950-5158
Pharmacy customer service (commercial members)	1-800-905-0201
Pharmacy notification (commercial members) – available 24 hours per day, seven days per week, including holidays	1-800-753-2851
Pharmacy customer service (Medicare members)	1-800-711-4555
Pharmacy precertification – (Medicare members)	1-800-711-4555

Services and resources contact information (continued)

Physical and occupational therapy – OptumHealth (commercial members); St. John's ASO members; Mosaic Medicare members	
Physician services	
Claim inquiry	1-877-369-7564
Precertification by fax	1-866-695-6923
Claims and payment inquiry	1-800-666-1353
Radiology information – CareCore National LLC (commercial and Medicare radiology)	1-877-PREAUTH

Medicare customer service contact information

Medicare Member Complaints, Appeals and Grievances department fax	1-866-950-5158
Medicare member fraud, waste and abuse complaints	1-877-637-5595
Behavioral Health department –	
(for precertification only)	1-800-201-6991
Fax	1-800-760-4041
Clinical Appeals department fax	1-203-459-7351
Complementary and Alternative Medicine fax	
(care plans)	1-800-201-7025
Electronic solutions support	1-800-599-4334
Fraud hotline	1-800-915-1909
Fraud hotline – Medicare Part D only	
(may be shared with patients)	1-877-637-5595
Montefiore-CMO arrangement for Medicare members in Bronx county	
Medical management/physician services, claim information	1-800-876-7455
Referral fax number	1-914-467-4362
Pharmacy customer service –	
(commercial members)	1-800-905-0201
Pharmacy notification	
(commercial members)	
(Mon. – Sat., 8 a.m. – 10 p.m. ET; Sun. 7 a.m. – 9 p.m. ET)	1-800-753-2851
Pharmacy customer service	
(Medicare members)	1-800-711-4555
Pharmacy precertification –	
(Medicare members)	1-800-711-4555

Claims submission addresses

All claims should be submitted electronically with our Payer ID: 06111.

For more information on submitting electronic claims, please call our Physician eSolutions support team at **1-800-599-4334.**

If mailing an initial paper claim using the CMS-1500 or UB-04 form, please send the claim to the appropriate address below within 90 days of rendering services.

Commercial and Medicare claims
Oxford Claims
P.O. Box 7082
Bridgeport, CT 06601-7082

Montefiore-CMO claims
Physicians or other health care professionals participating in a delegated risk agreement for Medicare in Bronx County should submit claims to:

Contract Management Organization, LLC
Attn: Claims Department
200 Corporate Drive
Yonkers, NY 10701

Contact information for disease and intensive case management programs

Please use the telephone number listed below to contact the specific program coordinator.

Active Care Engagement℠ (ACE)	1-877-759-3059
Better Breathing® (asthma)	1-800-665-4686
Chronic Obstructive Pulmonary Disease (COPD) Program	1-800-665-4686
Depression Program	1-800-665-4686
Heart Smart℠ programs:	
Cardiovascular disease	1-800-665-4686
Heart failure	1-800-665-4686
Living with Diabetes℠	1-800-665-4686
Oxford Cancer Support Program℠	1-800-835-8021
Rare Chronic Care Program	1-866-217-2921
Transplant Program	1-888-201-4257

Information on anonymous counseling and HIV testing programs

Centers for Disease Control and Prevention (CDC)	
National AIDS Hotline	1-800-232-4636
Connecticut	
Connecticut Infoline	1-800-203-1234
This number is only accessible when calling from Connecticut and provides referrals to all state and local hotlines and resources.	
New Jersey	1-800-624-2377
Available 24 hours, seven days a week, this number is only accessible when calling from New Jersey.	
New York	
New York state and New York City information	1-800-541-2437
New York state Spanish/bilingual information	1-800-233-7432
New York state TTY/TDD (for the hearing-impaired)	1-800-369-2437
New York City Department of Health Testing Hotline	1-800-825-5448
Pretesting counseling is conducted over the phone, and appointments are made for callers at testing centers throughout the five boroughs. This service is linked to a crisis intervention hotline.	

Section Two: Member Responsibilities and Management Information

Member rights and responsibilities

Commercial members

Commercial members have the right to:

- Be treated with respect and dignity by our personnel, network physicians and other health care professionals
- Privacy and confidentiality for treatments, tests and procedures they receive
- Voice concerns about the service and care they receive
- Register complaints and appeals concerning their health plan or the care provided to them
- Receive timely responses to their concerns
- Participate in a candid discussion with their physician about appropriate and medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- Access to physicians, health care professionals and other health care facilities
- Participate with their physician or other health care professional in care decisions
- Receive and make recommendations regarding the organization's members' rights and responsibilities policies
- Receive information about us, our services, network physicians and other health care professionals
- Be informed of, and refuse to participate in, any experimental treatment
- Have coverage decisions and claims processed according to regulatory standards, when applicable
- Choose an Advance Directive to designate the kind of care they wish to receive should they be unable to express their wishes
- Make recommendations regarding the organization's member rights and responsibilities policies by writing to:

Oxford Quality Management Department
Attn: Director of Quality Management
44 South Broadway
White Plains, NY 10601

To request a copy of this information, please call our Customer Service department at **1-800-444-6222 (TTY/TDD: 1-800-201-4875)**.

Commercial members have the responsibility to:

- Know and confirm their benefits before receiving treatment
- Contact an appropriate health care professional when they have a medical need or concern
- Show their member ID card before receiving health care services
- Pay any necessary copayment at the time they receive treatment
- Use emergency room services only for injury or illness that, in the judgment of a reasonable person, requires immediate treatment to avoid jeopardy to life or health
- Keep scheduled appointments
- Provide information needed for their care
- Follow agreed-upon instructions and guidelines of physicians and other health care professionals
- Participate in understanding their health problems and developing mutually agreed-upon treatment goals
- Notify their employer's human resource department of changes in their address or family status
- Visit our website, ***www.oxfordhealth.com***, or call Customer Service when they have a question about their eligibility, benefits, claims and more
- Visit our website, ***www.oxfordhealth.com***, or call Customer Service to verify that their physician or health care professional is participating in our network before receiving services

In addition to the above noted information, members are entitled to rights and responsibilities, subject to applicable state law. These rights and responsibilities are outlined in their member health benefit plan.

If commercial members have questions concerning their rights and responsibilities, they should call Customer Service at **1-800-444-6222**.

Medicare members

Medicare members' rights and responsibilities

Our members have the following rights and responsibilities, all of which are intended to help uphold the quality of care and services. Please feel free to distribute this statement to your patients.

Medicare members have the right:

- To receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- To be treated with respect and recognition of their dignity and right to privacy.
- To participate with practitioners in making decisions about their health care.
- To have a candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
- To voice a complaint or appeal about the organization or the care it provides.
- To make recommendations regarding the organization's member rights and responsibilities policy.
- To receive assistance in a prompt, courteous, responsible and culturally competent manner.
- To choose a contracted primary care provider, when applicable, without interference.
- To refuse treatment, including any experimental treatment, and be advised of probable consequences of their decision.
- To initiate a grievance procedure if they are not satisfied with their Medicare Advantage Health Plan's decision regarding their complaint.
- To receive timely access to the records and information that pertains to them.
- To choose an Advance Directive to designate the kind of care they wish to receive should they become unable to express their wishes.
- To have their physician or other health care professional request their consent for all treatment unless there is an emergency and they are unable to sign a consent form and their health is in serious danger.

Medicare members have the responsibility:

- To know their benefits prior to receiving treatment.
- To show their Member ID card before receiving services and to protect against the wrongful use of their ID card by another person.
- To keep scheduled appointments and pay any necessary copayments/coinsurance at the time they receive treatment.
- To express their opinions, concerns and complaints to us.
- To supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- To follow plans and instructions for care that they have agreed to with their practitioners.
- To understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Members should visit **www.SecureHorizons.com**, or call SecureHorizons® Customer Service when they have a question about their eligibility, benefits, claims and more. They may access our website **www.SecureHorizons.com** or they may call SecureHorizons Customer Service to verify that their physician or health care facility is participating in the network before receiving services.

If Medicare members have questions concerning their rights and responsibilities, they should call the Customer Service department at the number on the back of their ID card.

Management information

Confidentiality – HIPAA privacy practices

We are committed to maintaining the confidentiality of our members' protected health information (PHI). PHI is individually identifiable information about members that is used or disclosed by us to administer insurance coverage and to pay for the medical treatment members receive. It includes demographic information, such as names, addresses, telephone numbers, Social Security numbers, and any medical information pertaining to members.

As required by HIPAA, we have provided members with a copy of our Notice of Privacy Practices.

For a complete copy of the notice, please visit our website at ***www.oxfordhealth.com*** or call Physician Services at **1-800-666-1353**.

Selecting a primary care physician (PCP)

- Members enrolled in a gated HMO or HMO-based plan must select a PCP who provides primary care services and coordinates other services. Non-gated HMO and HMO-based products require the selection of a PCP; however, a member does not need to receive primary care from their selected PCP or obtain referrals to other network PCPs.
- In accordance with New York Department of Health Regulations, information about services received from physicians and other health care professionals may be sent to the PCP. Some insurance products require the selection of a PCP, however, members of our Freedom Plan® Select, Access and Direct, and Liberty Plan℠ Select, Access and Direct Plan members do not need referrals and may receive primary care from any network physician or other health care professional.
- Members can only select a PCP within their network (e.g., a Liberty Plan℠ member must select a Liberty Network participating PCP).
- Adult female members may also select an obstetrician/gynecologist (OB/GYN) whom the member may see without a referral from her PCP.
- Family members do not have to select the same PCP (see list of exceptions in Section Four).
- For gated plans, all services performed by physicians and other health care professionals other than the member's PCP or OB/GYN require a referral or precertification in order to be covered on an in-network basis; the exceptions to this procedure are medical emergencies and urgent care received from a network physician or other health care professional; members of commercial plans that do require a referral will have "In-network Referral Required" printed on the back of the member's ID card.
- Members who are enrolled in a non-gated plan may self-refer to specialists on an in-network basis; these members have "No Referral Required" printed on the back of the member ID card; if the member's plan also includes out-of-network coverage, the member is required to pay deductibles and coinsurance as provided by the out-of-network benefit.
- If there is no referral indicator on the member's card, referrals are required for in-network specialty care.

Primary care or specialist physician change

There are times when a member may need to change their primary care or specialist physician. Members can change their PCP through one of the following methods:

- Commercial members may call Customer Service at 1-800-444-6222 or visit ***www.oxfordhealth.com***
- Medicare members may call Customer Service at the number on the back of their ID card

Members should consult with their PCP in order to change a specialist physician or other health care professional in order to remain under the supervised care of the PCP, and obtain any necessary referrals.

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

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

For more information about transitional care, commercial members may call Customer Service at **1-800-444-6222**; Medicare members may call Customer Service at the number on the back of their member ID card.

Member eligibility

Our goal is to make all administrative processes involving physicians and other health care professionals as efficient as possible. Because eligibility inquiries can be completed using multiple electronic channels, we now require that all inquiries related to the eligibility of a patient be done electronically. To perform an electronic eligibility inquiry, use any of the following methods:

- Oxford Express® (1-800-666-1353)
- ***www.oxfordhealth.com***
- AthenaHealth
- Emdeon™
- ENS
- MedAvant
- MISYS
- RelayHealth (formerly NDCHealth, PerSe and McKesson)
- Transaction Methods Inc.

In addition to providing multiple electronic channels for an electronic eligibility inquiry, our HIPAA 270/271 Eligibility Inquiry and Response System provides increased flexibility, accuracy and detailed information on individual patients.

Search options

- Member ID number
- Member first name and Social Security number
- Member last name, first name and date of birth

Information available on an inquiry

- Ability to search one year in the past and seven days in the future
- PreAuth/Cert Required (will only display when a referral is required)
- PCP in-network and out-of-network copayment, deductible and coinsurance information
- Specialist in-network and out-of-network copayment, deductible and coinsurance information
- Facility in-network and out-of-network copayment, deductible and coinsurance information
- Emergency room (ER) copayment and deductible information (will display only if benefit is available)

Benefits of checking patient eligibility

Having the ability to check a member's eligibility status prior to rendering services will help to:

- Determine if a member is eligible to receive these benefits
- Identify the member's copayments specific to their plan
- Verify if the member was eligible to receive services on a specific date
- Establish the need for a referral
- Reduce the number of claims that get denied for a termed member

Additional material describing each of the electronic inquiry methods available can be obtained by calling Physician Services at **1-800-666-1353** or the Physician eSolutions support team at **1-800-599-4334**.

Please note: *Confirmation means only that the individual is listed in our records as a member as of the confirmation date. Member eligibility is subject to change. Changes in the member's relationship with the group, changes in the member's marital or dependent status or other reasons that are not immediately known by us may affect a member's eligibility. We update our eligibility information; you should periodically reconfirm members' eligibility, especially members who are in a course of treatment. We are not liable for payment of services provided to patients who are not members at the time the service was provided.*

Member out-of-pocket costs

Out-of-pocket amounts for outpatient and inpatient care vary by group, type of physician or other health care professional and type of plan. Please check the member's identification card for the out-of-pocket cost specific to their plan. Out-of-pocket cost may include a copayment (i.e., fixed fee), a deductible (in-network or out-of-network) and/or coinsurance (in-network or out-of-network).

For information regarding emergency room or inpatient out-of-pocket costs, please check the member's eligibility using one of our electronic solutions or contact Physician Services at **1-800-666-1353**.

* Refer to the applicable member's plan for specific out-of-pocket cost guidelines, as some plans have different out-of-pocket costs for preventive care, laboratory testing, diagnostic testing, etc.

You should collect out-of-pocket costs for illness visits, allergy visits, all in-office procedures, and all office consultations. Generally, do not collect out-of-pocket costs* for the following services:

- Annual preventive care visits
- Well-woman exams
- Well-baby care
- Prenatal care (after first visit)
- Radiological diagnostic testing
- Laboratory tests
- Immunizations and vaccines
- Follow-up services included in the Global Surgical Package

Please be aware that repeated waiver of out-of-pocket costs or other member financial responsibility is a violation of our policies and procedures and possibly applicable law.

Member identification cards

Each member is given an identification card. The member should present his or her card when requesting any type of covered health care service.

This card is for identification only and does not establish eligibility for coverage. We suggest that each time you check a member's identification card, you also request a photo identification to minimize any risk of an unauthorized use of the member's card.

See **Member eligibility** in this section for more information.

Section Three: Participating Physician and Other Health Care Professional Responsibilities and Information

Participating physician and other health care professional responsibilities

Primary care physicians

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

As a participating PCP, you agree to provide the following when applicable:

- Treatment of routine illness
- Child care from birth
- Pediatric and adult immunizations, according to the recommendations of the American Academy of Pediatrics and *The Guide to Clinical Preventive Services: Report of the United States Preventive Services Task Force*

  See the **Clinical Guidelines** in this section.
- Vision and hearing screenings for members up to age 18 (except for refraction for prescription vision correction)
- Treatment that follows current published clinical practice guidelines
- Laboratory procedures that may be performed in your office that are on our laboratory exception list

  See Section Six on **Ancillary Services** for the complete laboratory exceptions list.
- Pap smears and pelvic exams. Please be advised that while you are required to offer Pap smears and pelvic exams, adult female members may also choose an obstetrician/gynecologist (OB/GYN), whom they may see without a referral; however, members are not required to choose an OB/GYN for gynecological exams
- Personal attendance to, or appropriate coverage for, your patients who may be in a facility or skilled nursing facility
- Educational services, including:
  - Information to assist members in using health care services appropriately
  - Information on personal health behavior
  - Information on achieving and maintaining physical and mental health
- Maintenance of appropriate standards for your office, service and medical records
- Access to your records relating to services rendered to our members; if you believe consent is required from the specific member prior to granting us access to the records, you must obtain their consent; if you cannot obtain such consent, we shall not be responsible for payment of services rendered to such member
- Coordination of referrals to participating specialists and precertification within the member's network of participating physicians and other health care professionals, unless the member specifically elects, after full disclosure, to utilize any out-of-network benefits available
- If a member receives services from a facility, physician or other health care professional who does not participate in our network, we may make the claim payment directly to the member instead of to the nonparticipating physician or other health care professional; in such cases, the nonparticipating physician or other health care professional will be instructed to bill the member for services rendered; the member will then be responsible for making payment to the nonparticipating physician or other health care professional for the full amount of the check mailed to them by us, in addition to any applicable copayment, deductible, coinsurance or other cost share allowances, according to the member's benefit plan.
- Arrangement of coverage for the provision of medical services, 24 hours a day, seven days a week, including:
  - Telephone coverage after hours: You must have either a constantly operating answering service or a telephone recording that directs members to call a special telephone number to reach a covering medical professional who is able to evaluate the member's health status and treat or triage the patient in a clinically appropriate manner. If you utilize an answering machine, the message must direct the

member to go to the emergency room or call 911 in the event of an emergent situation; the message should be in English and any other relevant languages if your panel consists of patients with special language needs

- Covering physicians and other health care professionals: You must provide coverage of your practice 24 hours a day, seven days a week; your covering physician or other health care professional must be a participating physician or health care professional; in the event that there is no participating physician or other health care professional available, a nonparticipating physician or other health care professional may deliver service; in this case, you must obtain precertification from us to ensure that the covering physician or other health care professional receives the correct payment of the claim; we will consider the covering, nonparticipating physician or other health care professional an agent of the participating physician; it is your obligation to inform the nonparticipating, covering physician or other health care professional that reimbursement will be their fee region rates, and that he or she may not balance bill the member; the participating physician or other health care professional will be held liable for any failure by the covering physician or other health care professional to follow our policies (i.e., the covering physician cannot attempt to balance bill).

Specialist services provided by PCPs

Some PCPs are also qualified to perform services ordinarily handled by a specialist. Such a PCP must also be listed as a participating specialist in the particular specialty in order for us to pay claims submitted for specialist services.

Transferring member medical records

If you receive a request from a member to transfer their medical records, please do so within seven days to ensure continuity of care. In order to safeguard the privacy of the member's records, please mark them as "Confidential" and be sure that no part of the record is visible during the transmission.

HIV confidentiality

In accordance with New York regulations, all physicians should develop and implement policies and procedures to maintain the confidentiality of HIV-related information.

The following procedures should be in place to comply with regulations specific to the confidentiality, maintenance and appropriate disclosure of HIV patient information. These include, but are not limited to:

- Office staff shall receive initial and annual in-service education regarding the legal prohibition of unauthorized disclosure.
- Office staff shall maintain a list containing job titles and specified functions for which employees are authorized to access such information. This list shall describe the limits of such access to information and must be provided to the employees during employee education sessions.
- Only employees, contractors and medical, nursing or health-related students who have received such education on HIV confidentiality, or can document that they have received such education or training, shall have access to confidential HIV-related information while performing the authorized functions.
- Office staff shall maintain and secure records, including records which are stored electronically, and ensure records are used for the purpose intended.
- Office staff shall maintain procedures for handling requests by other parties for confidential HIV-related information.
- Office staff shall maintain protocols prohibiting employees, agents and contractors from discriminating against persons having or suspected of having HIV infection.
- Office staff shall perform an annual review of the policies and procedures.

HIV testing must be performed on all newborns.

Prenatal care physicians should counsel their expectant mothers regarding the required testing of newborns and the importance of the mother getting tested, as well. Expectant mothers should also be advised of the counseling and services offered when results are positive.

In-office denial guidelines for Medicare members

Medicare members have the right to appeal our decision not to provide services that the member believes are covered. Should you, as a participating physician or other health care professional, deny a service for a Medicare member, we recommend that you call Provider Services at 1-800-666-1353 immediately. This will enable us to issue a written notice of denial and provide the member with his or her appeal rights. You may also direct the member to call Customer Service at the number on the back of the Medicare member's ID card. Remember that Medicare

members are entitled to receive all medically necessary Medicare-covered services, as well as any additional benefits offered under Medicare.

Specialists

As an Oxford participating specialist, you agree to the following, when applicable:

- Provide specialty services on referral, unless the member is in a non-gatekeeper plan
- Provide results of medical evaluations, tests and treatments to the member's PCP
- Precertify admission if a member under specialist care needs to be admitted to a facility, by using one of our electronic solutions or by calling our Medical Management department at 1-800-666-1353, and by notifying the member's PCP

  See Section Four on **Precertification** for more information.
- Receive compensation only from us and adhere to our balance billing policies
- Provide access to your records relating to services rendered to our members; if you believe consent is required from the specific member, you must obtain his or her consent; if you cannot obtain such consent, we shall not be responsible for payment for services rendered to such member
- Follow our authorization guidelines on the member's behalf for those services requiring precertification
- Follow published current clinical practice guidelines for illnesses you are treating
- Utilize participating physicians and other health care professionals – to the extent available – to assist in any tests or procedures, unless the member, after full disclosure, elects to utilize any out-of-network benefits available
- If a member receives services from a facility or physician who does not participate in our network, we may make the claim payment directly to the member instead of to the nonparticipating physician or other health care professional; in such cases, the nonparticipating physician or other health care professional will be instructed to bill the member for services rendered; the member will then be responsible for making payment to the nonparticipating physician or other health care professional for the full amount of the check mailed to them by us, in addition to any applicable copayment, deductible, coinsurance or other cost share allowances, according to the member's benefit plan.

You will only be reimbursed for services provided to our members if the member has a referral from his or her PCP, our medical director or Oxford On-Call, unless the member is using out-of-network benefits or is in a non-gatekeeper plan. When a member schedules services, please confirm whether we have a referral on file for the service.

- If we have a referral on file or the member has a non-gatekeeper plan and the service is covered and medically necessary, we will be responsible for reimbursing the entire contracted fee and the member will be responsible for any applicable out-of-pocket cost.
- If a referral is not on file and the member has an out-of-network benefit (i.e., a POS plan), and if the service is covered and medically necessary, you will be entitled to the contracted rate, but the member will be required to pay any deductible and/or coinsurance based on his or her out-of-network benefits.
- If the member is enrolled in a plan without an out-of-network benefit (i.e., an HMO plan), we are not responsible for payment (except in cases of emergency), nor can the member be balance billed.

Specialists as PCPs

A member who has a life-threatening condition or a degenerative and disabling condition (i.e., complex medical condition) or disease, either of which requires specialized medical care over a prolonged period of time, is eligible to elect a network specialist as his or her PCP. That PCP then becomes responsible for providing and coordinating all of the member's primary care and specialty care. The PCP, specialist and health plan must all be in agreement with the established treatment plan.

If such an election appears to be appropriate, our Medical Management department will fax the specialist a form to complete. The completed form must be returned to us by fax before we can process the request. Only after the form is completed and accepted by us will such services be covered without a referral, otherwise a referral would be required for members with a gatekeeper plan.

Standing referrals

We will grant standing referrals to specialists or ancillary facilities for members who may require ongoing specialist treatment, including any member with a life-threatening or degenerative and disabling condition. Standing referrals may be authorized when the physician or other health care professional is requesting more than 30 visits within a six-

month period or covered services beyond a six-month period but within 12 months. Under a standing referral, a member may seek treatment with a designated specialist or facility without having to seek a separate PCP referral for each service. If a standing referral is appropriate, we will fax a form to the requesting physician or other health care professional. The physician or other health care professional must complete the form and fax it back to us for processing.

For more information on specialists as PCPs and standing referrals, or to request precertification, please call our Medical Management department at 1-800-666-1353.

Hospitals and ancillary facilities

To receive hospital and ancillary facility services, a member must be enrolled and effective with us on the date the service(s) are rendered. Once the facility verifies a member's eligibility with us (we will maintain a system for verifying member status), that determination will be final and binding on us, except to the extent the member or group made a material misrepresentation to us or otherwise committed fraud in connection with the eligibility or enrollment. If the Centers for Medicare & Medicaid Services (CMS) or an employer or group retroactively disenrolls the member up to 90 days following the date of service, then we may deny or reverse the claim. If there is a retroactive disenrollment for these reasons, the facility may bill and collect payment for those services from the member or another payer. Furthermore, a member must be referred by a participating physician to a participating facility within his or her applicable network;* in-network services require an electronic referral or precertification, in accordance with the member's benefits.

See Section Four on **Precertification** for more information.

Hospitals

Participating hospitals agree to:

- Verify a patient's status, since no payment will be made for services rendered to persons who are not our members
- Obtain precertification/authorization from us or a delegated vendor for all hospital services that require precertification; precertification/authorization must be obtained prior to rendering services
- Generally, all hospital services require our precertification/authorization

  See **Services Requiring Precertification** in Section Four for additional information on what services require precertification.
- Notify us of all elective/scheduled admissions of members at least 14 days prior to the admit date**
- Notify us of any patient who changes level of care, including, but not limited to, NICU, ICU, etc.
- Notify us of all emergency/urgent admissions of members upon admission or on the day of admission**
- Notify us within 24-48 hours when an ambulatory surgery occurs as a result of an emergency room or urgent care visit; provide care to any member who is admitted by a physician or other health care professional with appropriate privileges
- Admit and treat members on the same basis as all other facility patients (i.e., according to the severity of the medical need and the availability of covered services)
- Render services to members in a timely manner; the services provided will be consistent with the treatment protocols and practices utilized for any other facility patient
- Work with the responsible PCP to ensure continuity of care for our members
- Maintain appropriate standards for your facility
- Cooperate with our utilization review program and audit activities
- Receive compensation only from us and adhere to our balance billing policies

* This is only true for payment of in-network services; a member can use his or her out-of-network benefit when going to a nonparticipating network facility.

** If the facility is unable to determine on the day of admission that the patient is our member, the facility will notify us as soon as possible after discovering that the patient has coverage with us.

- Complete appeals process in a timely manner prior to proceeding to arbitration

Ancillary facilities and physicians (including facilities providing ancillary services)

Participating ancillary facility/physicians agree to:

- Obtain authorization from us or our delegated vendor for all services that require precertification, and obtain referrals for those services that require Oxford referrals

  See Section Four on **Precertification** for more information.

- Work with PCPs to ensure coordination of care for our members, including advising PCPs, in writing, of treatments and services performed
- Maintain appropriate standards for your facility
- Receive compensation only from us, and adhere to our balance billing policies
- Cooperate with us in any audit, including providing access to all records relating to services provided to our members
- Complete the appeals process in a timely manner prior to proceeding to arbitration

New York physicians and other health care professionals and the New York Health Care Reform Act of 1996 (HCRA)

The enactment of the HCRA, in part, created an indigent care (bad debt and charity care) pool to support uncompensated care for individuals with no insurance or who lack the ability to pay. As a result of this act, the New York Bad Debt and Charity (NYBDC) surcharge is applied on a claim-by-claim basis. The NYBDC surcharge applies to most services of general facilities and most services of diagnostic and treatment centers in New York.

The physician's or other health care professional's obligation is to:

- Understand their eligibility as it relates to HCRA
- Know what services are surchargeable services, and bill such services accordingly

For additional information on HCRA, physicians and other health care professionals should reference the New York Department of Health's website: **www.health.state.ny.us/nysdoh/hcra/hcrahome.htm**.

Additional information on HCRA includes:

- Designated physicians of services under HCRA
- Net patient service revenues subject to the NYBDC surcharge
- Their obligations under HCRA

Medically necessary services

Medically necessary services are services or supplies provided by a hospital, skilled nursing facility, physician or other health care professional which are required to identify or treat a member's illness or injury, as determined by our Medical director. These services or supplies must be:

- Consistent with the symptoms or diagnosis and treatment of a member's condition;
- Appropriate with regard to standards of good medical practice;
- Not solely for the member's convenience or that of any physician or other health care professional; and
- The most appropriate supply or level of service which can safely be provided. For inpatient services, it further means that the member's condition cannot safely be diagnosed or treated on an outpatient basis.

Basic administrative procedures

Overview

Appropriate site of service

The usual sites of service are the physician's office, a freestanding outpatient or ambulatory center, a facility-associated outpatient or ambulatory surgery center, or an inpatient facility. We approve all services for the appropriate site and give consideration to a member's clinical needs for a higher level of care.

Alternative level of care

Alternative level of care refers to the use of a subacute level bed for a skilled nursing facility (SNF) level of care, as well as an inpatient physical rehabilitation level of care.

We maintain a large network of physicians and other health care professionals and facilities capable of delivering appropriate care at various levels. For the purposes of reimbursement, we reserve the right to determine the appropriate level of care for inpatient stays based on the services the member receives, and to pay for such care at levels specified in the physician agreement or in accordance with our payment policy.

Notification

Referrals and precertification are examples of how physicians and other health care professionals give us notice of services performed. Please be advised that notification must be timely and concurrent with care delivery to permit effective case management and coordinated care across the continuum.

Significant penalties apply for failure to provide proper notification.

Physicians and other health care professionals are required to notify us of any patient who changes level of care, including, but not limited to, NICU, ICU, etc.

See Section Four on **Precertification and referrals** for more information.

Office standards

Your office must adhere to policies regarding the following:

- Confidentiality of member medical records and related patient information
- Patient-centered education
- Informed consent
- Maintenance of advance directives
- Handling of medical emergencies
- Compliance with all federal, state and local requirements
- Minimum standards for appointment and after-hours accessibility
- Safety of the office environment
- Use of physician extenders, such as physician assistants (PA), nurse practitioners (NP) and other allied health professionals, together with the relevant collaborative agreements

Insurance

All physicians and other health care professionals must maintain general liability and professional malpractice insurance. This is to insure physicians and other health care professionals and their employees against any claims arising from personal injury or death that may occur or be alleged to occur because of services performed by a physician or other health care professional or his or her staff. Unless we agree in writing, physicians and other health care professionals must maintain a minimum of $1 million in malpractice insurance per occurrence and $3 million as an annual aggregate.

Access and availability standards

We determine the standards of physician and other health care professional access and availability based on the needs of the membership. A participating physician or other health care professional appointment system must adhere to the following guidelines on access:

Access standards

General Care	
Type of service	**Standard**
Preventive care	Within four weeks
Customer Service telephone access average speed to answer (ASA)	30 seconds
Abandonment rate	2 percent
Emergency care	Immediate
Urgent care appointment	Same day
Routine symptomatic	Within 72 hours
Regular and routine care appointment	Within 14 days
Gynecology – well-woman physical	Within six weeks
Newborn first PCP visit	Within two weeks
Access to after-hours care	24-hour access, seven days per week for primary physicians
Minimum number of days and hours per week	Minimum four days/20 hours per week
Maximum number of appointments per hour PCP	Less than or equal to five appointments per hour
In-office wait time, all physicians and other health care professionals	Less than or equal to 30 minutes
Mental health/substance abuse care	
Type of service	**Standard**
Emergency	Immediate
Non-life-threatening emergency	Within six hours
Urgent care	Within 48 hours
Routine care	Within 10 business days

Acceptable after-hours access and systems include:

- Answering service
- Answering machine that informs patients how to access emergency care and directs patients needing urgent care to call an answering service pager, covering physician or other health care professional
- Phone forwarded to physician's or other health care professional's home
- Phone forwarded to covering physician or other health care professional
- Response time to an urgent after-hours call – within 30 minutes

Availability standards

We establish standards for practitioner, physician and other health care professional availability in our service areas. For the purpose of measuring practitioner availability, a PCP is defined as a practitioner with one of the following specialties: family medicine, general medicine, internal medicine, or pediatric medicine. We also have standards for high-volume specialties. We determine which specialties are high-volume based on utilization and claims data. We do not contract with foreign physicians to satisfy network requirements.

Please note: The following grids are used in the monitoring of network availability and compliance, and do not provide Oxford's guidelines and processes for in-network exception requests. Exceptions may be considered upon request only when our medical director determines in advance that our network does not have an appropriate network physician or other health care professional who can deliver the necessary care. Where availability standards are measured in both travel time and distance, the standards are met if either the travel time or distance is met.

High-volume specialists

Practitioner type	Standard ratio*
Orthopedics	1 : 2,000 members
Allergy/Immunology	1 : 10,000 members
Hematology/Oncology	1 : 4,000 members
Neurology	1 : 4,000 members
PCP	1 : 1,000 members
Cardiologist	1 : 2,000 members
Dermatologist	1 : 8,000 members
ENT	1 : 4,000 members
Gastroenterologist	1 : 4,000 members
Ophthalmologist	1 : 2,000 members

Practitioner type	Standard ratio
OB/GYN	1 : 2,000 members
General Surgeon	1 : 2,000 members
Psychiatrist	50 : 1,000 members
Behavioral health (20% psychiatrist; 80% nonpsychiatrist)	1.75 : 1,000 members

* Ratios are based on published literature on availability of practitioners in the United States and analysis of past performance of UnitedHealthcare health plans.

Type of standard	Oxford standard
Normal distance and travel time to PCP	Urban – two (2) PCPs within 8 miles Suburban – two (2) PCPs within 15 miles Rural – two (2) PCPs within 30 miles Travel time – 30 minutes*
Normal distance and travel time to a facility	Urban – two (2) facilities within 15 miles Suburban – two (2) facilities within 30 miles Rural – two (2) facilities within 60 miles Travel time – 30 minutes*
Normal distance and travel time to (1) each psychiatrist and nonpsychiatrist behavioral health (BH) practitioner	Urban – one (1) each psychiatrist and nonpsychiatrist BH practitioner within 10 miles Suburban – one (1) each psychiatrist and nonpsychiatrist BH practitioner within 20 miles Rural – one (1) each psychiatrist and nonpsychiatrist BH practitioner within 45 miles Travel time < 30 minutes*
Normal distance and travel time to a network pharmacy	One (1) pharmacy within two (2) miles
Ratio of high-volume specialists to covered lives	See chart above
Number of open panels	80 percent

* 60 minutes for New Jersey commercial members; per NJAC 11:24-6.2

Practice guidelines

Basic standards of practice

All services performed for members must be consistent with the proper practice of medicine and be performed in accordance with the customary rules of ethics and conduct of the American Medical Association and other bodies, formal or informal, governmental or otherwise, from which physicians and other health care professionals seek advice and guidance or to which they are subject to licensing and control.

All physicians and other health care professionals shall immediately notify us if any medical license, board certification, facility admitting privileges, or other government certification to furnish health care services applicable to the physician or other health care professional is ever revoked, restricted or surrendered in any manner.

All our physicians and other health care professionals agree to cooperate with peer-review programs, including utilization review and quality assurance programs, precertification, external audit systems, administrative and grievance procedures, and all other policies as they are established by us. All our physicians and other health care professionals agree to comply with all final determinations rendered by our quality assurance programs, peer-review programs, audit programs, or grievance procedures.

In addition, all our participating physicians and other health care professionals agree to comply with our credentialing and recredentialing, administrative policies and procedures, patient referral, utilization review, quality assurance, and reimbursement procedures that we have established or will establish.

Member cost of services

Physicians and other health care professionals are responsible for advising a member, prior to initiating services, when a particular service is not covered through his or her health plan. Please also advise the member of the amount required to pay for the service.

Americans with Disabilities Act guidelines

Federal civil rights laws – Americans with Disabilities Act (ADA)

Section 504 of the Rehabilitation Act of 1973 and the Department of Health and Human Services (HHS) implements regulations that prohibit discrimination against otherwise qualified individuals on the basis of disability,* who are enrolled in programs administered by HHS, including Medicare. Any managed care organization (MCO) or plan that receives federal funds administered by HHS, including Medicare, must also comply with Section 504.

Title I of the Americans with Disabilities Act (ADA) bars discrimination by an employer and affects insurance companies in their capacity as administrator or fiduciary under the Employee Retirement Income Security Act (ERISA).

Title II of the ADA provides that no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or denied access to the benefits of services, programs or activities of a public entity, or be subject to discrimination by such an entity. Public entities include government programs. Since Medicare is a government program, health services provided through Medicare managed care, such as the MedicareComplete® plan offered by us, must be accessible to all who are enrolled in the program. Further, to the extent they qualify as the owners of a place of public accommodation, managed care organizations and professional offices of a health care physician or other health care professional must follow guidelines that are consistent with the provisions of the ADA.

Title III of the ADA prohibits discrimination on the basis of disability in the full enjoyment of goods, services, facilities, privileges, or accommodations of any place of public accommodation. Title III applies to nongovernmental providers of health care. Places of public accommodation include, but are not limited to, stores (including pharmacies), offices (including doctors' offices), facilities, and social service centers.

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

Finally, we are expected to promote the fact that our facilities and those of a sufficient number of affiliated physicians and other health care professionals are readily accessible to the physically and mentally disabled, that

* Disability is defined as a mental or physical impairment that substantially limits one or more of the major life activities of an individual; a record of such impairment; or being regarded as having such impairment.

translator services are available as needed for non-English speaking members, and that interpreter services and other accommodations (such as a teletypewriter or TTY/TDD connections for member services) are made available to the hearing-impaired. Title III of the ADA also requires that covered entities make currently inaccessible facilities physically accessible to people with disabilities to the extent it is readily achievable for them to do so.

In this regard, new construction and renovations, as well as barrier reductions required to achieve program accessibility, must be undertaken in accordance with the established accessibility standards of the ADA guidelines.

See **Accessibility Standards** in this section.

Our commitment to the Americans with Disabilities Act

We are committed to complying with the applicable requirements of the ADA, including making services, programs and activities readily accessible and usable by individual members with disabilities. In the event that it comes to our attention that certain program sites may not be readily accessible, we have developed a process for providing reasonable alternative methods for making the services or activities accessible and usable. The goal of compliance with ADA requirements is to offer a level of service that allows people with disabilities access to the programs and services offered by us, and the ability to achieve the same health care results as any other member.

The objectives of the ADA guidelines are three-fold:

- To ensure that our services are accessible for people with disabilities in accord with ADA requirements
- To provide a framework for the continued development of processes to ensure compliance with the ADA
- To provide standards for our participating physicians and other health care professionals that are open to review by us from time to time upon audit, credentialing and recredentialing

These guidelines include a general standard, followed by a discussion of specific considerations and suggestions for assuring compliance. Please be advised that although these guidelines and any subsequent reviews by us (or regulators) can give you guidance, it is ultimately your obligation to ensure that you comply with your contractual obligations, as well as with requirements of the ADA, and other applicable federal, state and local laws.

Other federal, state and local statutes and regulations also prohibit discrimination on the basis of disability and may impose requirements in addition to those established under ADA. (For example, while the ADA covers those impairments that "substantially" limit one or more of the major life activities of an individual, in New York, the New York City Human Rights Law deletes the modifier "substantially.")

What we may request from a physician's or other health care professional's office

Any of the following ADA-related information may be requested from you:

- A description of accessibility to your office or facility or of a reasonable alternative means to access your services for members using wheelchairs (or other mobility aids)
- A description of the methods that you or your staff will use to communicate with members who have visual or hearing impairments, including any necessary auxiliary aid/services for members who are deaf or hard of hearing, and TTY/TDD technology available through a toll-free telephone number
- A description of the training your staff receives to learn and implement these guidelines and to become sensitive to the needs of persons with disabilities

Suggested accessibility standards

Standard methods for making your office locations and services accessible to, and usable by, people with disabilities include the following:

- If parking is provided, nearby spaces reserved for people with disabilities, curb cuts at driveways and drop-offs
- Exterior walks, at least 36 inches wide, leading from parking areas or public transportation stops into the office building and/or facility
- Stable, slip-resistant routes of travel into the office/facilities, with all steps greater than 1/2 inch high ramped, and doorways with a minimum 32-inch opening
- Waiting rooms, restrooms and other rooms used by members accessible to people with disabilities
- Interior halls and passageways to bathrooms and other rooms commonly used by members with a clear and unobstructed path of travel at least 36 inches wide
- New member orientation, if any, available in audio or by interpreter services

- Staff trained in the use of telecommunication devices for members who are deaf or hard of hearing (TTY/TDD), as well as in the use of state-provided relay for phone communication
- Policy that when member services staff receives calls through the state relay, they will offer to return the call utilizing a direct TTY/TDD connection
- Staff training that includes sensitivity training related to disability issues

Please note: *Resources and technical assistance are available in New York State, through the New York State Office of Advocate for Persons with Disabilities – 1-800-624-4143 V/TTY; and the Mayor's Office for People with Disabilities – 212-788-2830; in Connecticut, through the Connecticut Office of Protection and Advocacy – 1-800-842-7303 (toll-free), 1-860-297-4300, 1-860-297-4380 (TTY); in New Jersey, through the New Jersey Office on Disabilities – 1-888-285-3036 (toll-free), 1-609-292-7800 (TTY).*

Identifying members with disabilities

We are expected to have satisfactory methods/guidelines in place for identifying persons having, or at risk for, chronic diseases and disabilities and for determining their specific needs in terms of specialist/physician referrals, durable medical equipment, medical supplies, home health services, etc. We expect your cooperation to achieve this goal and to implement the compliance methods listed below. Affiliated physicians and other health care professionals may not discriminate against a potential member based on his or her current health status or anticipated need for future health care, and may not discriminate on the basis of disability or perceived disability against a current member or his or her family member(s).

Suggested methods for compliance

- Appropriate post-enrollment health screening for each member, using health-screening tools approved by the state or the Centers for Medicare & Medicaid Services (CMS), as applicable
- Patient profiles by condition/disease for comparative analysis to national norms, with appropriate outreach and education
- Process for follow-up of needs identified by initial screening (e.g., referrals, assignment of case management, and assistance with scheduling/keeping appointments)
- Enrollment population disability assessment survey
- Process for members who acquire a disability subsequent to enrollment to access appropriate services

Additional suggestions

You should identify special health care, physical access or communication needs of members on a timely basis, including but not limited to, the health care needs of members who:

- Are blind or have visual impairments (also identify the type of auxiliary aids and services* the member requires)
- Are deaf or hard of hearing (also identify the type of auxiliary aids and services* the member requires)
- Are mobility-impaired (also explain the extent, if any, to which the member can ambulate)
- Have other physical or mental impairments or disabilities, including cognitive impairments
- Have conditions that may require more intensive case management

* Auxiliary aids and services may include qualified interpreters, note-takers, computer-aided transcription services, written materials, telephone handset amplifiers, assisted listening systems, telephone compatible with hearing aids, closed-caption decoders, opened and closed captioning, telecommunications devices for members who are deaf or hard of hearing (TTY/TDD), video test displays, and other effective methods of making aurally delivered materials available to individuals with hearing impairments. Also included are qualified readers, taped texts, audio recordings, Braille materials, large print materials, or other effective methods of making visually delivered materials available to individuals with visual impairments.

Patient education for members with disabilities

Just as a managed care organization's materials may be made available to persons with disabilities in alternative formats (such as Braille, large print and audiotapes), you should develop or have available pertinent materials in similar formats and offer them to your disabled patients.

Suggested methods for compliance

- Provide physically accessible office location(s)
- Make materials available in alternative formats such as Braille, large print, audiotapes
- Institute staff instruction, including sensitivity training related to disability issues
- Include sign-language interpreters upon request

- Offer health promotion materials targeted specifically to persons with disabilities (e.g., secondary infection prevention, decubitus prevention, special exercise programs, etc.)
- Communicate to individuals who are blind or vision-impaired that office staff will read or summarize any written materials that are typically distributed to all patients
- Provide staff and resources to assist individuals with cognitive impairments in understanding office procedures and materials

Clinical care and effective communication

Effective communication is a critical part of rendering appropriate clinical care. Physicians and other health care professionals should provide members with the information they need to:

- Make informed choices about treatment options
- Effectively utilize health care resources
- Assist them in making appointments
- Field questions and process complaints when applicable

Care for members who are hearing-impaired

There are federal requirements pertaining to physicians and other health care professionals who render services to members who are deaf or hard of hearing:

- Title III of the Americans with Disabilities Act, 42 U.S.C. Sect. 12182, 12183, provides people with disabilities with the rights to equal access to public accommodations.
- The U.S. Department of Justice regulation to Title III of the ADA requires that public accommodations provide auxiliary aids when such are necessary to enable a person with disabilities to benefit from their services: "A public accommodation shall furnish appropriate auxiliary aids and services where necessary to ensure effective communication with individuals with disabilities."*

Auxiliary aids and services required by the ADA include "qualified licensed and insured interpreters"** to ensure that effective communication is provided at critical points during the provision of health care services as follows:

- When critical medical information is communicated
- When explaining a medical procedure
- When informed consent is required for treatment

Please note: *It is important for everyone to be able to communicate with his or her physicians and other health care professionals. Refusing to provide care or the assistance of an interpreter while caring for a person with a qualifying disability is a violation of the ADA. Members who are hearing-impaired have the right to use sign-language interpreters to assist them at their doctor visits. We will bear the reasonable cost of providing an interpreter; the member must not be billed for interpreter fees (28 CFR Sect. 36.301(c). Interpreters are reimbursed by the physician/facility for their services. The physician/facility should bill us for these services by submitting a claim form with Current Procedural Terminology (CPT) code 99199 with a description of the interpreter service.*

* 28 CFR Sect. 36.303(c)

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

Locating qualified interpreters for members who are hearing-impaired

An interpreter is necessary during a medical appointment with a member who is hearing-impaired. These agencies serve as a resource to connect interested parties with qualified interpreters.

Connecticut

State of Connecticut Commission on Deaf and Hearing-Impaired	860-708-6796 (TTY/Voice) 860-231-8756 (TTY/Voice) 860-231-7623 (Interpreting Emergencies)

New Jersey

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

New York

New York Society for the Deaf	212-777-3900
New York City Metro Registry of Interpreters for the Deaf	212-821-9588
Deaf and Hard of Hearing Interpreting Services, Inc.	718-433-1092

To access our telecommunications device for the deaf (TTY/TDD), please call **1-800-201-4875** to assist commercial members or **1-800-201-4874** to assist Medicare members.

Translator assistance for non-English-speaking members

According to CMS and NCQA guidelines, we are required to ensure that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds. Our physicians and other health care professionals play a key role in fulfilling these requirements by:

- Being responsive to the needs of a diverse patient population
- Demonstrating knowledge and sensitivity to the unique, culturally-based health care beliefs of patients
- Incorporating educational programs for office staff to improve their knowledge, attitudes and skills to be as culturally appropriate as possible

Our service associates are available to assist members in Chinese, Mandarin, Cantonese, and Korean. To speak with a service associate:

- In Chinese, Mandarin or Cantonese, call **1-800-303-6719**
- In Korean, call **1-888-201-4746**
- In English and other languages, call **1-800-444-6222** regarding commercial members or the number on the back of the Medicare member's ID card

Please note: *We utilize a special translating service to communicate with members in the language they are most comfortable speaking. Members can request a copy of the Medicare Evidence of Coverage on audiocassette or in Braille by calling the number on the back of the Medicare member's ID card (TTY/TDD 1-800-201-4874).*

Patient education and treatment

It is your responsibility to share with your patients the findings of their history, examinations and tests, and to discuss potential treatment options without regard to plan coverage limitations. You should also inform patients about any side effects associated with treatment, as well as how to manage symptoms.

You should explain clearly and objectively to your patients the benefits, drawbacks and likelihood of success of any proposed treatment, and discuss the consequences of refusal or non-compliance with the recommended treatment plan. Ultimately, it is the patient who must choose the final course of action among clinically acceptable choices.

Advance medical directives

We support a patient's right to participate in health care decision-making. The Patient Self Determination Act of 1991 guarantees an individual the right to accept or refuse any medical treatment or procedure.

In order to comply with the CMS regulations regarding advance directives, we ask you to document in a prominent place in the medical record whether or not your patients have advance directives. If a patient has created such a document, a copy should be included in a prominent place in his or her medical record.

You are responsible for providing your patients with comprehensive, clear information about therapeutic and diagnostic options. We encourage collaboration and open communication. Please make yourself available to discuss advance directives, life-prolonging measures and "do not resuscitate" orders with patients and/or families who have questions.

Disease and intensive case management

We have created a number of programs designed to improve outcomes for our members and to allow us to better manage the use of medical services. Practitioners may refer members to these programs, or members may self-refer.

Active Care Engagement℠ (ACE) — 1-877-759-3059

The ACE program is a comprehensive health management program for high-risk members with congestive heart failure, coronary artery disease and diabetes. The program is designed to help members manage their chronic condition to improve health status and quality of life. We are contracted with Healthways, Inc. to manage the ACE program. Additionally, the ACE program assists physicians in the successful management of the chronically ill member. Physicians with members participating in the program will receive disease specific guidelines for care, patient specific data reports and a variety of educational and support materials geared toward improving adherence to nationally recognized care guidelines for cardiac and diabetic conditions.

Better Breathing® Asthma Intervention Program — 1-800-665-4686

The asthma program is designed to emphasize patient education and promote compliance with the guidelines established through the National Institutes of Health. Its purpose is to complement the care a member receives from his or her doctor by providing educational mailings on topics such as the proper technique for administering medications and avoiding the triggers of asthma.

Depression Program — 1-800-665-4686

The depression program was developed to educate members with depression about their condition and its effective treatment, as well as the importance of coordinating care and continuing treatment. By partnering with physicians, we hope to educate members about the importance of managing their condition. In addition, the program provides current treatment and screening information to physicians through the distribution of clinical practice guidelines.

Living with Diabetes℠ — 1-800-665-4686

Our diabetes program is structured to educate members with diabetes and to improve their self-management by providing them with resources such as educational materials and support organizations. In addition, the program is designed to educate physicians about current treatment guidelines set by the American Diabetes Association (ADA) and to promote the use of these guidelines in diabetic treatment. The overall goal of the program is to improve the glycemic and lipid control of members with diabetes, thereby reducing morbidity and mortality associated with the disease.

Heart Smart℠ Programs:

Cardiovascular Disease — 1-800-665-4686

The Heart Smart cardiovascular disease (CVD) program is designed to address the health needs and concerns of members who are at risk or at high risk for CVD (primary), and those who have experienced a CVD-related event (secondary). The program also provides up-to-date treatment and prevention information to physicians through the distribution of clinical practice guidelines, practice feedback and member-specific information.

Heart Failure — 1-800-665-4686

The Heart Smart heart failure (HF) population health management program is a comprehensive, population-based health management program for people with heart failure. The program also provides up-to-date treatment and prevention information to physicians through the distribution of clinical practice guidelines, practice feedback and member-specific information.

Disease and intensive case management (continued)

Oxford Cancer Support Program℠ 1-800-835-8021

The cancer support program focuses primarily on members who have the potential to experience complications associated with their cancer treatment and who would benefit from case management interventions. As a physician, you can refer members over the age of 18 with an Oxford plan, who are diagnosed with cancer (excluding acute leukemia) and are in active treatment or end-stage management. For additional information about the Oxford Cancer Support Program, go to ***www.oxfordhealth.com*** > **Tools and Resources** > **Oncology Resource Center**.

Preventive Health Program 1-800-665-4686

The preventive health program is designed to empower members to make informed, educated decisions about their personal health care. The program focuses on childhood and adolescent well care and immunizations, women's health, (mammography, Pap smears), colorectal screening, and adult immunizations. The overall goal is to improve health outcomes and quality of care of our members by educating physicians and other health care professionals and members about general health and wellness and condition-specific preventive care.

Rare Chronic Care Program 1-866-217-2921

We have contracted with Accordant Health Services to deliver an integrated, comprehensive case management program to empower members to successfully manage their chronic illness through education and symptom management, while encouraging compliance with the physician's care plan. Conditions addressed include myasthenia gravis, lupus, hemophilia, cystic fibrosis, and multiple sclerosis.

Transplant Program 1-888-201-4257

The transplant team manages all aspects of every transplant to ensure medically appropriate care, including precertification and coordination of services.

Transitional Case Management 1-888-201-4257

The transitional case management program supports members in transition from an inpatient setting to a home setting. In our effort to prevent avoidable readmissions of recently discharged individuals, we help ensure that a discharge plan is in place and that the member is compliant with his or her medications and follows up with his or her physician.

NICU Program 1-888-936-7246

We have contracted with OptumHealth Neonatal Resource Services (NRS) to provide Neonatal Intensive Care Unit (NICU) on-site and telephonic case management services for members. The objectives of the NRS program are to promote continuity of service and care, encourage family involvement, and assist with the neonate's successful transfer home by coordinating discharge planning needs. NRS clinical staff will help support the facility's NICU staff and neonatologists in their role as clinical decision-makers, optimizing family involvement in the baby's care.

Medicare Part D and risks of fraud, waste and abuse for physicians and other health care professionals

We are a Part D Plan Sponsor that adheres to the regulatory requirements under 42 C.F.R. § 423.504(b)(4)(vi)(H) to have in place a comprehensive fraud and abuse plan to detect, correct and prevent fraud, waste and abuse as an element of our compliance plan. As a Part D Plan Sponsor, we have an ultimate responsibility to detect, correct and prevent fraud, waste and abuse, it is necessary for the sponsor to engage first tier and downstream entities to collaborate in these efforts.

Physicians and other health care professionals are defined as any Medicare physician or supplier (e.g., facility, skilled nursing facility, home health agency, outpatient physical therapy, comprehensive outpatient rehabilitation facility, renal dialysis facility, hospice, physician, non-physician practitioner, laboratory, supplier, pharmacy, or pharmacist). For purposes of this manual, we direct this information to individuals or organizations that prescribe or supply prescription drugs that are reimbursable under Part D.

Physicians and other health care professionals may encounter behaviors/activities indicative of fraud, waste and/or abuse when treating a Part D eligible individual, an individual who is entitled to Medicare benefits under Part A or enrolled in Part B and lives in the Part D plan's service area pursuant to 42 C.F.R. § 423.30(a). Physicians and other health care professionals may also encounter behaviors/activities indicative of fraud, waste and/or abuse when working with representatives of pharmaceutical manufacturers.

Additional information on the regulations pertinent to Medicare Part D may be researched in the Centers for Medicare and Medicaid Services *Prescription Drug Benefit Manual*, Chapter 9 – Part D Program to Control Fraud, Waste and Abuse.

Physicians and other health care professionals may offer great assistance in efforts to deter, detect and correct fraud, waste and abuse. Should a member provide information of this nature, the physician or other health care professional may report the complaint directly via the hotline telephone number **1-877-637-5595**. The same hotline telephone number may be provided to members for direct reporting of alleged fraud, waste and abuse.

Physician and other health care professional awareness: Examples of fraud, waste and abuse behaviors

The following provides information regarding possible schemes, activities and behaviors of potential fraud, waste, and abuse that may affect or may be encountered by physicians and other health care professionals. This list is not exhaustive and is for information purposes.

Illegal remuneration schemes – Prescriber is offered, or paid, or solicits, or receives unlawful remuneration to induce or reward the prescriber to write prescriptions for drugs or products.

Prescription drug switching – Drug switching involves offers of cash payments or other benefits to a prescriber to induce the prescriber to prescribe certain medications rather than others.

Script mills – Physician or other health care professional writes prescriptions for drugs that are not medically necessary, often in mass quantities, and often for patients who are not theirs.

Theft of prescriber's DEA number or prescription pad – Prescription pads and/or DEA numbers can be stolen from prescribers. In the context of e-prescribing, this includes the theft of the physician's or other health care professional's authentication (login) information.

Inappropriate relationships with physicians – Potentially inappropriate relationships between pharmaceutical manufacturers and physicians or other health care professionals, such as "switching" arrangements to induce a physician or other health care professional to switch the prescribed drug from a competing product; incentives offered to physicians or other health care professionals to prescribe medically unnecessary drugs; consulting and advisory payments, payments for detailing, business courtesies and other gratuities, educational and research funding; improper entertainment or incentives offered by sales agents.

Illegal usage of free samples – Providing free samples to physicians or other health care professionals knowing and expecting those physicians or other health care professionals to bill the federal health care programs for the samples.

Physicians and other health care professionals should be aware that there are schemes perpetrated by beneficiaries. The following are a list of types of fraud, waste and abuse that could be perpetrated by beneficiaries in Part D:

Prescription forging or altering – Prescriptions are altered, by someone other than the prescriber or pharmacist, without prescriber approval, to increase quantity or number of refills.

Prescription diversion and inappropriate use – Beneficiary obtains prescription drugs from a physician or other health care professional, possibly for a condition from which they do not suffer, and gives or sells this medication to someone else. This can also include the inappropriate consumption or distribution of a beneficiary's medications by a caregiver or anyone else.

Resale of drugs on black market – Beneficiary falsely reports loss or theft of drugs or feigns illness to obtain drugs for resale on the black market.

Doctor shopping – Beneficiary or other individual consults a number of doctors for the purpose of inappropriately obtaining multiple prescriptions for narcotic painkillers or other drugs.

Misrepresentation of status – A Medicare beneficiary misrepresents personal information, such as identity, eligibility, or medical condition in order to illegally receive Medicare benefits (also, *Identity theft*).

Federal Civil False Claims Act

The False Claims Act, 31 U.S.C. § 3729(a)(1)-(7) prohibits knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval. Additionally, it prohibits knowingly making or using (or causing to be made or used) a false record or statement to get a false or fraudulent claim paid or approved by the federal government or its agents, like a carrier, other claims processor, or state Medicaid program.

The False Claims Act is enforced against any individual/entity that knowingly submits (or causes another individual/entity to submit) a false claim for payment to the Federal government. In addition, parties have a continuing obligation to disclose to the government any new information indicating the falsity of the original statement. Since the health plan, acting as a sponsor for Medicare programs, maintains ultimate responsibility for adhering to all terms and conditions of its contract with Centers for Medicare and Medicaid Services, they must monitor their subcontractors for compliance with all applicable regulations pursuant to 42 C.F.R. § 423.504(i).

The anti-kickback statute

Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a-7b(b) provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration in order to induce or reward business payable (or reimbursable) under Medicare or other Federal health care programs. In addition to applicable criminal sanctions, an individual or entity may be excluded from participation in Medicare and other Federal health care programs and may be subject to civil monetary penalties. For purposes of the anti-kickback statute, "remuneration" includes the transfer of anything of value, directly or indirectly, overtly or covertly, in cash or in kind. Sponsors shall have policies and procedures employed to ensure that illegal remuneration is not permitted and shall specify follow-up procedures if they uncover unlawful remuneration schemes pursuant to 42 C.F.R. § 423.504(b)(4)(vi)(A) & (G).

Physicians and other health care professionals with a history of complaints

As a Part D Plan Sponsor, we maintain files on physicians and other health care professionals who have been the subject of complaints, investigations, violations, and prosecutions. We are expected to comply with law enforcement, Centers for Medicare and Medicaid Services and designee requests to monitor physicians and other health care professionals within our network that Centers for Medicare and Medicaid Services has viewed as potentially abusive or fraudulent.

Physicians and other health care professionals should be aware that we will not pay for drugs prescribed or provided by a physician or other health care professional excluded by either the HHS OIG or GSA pursuant to 42 C.F.R. § 1001.1901.

Utilization management

Utilization management (UM) is a process commonly used across a broad spectrum of industries, including health. Our UM represents a combination of different disciplines, including: utilization review with benefit and eligibility requirements, effective and appropriate delivery of medically necessary services, quality of care across the continuum, discharge planning, and case management.

The goals of UM are to:

- Promote the delivery of appropriate care for all members
- Promote necessary care in the appropriate setting, at the appropriate time and using appropriate resources

- Assess and offer appropriate alternative services

Descriptions of our utilization management requirements, including services requiring precertification, are contained in the following sections of this manual:

- Section Four – Precertification and Referrals
- Section Five – Hospitalization, Urgent Care and Behavioral Health Care Services
- Section Six – Ancillary Services
- Section Nine – Payment Appeals and Grievances

A copy of our utilization management policies and procedures can be accessed from our website at ***www.oxfordhealth.com*** or by calling Provider Services at **1-800-666-1353**.

Appropriate service and coverage

Our Medical Management department monitors services provided to members to identify potential areas of over and underutilization. UM decision making is based only on appropriateness of care and service and existence of coverage. We do not specifically reward or offer incentives to practitioners or other individuals for issuing denials of coverage or service care. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

We may compile information regarding procedures that, based on a review of our members' claims experience, are performed more frequently or with unclear or controversial indications. We may also conduct reviews regarding overutilization, including but not limited to, working with physicians and other health care professionals to improve performance, and disciplining repeat offenders.

Compliance with quality assurance and utilization review

Physicians and other health care professionals agree to fully comply with and abide by the rules, policies and procedures that we have or will establish, with written notice of any changes provided 30 days in advance, including, but not limited to, the following:

- Quality assurance, including, but not limited to, on-site case management of patients, intensivist programs and notification compliance measures
- Utilization management, including, but not limited to, precertification procedures, referral processes or protocols and reporting of clinical accounting data
- Member and physician and other health care professional grievances
- Physician and other health care professional credentialing
- Any similar programs developed by us

Utilization review of services provided to New York commercial members

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

Requirements for initial utilization review determinations

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

Preauthorization – UR decisions will be made and notice will be provided to you and the member, by phone and in writing, within three (3) business days of receipt of necessary information.*

Concurrent review – UR decisions will be made and notice will be provided to the member or the member's designee by phone and writing within one (1) business day of receipt of necessary information. Please note that this requirement may be satisfied by giving notice to you, the physician or other health care professional, by telephone and in writing, within one (1) business day of receipt of necessary information.

Retrospective – UR decisions will be made within 30 days of receipt of necessary information. We will notify you of the determination in a Remittance Advice statement or a separate notice.

A written notice of an initial adverse determination will include:

- The reasons for the determination including the clinical rationale, if any;
- Instructions on how to initiate standard and expedited internal and external appeals;
- Notice of the availability, upon request of the member or the member's designee, of the clinical review criteria relied upon to make such determination;

* Per Section Four of this manual, the telephonic notification to members has been delegated to you. Please remember to call the member.

- The notice will also specify what, if any, additional necessary information must be provided to, or obtained, to render a decision on the appeal.

A preauthorized treatment, service or procedure may be reversed on retrospective review under the following circumstances:

- Relevant medical information presented to us or utilization review agent upon retrospective review is materially different from the information that was presented during the preauthorization review; and
- The information existed at the time of the preauthorization review but was withheld or not made available; and
- Health plan or the UR agent was not aware of the existence of the information at the time of the preauthorization review; and
- Had they been aware of the information, the treatment, service or procedure being requested would not have been authorized.

In the event that an initial adverse UR determination is rendered without attempting to discuss such matter with the member's physician or other health care professional who specifically recommended the health care service, procedure or treatment under review, such physicians and other health care professionals shall have the opportunity to request a reconsideration of the adverse determination. Except in cases of retrospective reviews, such reconsideration shall occur within one (1) business day of receipt of the request and shall be conducted by the member's physician or other health care professional and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer cannot be available. In the event that the adverse determination is upheld after reconsideration, a written adverse determination notice containing the items specified in the last bullet will be sent to you. Nothing in this section shall preclude the member from initiating an appeal from an adverse determination.

Failure to make an initial UR determination within the time periods described above is deemed to be an adverse determination eligible for appeal.

Criteria for determining coverage

Our medical directors are available to discuss their decisions with you. Contact our Medical Management department directly at 1-800-666-1353 (Mon. - Fri., 8 a.m. - 6 p.m. ET) and ask to speak to one of our medical directors. Medical policies are also available online at ***www.oxfordhealth.com*** **> Provider home page > Tools and Resources > Medical and Administrative Policies**.

Requirements for appeals of initial adverse utilization review determinations

Member appeals must be submitted to us or our delegate within 180 days from the receipt of the initial adverse UR determination. While member appeals may be initiated verbally by calling our Customer Service department at the number on the member ID card or at 1-800-444-6222, we strongly recommend that the appeal be filed in writing. A written request will give us a clear understanding of the issues being appealed, and must include any documentation/information already requested by us (if not previously submitted) and any additional information the member or the member's designee would like to submit in support of the appeal. Additional information about member appeals is contained in the Provider Reference Manual (PRM) and will be sent with each initial adverse UR determination.

An expedited UR appeal may be filed for denials of:

- Continued or extended health care services, procedures or treatments;
- Additional services for member undergoing a course of continued treatment; and
- Health care services for which the physician or other health care professional believes an immediate appeal is warranted.

Determinations concerning services that have already been provided are not eligible to be appealed on an expedited basis.

The process for handling expedited appeals includes mechanisms which facilitate resolution of the appeal including but not limited to:

- The sharing of information by telephone or fax;
- Reasonable access to the clinical peer reviewer within one (1) business day of our receipt of notice of the taking of an expedited appeal; and
- A mechanism for immediately requesting necessary information from the member and the member's physician or other health care professional by telephone and/or fax.

Expedited UR appeals will be determined within two (2) business days of receipt of necessary information to

conduct such appeal. Written notice of final adverse determination concerning an expedited UR appeal will be transmitted to the member within 24 hours of rendering the determination. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process.

Standard (non-expedited) UR appeals may be filed by telephone or in writing by the member or member's designee. Written acknowledgment of the filing of the appeal will be provided to the appealing party within fifteen (15) days of the filing of a standard appeal if a determination is not made within fifteen days of the filing of the appeal. The process for standard appeals also includes a mechanism for requesting necessary information from the member and the member's physician or other health care professional in writing within fifteen (15) days of receipt of the appeal and a follow-up as appropriate, if information is not received.

A determination will be made within sixty (60) days of the receipt of necessary information to conduct the appeal. The member, the member's designee and, where appropriate, the member's physician or other health care professional, will be notified of the appeal determination in writing within two (2) business days of the rendering of such determination. The notice will include reasons for determination. If an adverse UR determination is upheld on appeal, the notice will include the clinical rationale for such determination and a notice of the member's right to an external appeal together with a description of the external appeal process.

Failure to make a determination within the applicable time periods shall be deemed to be a reversal of an initial adverse UR determination. The law allows the member and the health plan to jointly agree to waive the internal UR appeal process. Typically, we will not agree to waive the internal UR appeal process. In those rare situations where we are willing to waive the internal UR appeal, we will inform the appeal requester and/or member verbally and/or in writing. If the member agrees to waive the internal UR appeal process, we will provide a written letter with information regarding filing an external appeal to the member within 24 hours of the agreement to waive the internal appeal process.

Members' rights to external appeal

The member has a right to an external appeal of a final adverse determination (FAD). An external appeal may also be filed if the member and the plan jointly agree to waive the internal UR appeal process and the issue would otherwise be the type eligible for external appeal if the first-level internal appeal had been processed.

A FAD is a first-level appeal denial of an otherwise covered service where the basis for the decision is either a lack of medical necessity or the experimental/investigational exclusion. Determinations concerning clinical trials and experimental or investigational procedures may be appealed through the external appeal process only if the member's physician is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member's condition or disease, and has certified that:

- The member's condition meets the statutory definition of a "life threatening" or "disabling" condition or disease for which standard health services or procedures have been ineffective or would be medically inappropriate; or
- There does not exist a more beneficial standard health service or procedure covered by the health care plan; or
- There exists a clinical trial; and
- The member's attending physician must have recommended either:
  - A health service or procedure [including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B)] that based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or
  - A clinical trial for which the member is eligible; and
  - The specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for our determination that the health service or procedure is experimental or investigational.

Furthermore, the physician's certification must include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and an external appeal must be submitted within 45 days upon receipt of the FAD, regardless of whether or not a second level appeal is requested. If a member chooses to request a second level internal appeal, the time may expire for the member to request an external appeal.

Criteria and guidelines

We have adopted the Milliman Care Guidelines® and criteria for inpatient care where an optimal recovery guideline exists. In addition to these guidelines, we

develop specific policies related to covered services; each policy describes the service and its appropriate utilization.

For Medicare general members, Medicare Coverage Guidelines (MCG) and the written coverage decisions of local Medicare contractors are also used to determine medical necessity of services requested, consistent with state and federal coverage determinations. MCG include a compendium of regulations, including the Medicare Managed Care Manual and the Medicare Claims Processing Manual, based on medical appropriateness criteria and the clinical status of the patient. Medicare contractors such as ourselves are required to use them to support decision making for concurrent review of Medicare beneficiaries' services. We do not determine coverage of or payment for counseling, referral or emergency services based on moral or religious grounds.

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

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

Clinical guidelines and medical policy changes

A Policy Update Bulletin summarizing all recently approved and/or revised policies is available on ***www.oxfordhealth.com*** on the first business day of every month. By accessing the bulletin, you may view new and/or updated policies, in their entirety, 30 days prior to implementation. We encourage you to view this information in its entirety to determine the guidelines and criteria that will be applied to each policy. This communication serves as your 30-day prior notification of new and revised policies and may be accessed from the physician or facility home page under **Tools and Resources > Practical Resources > Medical and Administrative Policies > Policy Update Bulletin**.

To ensure you are aware of new and revised policies as they become effective, please log in to ***www.oxfordhealth.com*** regularly and view the Policy Update Bulletin.

If you would like a hard copy of medical polices, please send a written request to:

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

Clinical guidelines

We employ a process for adopting and updating clinical practice guidelines for use by network physicians and other health care professionals. Clinical practice guidelines help practitioners and members make decisions about health care in specific clinical situations. Guidelines are developed for preventive screening, acute and chronic care, and appropriate drug usage, based on:

- Availability of accepted national guidelines
- Ability to monitor compliance
- Projected ability to make a significant impact upon important aspects of care

Clinical practice guidelines are available on our website. Simply log in as a physician or facility at ***www.oxfordhealth.com***, click on **Tools and Resources** then on **Clinical & Preventive Guidelines** and select **Clinical Practice Guidelines**.

You can also request a printed copy of the clinical practice guidelines by writing to:

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

Section Four: Precertification and Referrals

Precertification

Responsibility for precertification or notification

- Our participating facilities, physicians and other health care professionals must notify us at least 14 days prior to a patient's scheduled procedure. Obstetrical admissions for normal delivery should be precertified as early as possible in the course of prenatal care, based on the expected date of delivery.

Physicians and other health care professionals can notify us of such procedures online at ***www.oxfordhealth.com***, through an EDI vendor, or by calling our Medical Management department at **1-800-666-1353**.

- Participating physicians and other health care professionals and facilities are responsible for contacting us for all procedures requiring precertification; however, an active referral* must also be on file for services to be covered in-network, depending on the member's benefits.
- Neither precertification nor referral is required for Medicare members to access a participating women's health specialist for routine and preventive health care services. Women's health specialists include, but are not limited, to gynecologists and/or certified nurse midwives. Routine and preventive health care services include breast exams, mammograms, and Pap tests.
- If a participating PCP would like to direct a member to a nonparticipating physician or other health care professional because there are no participating physicians or other health care professionals able to perform the specific service in the area, then the PCP is responsible for obtaining precertification for an in-network exception on behalf of the member by calling 1-800-666-1353. A referral cannot be made to a nonparticipating provider without our approval.
- If a member asks you for a recommendation to a nonparticipating physician or other health care professional, then it is the member's responsibility to obtain all required precertifications by calling 1-800-444-6222 for commercial members, or the number on the back of the Medicare member's ID card (TTY/TDD 1-800-201-4874) for Medicare members. Please remember to tell the member that you may not refer the member to a nonparticipating provider, and the member must contact Oxford to obtain the required precertification.
- Participating physicians and other health care professionals are responsible for notifying us when there has been a change of treating physician or other health care professional, CPT codes or dates of service for the precertified service.
- Members are responsible for notifying us of emergency facility admissions to a nonparticipating facility. Participating physicians, other health care professionals and contracted facilities must notify us of all member emergency admissions upon admission or on the day of admission. If the physician/facility is unable to determine on the day of admission that the patient is our member, the physician/facility will notify us as soon as possible after discovering that the patient has coverage with us.
- Participating physicians and other health care professionals will be notified of all determinations involving New York commercial members by phone and in writing. All participating physicians and other health care professionals are responsible for calling the member the same day that the physician or other health care professional receives notification to inform the member of our determination.
- We may require that your patient see a physician or other health care professional, selected by us, for a second opinion. We reserve the right to seek a second opinion for any surgical procedure; there is no formal list of procedures requiring second opinions; members may also seek a second opinion when appropriate.

Using nonparticipating facilities

As a participating physician or other health care professional, you are required to utilize participating physicians, other health care professionals and facilities within the network (i.e., Freedom Network and Medicare) applicable to the member's plan. We have implemented a compliance program to identify participating physicians and other health care professionals who regularly use physicians and other health care professionals and facilities that do not participate in our network, and will take the appropriate measures to enforce compliance.

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

- This means that the reimbursement to the non-participating facility will be subject to the member's out-

* Not required when a member is seeing their designated participating OB/GYN.

of-network deductible and coinsurance obligations. Also, the non-participating facility's charges are only eligible for coverage up to the reimbursement levels available under the member's plan, using either a usual, customary and reasonable (UCR) fee schedule, or a Medicare reimbursement system called the Out-of-Network Reimbursement Amount.

- Additionally, we may make the claim payment directly to the member instead of to the nonparticipating facility. In such cases, the nonparticipating facility will be instructed to bill the member for services rendered. The member will then be responsible for making payment to the nonparticipating physician or other health care professional for the full amount of the check mailed to them by us, in addition to any applicable copayment, deductible, coinsurance or other cost share allowances, according to the member's benefit plan.
- Commercial members will be responsible for paying their out-of-pocket cost as well as the difference between the UCR fee or Out-of-Network Reimbursement Amount and the non-participating facility's billed charges. Please remind the member that his or her expenses may be significantly higher when using a nonparticipating provider.

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

Please note: *Exceptions may be considered upon request only when our Medical Director determines in advance that our network does not have an appropriate participating network physician or other health care professional who can deliver the necessary care.*

Services requiring precertification

The appearance of an item on this list is not a guarantee of coverage. Precertification requirements and covered services may vary depending on the member's plan of coverage. Precertification and payment of covered services are subject to the terms, conditions and limitations of the member's contract or certificate, eligibility at time of service, and approval by our Medical Management department. This list may be changed by us, and any changes will be communicated on ***www.oxfordhealth.com*** on the first business day of each month.

In addition, precertification requirements may differ by individual physician or other health care professional. If additional precertification requirements apply, the physician or other health care professional will be notified in advance of the precertification rules being applied.

Inpatient and outpatient care

As a general rule, any service rendered in an inpatient facility or an outpatient facility requires precertification. These settings include, but are not limited to, acute care centers, skilled nursing facilities, freestanding ambulatory surgery centers, radiology centers, radiation therapy centers, hospice centers, and rehabilitation centers.

Exceptions to this rule include emergency room visits not resulting in an admission and urgent care delivered at a participating urgent care facility. In addition, a list of outpatient services not requiring precertification is available in our policy *Precertification Exemptions for Outpatient Services*.

Emergency admissions do not require precertification. However, we must be notified within 24 to 48 hours of an admission.

If an ambulatory surgery occurs as a result of an emergency room or urgent care visit, the provider must notify Oxford within 24-48 hours of when the surgery is performed. Elective admissions require prior authorization at least 14 days prior to the date of admission for the following: acute care, skilled nursing, subacute care, and hospice care.

Transfer from one facility to another requires precertification prior to the transfer unless the transfer is due to a life-threatening medical emergency.

Assistant surgeons and co-surgeons

Participating physicians are required to use a participating physician's assistant surgeon when an assistant surgeon is warranted. Precertification is required; you must use one of our electronic solutions, or call the Oxford Medical Management department at 1-800-666-1353.

Home health care

Home health care includes, but is not limited to, physical therapy, nursing visits and occupational therapy.

Office-based procedures

- Any surgical procedure, major diagnostic test and endoscopic procedure

Potentially cosmetic procedures (including but not limited to)

- Repair of ptosis, blepharoplasty and repair of ectropion/ectropion
- Treatment of varicose veins and telangiectasia (e.g., ablation, ligation and stripping, sclerotherapy)

- Breast reduction (both male and female)
- Refractive eye surgery
- Rhinoplasty and nasal surgical procedures
- Destruction of cutaneous vascular proliferative lesions less than 10 sq. cm. for hemagiomas and port wine stains, birthmarks, strawberry nevis
- Destruction of cutaneous vascular proliferative lesions (e.g., laser technique) over 10 sq. cm.
- Abdominoplasty and body contouring procedures

Other services requiring precertification (all settings including in-office unless otherwise noted)

Complementary and alternative medicine

- Chiropractic services for commercial and Medicare members* require precertification**

  OptumHealth Care Solutions
  P.O. Box 5800
  Kingston, NY 12402-5800

* Coverage is based on member's benefit.

** Precertification is not required for certain groups.

Behavioral health/substance abuse

- Outpatient mental health; members of gated plans need a referral from their PCP or through our Behavioral Health department (1-800-201-6991)
- Cognitive and neuropsychological testing
- Inpatient care

Dental procedures

- Procedures to treat injury to sound natural teeth
- Procedures requiring inpatient/outpatient general anesthesia

DME/prosthetics/supplies/implantables

- All DME, orthotics, prosthetics and medical supplies for Medicare members
- For commercial members:
  - DME and orthotics over $500
  - All prosthetics, custom orthotics and custom DME (regardless of cost)
  - All rentals, repairs and replacements, and implantables
  - Beds, cribs and pressure-reducing mattresses/pads/overlays
  - Bone growth (osteogenesis) stimulators
  - Cochlear implants and osseointegrated (bone-anchored) hearing aids
  - Continuous passive motion devices
  - Cryotherapy devices
  - Electrical stimulation devices (e.g., wound care, muscle rehabilitation, pain management)
  - High-frequency chest wall compression devices
  - Mechanical stretching devices (dynamic and static)
  - Nutritional therapy (including formula and specialized foods)
  - Oxygen therapy, except in the office
  - Speech-generating devices
  - Standing systems
  - Wheelchairs (manual and power), power-operated vehicles (scooters), specialized strollers
  - Wigs (replacement)

Experimental and investigational therapies (including off-label therapies)

- Clinical trials
- All other experimental and investigational therapies

Radiology procedures – through CareCore National 1-877-PREAUTH (1-877-773-2884) Fax: 1-800-540-2406 Website: www.carecorenational.com

- CT scans
- MRI
- MRA
- PET scan
- Nuclear medicine studies
- Endoscopic/obstetrical ultrasounds

Rehabilitation services

- Occupational, physical and speech therapy for Medicare members
- Occupational and physical therapy for commercial members through OptumHealth Services (authorization is required for the initial evaluation)
- Speech therapy in the home for commercial members

Surgical procedures

- All outpatient and inpatient procedures

Transplantation

- Solid organ transplants
- Bone marrow/stem cell transplant

Transportation (land, air and water)

- Excluding emergency

Unlisted codes

Refer to our policy Unlisted CPT Codes Requiring Medical Director Review on ***oxfordhealth.com***

Unproven or ineffective treatment

Refer to our policy on Experimental/Investigational Treatment on ***oxfordhealth.com***

See pages 45 and 46 in this section for **medications requiring precertification** for drugs, medications and injectables.

Contracted hospital notification of admissions

Contracted hospitals are required to notify us of inpatient admissions. We may deny some or all of an inpatient admission if the hospital fails to:

- Notify of any admission
- Obtain precertification for a non-emergency admission or an outpatient procedure for which precertification is required, including ambulatory surgery resulting from an emergency room or urgent care visit
- Notify us of any patient who changes level of care, including, but not limited to, NICU, ICU, etc.
- Obtain precertification for a non-emergency admission or an outpatient procedure for which precertification is required
- Provide records as reasonably requested by us
- Cooperate with inpatient concurrent review

If we deny part or all of an inpatient admission for one of the reasons noted above, the hospital will have 48 hours (72 hours for New Jersey hospitals) in which to submit a request to Medical Management for reconsideration of the denied days (excluding case rates). If during the reconsideration process, we determine the previously denied days were medically necessary and appropriate, we will pay the hospital for the covered services at the allowable rates.

Performing services at contracted hospitals

- All participating physicians and other health care professionals are responsible for obtaining precertification when hospital services (inpatient, outpatient or emergency admissions), out-of-network services and other specific services are to be delivered.
- All services require precertification 14 days prior to the scheduled date of service, with the exception of emergency room service, or unless the need is defined as a medical emergency.

Medications requiring notification/precertification

Medications requiring notification/precertification for commercial members (through pharmacy benefits manager)

Selected medications may require notification to be eligible for coverage under the member's pharmacy benefit plan. This process is also known as precertification and requires that you submit a formal request for review. Coverage decisions are based upon clinical criteria established in advance by the Pharmacy and Therapeutics Committee. The medications (including generic equivalent, if available) that require notification for commercial members with prescription drug coverage through us are listed on ***oxfordhealth.com***. This list is subject to change without notice. To obtain notification, please call 1-800-753-2851 – available 24/7, including holidays.

If you have any questions regarding the medications on this list or any other medication, please call Pharmacy Customer Service at **1-800-905-0201**.

Please note: *Notification requirements may vary depending on the member's pharmacy benefit plan. Visit* ***www.oxfordhealth.com*** *for a current listing of medications requiring notification/precertification.*

Medications requiring precertification for MedicareComplete® and Evercare DH members (through pharmacy benefits manager)

Our pharmacy benefits manager, Prescription Solutions®, has established programs to encourage drug therapy that is appropriate and economical for our Medicare members. For most Medicare members with pharmacy benefit coverage through an AARP® MedicareComplete®, Evercare Plan DH or MedicareComplete Plan insured by Oxford Health Plans (NY/NJ/CT), Inc., the medications on the following list (including their generic equivalent, if available) generally require precertification through Prescription Solutions, based on our coverage criteria.

This list is subject to change. Precertification, also known as prior authorization, requires that you formally submit a request to, and receive approval from, Prescription Solutions in order for the member to receive coverage for a prescription for certain medications.

If you have any questions regarding the medications on this list or any other medication for Medicare members, please call Prescription Solutions at **1-800-711-4555**.

- Actiq
- Accuneb
- Acetylcysteine
- Actimmune
- Airet
- Albuterol Sulfate
- Alimta
- Androderm
- Androgel
- Android
- Anzemet
- Apokyn
- Aralast
- Avastin
- Aranesp
- Avonex
- Betaseron
- Baygam
- Byetta
- Carimune Nanofiltered (1gm Injection, 3 gm Injection, 6gm Injection)
- Cellcept
- Cellcept Intravenous
- Cerezyme
- Copaxone
- Cromolyn Sodium
- Cyclophosphamide
- Cyclosporine (capsule, injection, solution)
- Cyclosporine Modified
- Duoneb
- Elaprase
- Emend
- Enbrel
- Engerix-B
- Engerix-B SDV
- Erbitux
- Flebogamma
- Forteo
- Gamastan S/D
- Gammagard
- Gammagard S/D
- Gammar-P.I.V.
- Gengraf
- Immune Globulin
- Iveegam EN
- Genotropin
- Humatrope
- Humira
- Intron A
- Intron A w/Diluent
- Ipratropium Bromide
- Kineret
- Kytril
- Marinol
- Metaproterenol Sulfate
- Miacalcin
- Myfortic
- Neupogen
- Norditropin
- Nutropin AQ
- Octreotide Acetate
- Pegasys
- PEG-Intron
- PEG-Intron Redipen
- Polygam S/D
- Procrit
- Provigil
- Prograf
- Proleukin
- Pulmicort
- Ranexa
- Raptiva
- Rapamune
- Rebetol (solution)
- Recombivax HB
- Regranex
- Revatio
- Rebif
- Rebif Titration Pack
- Revlimid
- Ribasphere
- Ribatab
- Ribavirin
- Rituxan
- Roferon-A
- Remicade
- Saizen
- Sandostatin LAR Depot
- Somavert
- Sporanox solution
- Striant
- Symlin
- Testim
- Thalomid
- Tracleer
- Vancocin HCl
- Venoglobulin-S
- Vfend
- Topamax
- Xolair
- Xopenex
- Zelnorm
- Zofran
- Zofran tablet
- Zyvox

To obtain precertification or for the most up-to-date information, please call Prescription Solutions at **1-800-711-4555** for Medicare members.

Medications requiring precertification through Oxford's Medical Management department (for commercial and Medicare members)

The medications and injectables on the list below are covered under the member's medical benefit and require precertification through our Medical Management department.

To obtain precertification, please call our Medical Management department directly at 1-800-666-1353 (Mon. – Fri., 8 a.m. – 6 p.m. ET).

Biological response modifiers
- Erythropoietin (EPO, Epoetin Alfa, Epogen, Procrit)
- Darbepoetin (Aranesp)

Cardio/pulmonary drugs
- Chelation IV Therapy
- Deferoxamine Mesylate
- Dimercaprol Injection
- Edetate Calcium Disodium
- Nesiritide (Natrecor®)
- Prolastin[1]
- Xolair®
- Chelation IV Therapy
- Dimercaprol Injection
- Edetate Calcium Disodium
- Deferoxamine Mesylate

Dermatological drugs
- Amevive (Alefacept®)
- Botox
- Remicade™[3]

Gastrointestinal drugs
- ERT Therapy:
  - Fabrazyme
  - Aldurazyme
  - Cerezyme
  - Ceredase
  - Elaprase
  - Fabrazyme
  - Myozyme
  - Remicade™[1]
- Gonadotropin-Releasing Hormone Agonist
- Lupron Depot Pediatric 7.5 mg
- Lupron Depot Pediatric 11.25 mg
- Lupron Depot Pediatric 15 mg

Infertility drugs
- Follitropin alfa (Gonal-F)
- Follitropin beta (Follistim)
- Follitropin beta (Puregon)
- Urofollitropin (Bravelle)

Immunotherapy and chemotherapy drugs
- Avastin™[4]
- Bexxar[4]
- Bortezomib (Velcade™)[4]
- Campath (alemtuzumab)
- Cetuximab (Erbitux)[4]
- Herceptin (Trastuzumab)
- IV Antibiotic Therapy for Lyme Disease
- IVIG
- Oxaliplatin (Eloxatin®)[4]
- Pemetrexed (Alimta®)[4]
- Rituximab (Rituxan)[4]
- RSV Vaccine (Synagis/RespiGam)
- Vectibix[4]
- Zevalin™[4]

Multiple sclerosis
- Mitoxantrone (Novantrone)
- Nutritional therapy
- Formula and specialized food

Musculoskeletal and rheumatological
- Intrathecal Baclofen
- Euflexxa[1]
- Hyaluronan[1]
- Hyalgan[1]
- Orencia
- Orthovisc[1]
- Prosorba
- Supartz[1]
- Synvisc[1]
- Synvisc-One[1]
- Orencia
- Prosorba

Ophthalmologic drugs
- Avastin
- Lucentis
- Visudyne

[1] Precertification is not required in the office setting.

[2] Precertification through Oxford's Medical Management department is required for Medicare members only.

[3] Precertification is required in all settings for diagnosis of Plaque Psoriasis.

[4] Physicians and members may choose to have the drug reviewed for medical necessity either pre-service or when the claim is submitted.

If an eligible member has a diagnosis listed in the applicable drug's policy and the claim for the drug is submitted with an ICD-9 code reflecting that diagnosis, the claim will be reimbursed in accordance with the member's health benefits plan, whether or not precertification was requested. For uses of a drug for diagnoses not listed in the policy, all requests for coverage must be precertified and will be reviewed by a Medical Director using criteria outlined in our Experimental/ Investigational Treatment and Clinical Trials policies.

If precertification is not requested, the claim will be reviewed for medical necessity by a Medical Director at the time of submission and coverage will be either approved or denied based on the Medical Director's review.

How to submit precertification and referrals

Physicians and other health care professionals can submit electronic precertification requests through our website at ***www.oxfordhealth.com*** or through an EDI vendor. Submitting precertification requests through our website provides convenience and flexibility, as the services are available 24 hours a day. Many procedures are approved on a real-time basis. More complex procedures are captured and held over for follow-up within one business day.

Electronic precertification exclusions

The following requests must be made directly to our Medical Management department at 1-800-666-1353 or the appropriate delegated vendor for precertification:

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

To obtain access to submit a precertification request, log in to ***www.oxfordhealth.com*** or call 1-800-811-0881.

Log in by entering your username and password. Once in "My Account," go to **Submit** then click on **Precert Requests** and enter all required data.

Required information

The following data is required when submitting a precertification request:

- Patient's member ID number and date of birth
- Primary procedure code
- Quantity/visits requested
- Service date
- Principal diagnosis code
- Facility ID (required if services are not performed in the office or home care setting)
- Contact name and phone number; click enter to initiate your request

EDI solutions

For commercial and Medicare members: If you already have an Emdeon™ point-of-service terminal, you can submit your precertification requests electronically through this EDI vendor.

By telephone

For non-urgent precertification requests, please call accordingly:

Medical Management department	1-800-666-1353
Behavioral Health department	1-800-201-6991
Imaging – CareCore National	1-877-773-2884
Pharmacy requests (commercial members)	1-800-753-2851
Pharmacy – Prescription Solutions (Medicare members)	1-800-711-4555

Precertification inquiry online

You can also use our website to view the status of current and previous precertification requests by using the precertification inquiry tool. This feature, available to all physicians and other health care professionals, allows for better tracking of requests, as well as confirmation of approved services. You can check your precertification requests via ***www.oxfordhealth.com***, Oxford Express (our automated phone system) or through an EDI vendor.

To check the status of a precertification request, you will need the following:

- Patient's ID or Social Security number; or
- Reference number associated with the precertification request

You can view requests by:

- Last five requests on file
- Date of service (data retrieved will reflect plus or minus seven (7) days)

Precertification-by-fax program

We have implemented a precertification-by-fax program to alleviate the need for telephone transactions to obtain precertification or provide notification of admission.

In order for this program to be successful, we need you to use the forms (located on ***oxfordhealth.com*** **> Tools and Resources > Forms**) when submitting precertifications and notification of admissions. These forms will allow us to quickly review all requests and

provide you with timely service. We will only accept those faxes received on the appropriate forms.

Hospital Notification-by-Fax form

Please use this form to:

- Report an emergency admission
- Report an inpatient admission
- Report an emergency maternity admission

Precertification-by-Fax form

Physicians – Please use this form to:

- Precertify services being performed in the future
- Update an existing precertification request

Facilities – Please use this form to:

- Precertify services being performed in the future when a precertification request is not already on file

Please note: *We recommend that physicians and other health care professionals perform a precertification inquiry first to determine if there is already a precertification on file.*

Precertification-by-Fax form for non-emergency maternity admissions

Physicians – Please use this form to:

- Precertify maternity services being performed in the future
- Update an existing maternity precertification request

Precertification fax numbers

Please use the appropriate number to fax non-urgent precertification requests:

Primary care and specialty physicians and other health care professionals	1-800-303-9902
Facilities	1-800-699-4712
Behavioral health	1-800-760-4041
Complementary and alternative medicine providers	1-800-201-7025
Physical and occupational therapy providers	1-800-216-0810

Please note: *The precertification-by-fax program should not be used for precertification inquiry. To obtain information about a precertification request, physicians and other health care professionals can use our website or Oxford Express, our automated phone system.*

Referrals (gated plans only)

When our member needs medical care that the PCP cannot generally provide within the scope of his or her practice, a referral can be generated. Our physician contracts require referrals be issued to participating physicians and other health care professionals within the member's network, except in cases of emergency or when there are no participating physicians or other health care professionals who can treat the member's condition. If you want to direct a member to non-participating physicians and other health care professionals, our Medical Management department must approve an in-network exception request prior to the services being rendered (please refer to previous comments for your obligations to seek precertification). If the member requests to see a specialist and is unable to reach his or her PCP or OB/GYN (after-hours, weekends or holidays), the PCP may issue a referral up to 72 hours after services have been received.

Electronic referrals to participating physicians and other health care professionals can be submitted online at ***www.oxfordhealth.com***, through Oxford Express (our automated telephone system) or through an EDI vendor.

Locating a participating specialist

To locate a participating specialist, consult our *Roster of Participating Physicians and Other Health Care Professionals* for the relevant state or Oxford product via ***www.oxfordhealth.com*** and click on **Doctor Search**.

Call toll-free 1-800-666-1353 to request a copy of the roster or to locate a specialist. PCPs who have also contracted with us as specialists may provide specialty care services to their patients on an in-network basis, according to our policies. Other PCPs may also refer their patients to a PCP/specialist.

For further instructions, please call the Provider Services department at 1-800-666-1353.

Services obtained out-of-network

Participating physicians and other health care professionals cannot generate an electronic referral to a physician or other health care professional who does not participate in the member's selected network. The member's network can be found by checking the member's eligibility online at ***www.oxfordhealth.com***. It is also noted on the member's ID card. However, if a member prefers not to use a physician or other health care professional affiliated with his or her applicable network, the member may utilize his or her out-of-network coverage

(if applicable) without a referral. Claims for non-emergent and non-urgent care from nonparticipating physicians and other health care professionals received by members without out-of-network coverage will be denied.

Referral policies and guidelines

A referral should be made only when, in your professional opinion, you believe it is medically appropriate and necessary. If you have never seen the patient before, you have the right to ask the patient to come in for an examination and diagnosis before issuing a referral. If you do not examine the patient on the day you issue a referral, you may not charge for any evaluation and management service at that time. Please use the following guidelines when making a referral.

- Referrals are required for all in-plan specialist services, except for laboratory services performed at Lab Corp Network Laboratories, which require a physician script form.
- Referrals must be submitted electronically to us for all members except those members who have "No Referral Required" printed on their ID card.
- A referral should not be issued for services already provided; in cases where the participating physician or other health care professional is administratively unable to submit a referral prior to services being rendered, we will allow referrals to be generated up to 72 hours after the services were rendered. We reserve the right to monitor retroactive referral generation and compliance with this policy.
- Referrals are valid for the number of visits authorized. The maximum number of visits for which a referral can be generated is 30 visits. If the number of visits is not specified, the referral is valid for one visit only. When a physician or other health care professional indicates both a time limit and a number of visits, the referral defaults to whichever comes first.

  See Section Six on **Ancillary Services** for more details on these specialties, including referral considerations.

- If further visits are needed or if the referral expires before the number of visits on the referral have been provided, a new referral must be issued by the PCP.
- Referrals must be issued for physicians and other health care professionals within the member's network (e.g., a Liberty Plan℠ member must be referred to a Liberty network specialty physician or other health care professional).

Please note: *Effective January 1, 2008, all AARP® MedicareComplete®, Evercare Plan DH and MedicareComplete plans insured by Oxford Health Plans (NY/NJ/CT), Inc. are non-gated; this includes group retiree plans.*

- For Medicare members whose care is with a delegated Medicare vendor (e.g., Montefiore), physicians and other health care professionals must submit referrals to the applicable vendor who is specifically delegated to these Medicare members if required.
- Participating nephrologists, oncologists and infectious disease (HIV) specialists can submit referrals for all in-network specialist care; precertification guidelines still apply to covered services that require precertification.
- Any participating specialist can submit referrals for any adult or pediatric diagnostic procedure; any such referral must be to a participating physician or other health care professional.
- A participating adult or pediatric general surgeon, gynecological oncologist, hematologist-oncologist, oncologist pain management specialist, neurologist, orthopedist, physiatrist, neurosurgeon, or rheumatologist can submit a referral for any diagnostic procedure, or therapeutic services such as physical and occupational therapy (for commercial members); precertification guidelines still apply for those covered services that require precertification; any such referral must be to a participating physician or other health care professional.

  See **Exceptions to referral requirements** this section.

Our Behavioral Health department can issue a referral directly to the member if he or she is uncomfortable approaching his or her PCP for a referral to a behavioral health specialist (precertification may be required for member's with non-gated plans).

If a service requires a referral, and you perform the service without an electronic referral on file with us, the following rules will apply:

If the member is in this type of plan…	…and you treat them without a referral…
Commercial gatekeeper plan with no out-of-network benefits (HMO only)	Services would not be eligible for coverage
Commercial gatekeeper plan with out-of-network benefits (e.g., POS), we will pay contracted rates	Services would be eligible for out-of-network coverage less member out-of-pocket cost
Commercial non-gatekeeper plan with or without out-of-network benefits	Services would be eligible for in-network coverage

Members of non-gated plans (PPO, Freedom Plan® Access and Select, Liberty Plan℠ Access and Select plans) can self-refer to participating physicians or other health care professionals and receive in-network coverage. A referral from a participating physician or other health care professional is not necessary. Members with non-gated plans have "No Referral Required" printed on their ID cards. If the member wishes to stay in-network, it is their responsibility to make certain the physician or other health care professional they are using is participating with us.

Please note: *A referral does not guarantee that we will cover the services provided by the participating specialist.*

Payment for covered services is subject to:

- Medical necessity, as determined by our Medical Director, applying our medical policies and clinical judgment, subject to applicable law
- Member eligibility on the date(s) of service
- Member benefits as defined in the conditions, terms and limitations of the member's *Summary of Benefits and Certificate of Coverage/Evidence of Coverage*
- Submission of appropriate CPT diagnosis codes for the services rendered
- Other legal requirements for the provision of the services (i.e., licensure, our privileging policies, etc.)

Exceptions to referral requirements

The following types of service do not require a referral for commercial members:
Participating PCP visit
OB/GYN visit
Emergency care
Urgent care
Ambulance services in medical emergencies
Mammogram
Pneumococcal vaccine administered in any setting* (including nonparticipating Oxford physicians and other health care professionals)
Influenza vaccine administered in any setting
Participating radiology provider (precertification required for most services)
Covering physicians and other health care professionals (as long as they identify themselves as covering on the claim or have the same federal tax identification number (FTIN)
Certain diabetic supplies as provided by our policy (See ***www.oxfordhealth.com***)
Blood transfusion
Complementary and alternative medicine, if the member has an alternative medicine benefit
Laboratory and pathology services performed at a participating network lab; a lab slip or physician's order can be used instead of a referral
Durable medical equipment (DME)† under $500 and not custom molded, and certain medical supplies
Services rendered by a physician extender who is employed by, or works under supervision of, the member's PCP and/or OB/GYN

Please sign in to OxfordHealth.com > Tools & Resources > Practical Resources > Medical & Administrative Policy > Administrative Policies for more information.

* Excludes administering in the home.

† DME for commercial members. In place of a referral, we will accept either of the following: prescription or physician's or other health care professional's medical necessity.

Referral process

Issuing an electronic referral

A PCP, OB/GYN or Oxford On-Call nurse can issue a referral to a participating specialist online at ***www.oxfordhealth.com***. Referrals can be entered through Oxford Express at 1-800-666-1353, or using an EDI vendor. Once the referral is entered, the referring physician or other health care professional will receive a reference number that should be given to the member. The reference number indicates that the member is eligible and the referral has been completed correctly.

Specialist and outpatient facility services referrals

Once the PCP submits the referral electronically, it will be on file with us. If the electronic referral is generated through an Emdeon™ point-of-service terminal, it will print out a receipt, similar to a credit card receipt, which serves as confirmation that the referral is on file with us. This receipt can be given to the patient to bring with him or her to the specialist or the referred-to physician or other health care professional. A physician or other health care professional can also confirm the electronic referral online at ***www.oxfordhealth.com***, through Oxford Express, or using an EDI vendor. In addition, we offer the automatic referral notification feature. Upon submission of an electronic referral (whether submitted via Oxford Express, ***www.oxfordhealth.com*** or an EDI vendor), a fax will be sent to the referred-to-physician or other health care professional usually within 24 hours of the referral being submitted. This fax serves as a confirmation notice of the referral. Physicians and other health care professionals have the option to update their dedicated referral fax number or decline the auto-fax notification feature on our website under the "Your Account" section or via Oxford Express through a referral inquiry or submission transaction.

Standing referrals to specialty care centers

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

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

Referral verification

All referrals that have been entered into our system will be available for inquiry by facilities and physicians; this includes those submitted electronically and those initiated by **Oxford On-Call.** Physicians and other health care professionals can inquire about referrals by using **Oxford Express**, our automated telephone system at 1-800-666-1353. (Once you are in **Oxford Express**, select option 2 for verification). You may also go to our website at ***www.oxfordhealth.com***, or use an EDI vendor. You can also call Provider Services at 1-800-666-1353 and speak with an associate.

Submitting electronic referrals

www.oxfordhealth.com

To submit referrals for commercial and Medicare members, log onto our website and select **Referrals** under the Submit option on your physician home page.

Please enter the following:

- Patient identification information
- Servicing physicians and other health care professionals information
- Number of visits
- Effective date of the referral

To obtain a password, simply log onto ***www.oxfordhealth.com*** and click on **Need to Register?** under **Access Your Online Account Today**. Choose either **Healthcare Provider** or **Healthcare Facilities** as appropriate to set up your account.

Oxford Express®

You must have an access code to submit referrals through **Oxford Express**. To submit a referral, call 1-800-666-1353, select your physician or other health care professional type, and then option 1 for automated service and option 4 to generate a referral. A referral can be generated simply by following the prompts and entering the member's ID number, the referred-to-physician's or other health care professional's ID number, the number of visits, and the effective date of the referral.

How to obtain an access code or password

If your office does not have an access code, you can easily request one through Oxford Express. After you finish entering and verifying your physician ID number, press the pound sign (#) when asked for your access code. Press 1 if you are representing a physician or press 2 if you are representing a facility or ancillary facility. Physicians, please enter your Social Security number and your date of birth (MM/DD/YYYY). You will then be asked to enter a four- to six-digit access code of your choice and to confirm the code by re-entering it a second time. Your access code will be generated immediately if the information that you entered matches our system. Please record your access code for future use.

Hospitals and ancillary facilities will be transferred to a representative who will ask for contact information, including facility name, facility ID, contact name, and phone number. We will call back within five (5) business days to set up your access number.

If you need instructions on how to submit your referrals to us electronically, please contact the Physician eSolutions team at **1-800-599-4334**.

Section Five: Hospitalization, Urgent Care and Behavioral Health Care Services

Hospitalization

Emergency hospitalization

Definition of a medical emergency

New York and Connecticut

A medical emergency is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of such severity, including severe pain, that a prudent layperson with an average knowledge of medicine and health, could reasonably expect the afflicted member to suffer serious consequences in the absence of immediate medical attention. Those consequences may include:

- Jeopardy to physical health or, in the case of a behavioral condition, jeopardy to the health and safety of the member or others
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organs or parts
- Serious disfigurement

New Jersey

A medical emergency is defined as a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse, such that the absence of immediate attention could reasonably be expected to result in:

- Jeopardy to the health of the individual (or with respect to a pregnant member, the health of the mother or the unborn child)
- Serious impairment to bodily functions
- Serious dysfunction of a bodily organ or part

With respect to a pregnant member who is having contractions, an emergency exists when there is inadequate time to effect a safe transfer to another facility before delivery or when the transfer may pose a threat to the health or safety of the mother or the unborn child.

Medical emergencies include, but are not limited to, the following conditions:

- Severe or acute chest pains
- Severe or multiple injuries
- Severe shortness of breath
- Extreme fever
- Loss of consciousness (e.g., disorientation)
- Sudden change in mental status
- Severe bleeding or loss of blood
- Poisoning
- Convulsions
- Suspected heart attack, suspected stroke, diabetic coma, appendicitis, burns, fracture or threatened loss of limb, abdominal catastrophes, suspected severe infections, severe metabolic derangements, or other conditions requiring immediate treatment

Emergency admission review

If your patient is admitted to a hospital as a result of an emergency (as defined above), we will review the hospital admission for medical necessity and determine the appropriate length of stay based on our approved criteria for concurrent review. Review begins when we become aware of the admission. We must be notified of all emergency inpatient admissions (no later than 48 hours from the date of admission, or as soon as reasonably possible).

If the member is admitted to a contracted hospital, we will use reasonable efforts to transmit a decision about the admission to the hospital (to the facsimile number and contact person designated by the hospital) within 24 hours of making the decision. We may also communicate our precertification decision to the hospital by telephone.

Emergency room visits

Emergency room visits during which a patient is treated and released without admission do not require notice to us. If an ambulatory surgery occurs as a result of an emergency room or urgent care visit, the provider must also notify Oxford within 24-48 hours of when the surgery is performed. Any and all follow-up needs related to such emergency services should be coordinated through the member's primary care physician (PCP) and are subject to the standard referral process.

See Section Four on **Referrals** for more information.

In-area emergency services

You do not need authorization or notification from us for in-area emergency room treatment and subsequent release. Claims are subject to the prudent layperson standard. However, all emergency inpatient and emergency room admissions do require notification upon admission or on the day of admission (no later than 48 hours from the date of admission, or as soon as reasonably possible). In the case of ambulatory surgery occuring as a result of an emergency room or urgent care visit, the provider must also notify

Oxford within 24-48 hours of when the surgery is performed.

To notify us of an inpatient admission, use our electronic notification transaction by logging onto ***www.oxfordhealth.com***, go to **Transaction** and click on **Precert Requests;** or by fax to **1-800-303-9902** (24 hours a day, seven days a week); or call our Medical Management department at **1-800-666-1353**.

Out-of-area emergency services

Out-of-area coverage for emergency room (ER) services is limited to care for accidental injury, unanticipated emergency illness or other emergency conditions when circumstances prevent a member from using ER services within our service area.

Coverage

We cover emergency room services for medical emergencies. The member is responsible for paying the applicable copayment. Follow-up emergency room visits within our service areas are not covered. However, follow-up care, if appropriate, may be covered when it takes place in the PCP's office. Follow-up care in a specialist's office may be covered and is subject to referral guidelines.

For more information, commercial members should call our Customer Service department at **1-800-444-6222** (Mon. – Fri., 8 a.m. – 6 p.m. ET). Medicare members should call the Medicare Customer Service department at the number on the back of their member ID card.

Non-emergency hospitalization

Any hospitalization service that does not meet the criteria for an emergency or for urgent care requires precertification and is subject to medical necessity review. Participating physicians and other health care professionals are required to request precertification by contacting us, even if the member was directed to a hospital by the PCP without a referral.

See Section Four on **Precertification** for more information.

Maternity

It is crucial that the member, or the member's physician or other health care professional, notify us of a pregnancy as early as possible to ensure the proper application of benefits. Non-emergency maternity admissions should be precertified. Newborn coverage varies from plan to plan and state to state.

See Section Four on **Precertification** for more information.

To determine coverage guidelines in your state, contact our Customer Service department at **1-800-444-6222**.

Hospital services, admissions and procedures

You must precertify all elective and nonelective inpatient hospital admissions, as well as admissions to skilled nursing facilities, subacute and rehabilitation facilities.

Please precertify online at ***www.oxfordhealth.com*** or call the Medical Management department at **1-800-666-1353**.

Outpatient precertification is also required for surgical and major diagnostic testing performed in an outpatient clinic or any ambulatory or freestanding surgical or diagnostic facility. Precertification is the responsibility of the hospital or ancillary facility and the physician or other health care professional.

See Section Four on **Precertification** for more information.

Inpatient hospital copayment

State regulations for commercial plans determine when a member should be charged for subsequent inpatient hospital copayment(s) when readmitted into an inpatient setting. This assumes that the member's benefit structure has inpatient copayments. According to state laws, inpatient hospital copayments must be based on a "per continuous confinement" basis.

Medicare notification of hospital discharge and Medicare appeal rights for Medicare Advantage organizations

Hospitals must notify Medicare members who are hospitalized about their hospital discharge appeal rights. The term "member" means either a member or representative, when a representative is acting for a member. Hospitals will use a revised version of the Important Message (IM) from Medicare, a statutorily required notice, to explain the

member's rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within two (2) calendar days of admission, must obtain the signature of the member or his or her representative and provide a copy at that time. Hospitals will also deliver a copy of the signed notice as far in advance of discharge as possible, but not more than two (2) calendar days before discharge.

Detailed Notice of Discharge (Detailed Notice) – CMS 10066

If a member requests a Quality Improvement Organization (QIO) review, we must deliver a Detailed Notice of Discharge (Detailed Notice or DNOD) as soon as possible, but no later than noon of the day after the QIO's notification. Both the IM and the Detailed Notice must be the standardized notices provided by the Centers for Medicare & Medicaid Services (CMS). If the QIO notifies us that a member has requested an immediate review, we must, directly or by delegation, deliver a Detailed Notice to the member as soon as possible, but no later than Noon of the day after the QIO's notification. The health plan will complete the DNOD letter and coordinate with the hospital for the urgent delivery of the notice to the member or the designated member representative. If a member requests more detailed information prior to requesting a review, we may, directly or by delegation, deliver the Detailed Notice in advance of the member requesting a review.

Providing information to the QIO

If the QIO notifies us that a member has requested an immediate review, we, and the hospital, must supply all the information the QIO needs to make its determination, including copies of both the IM and the Detailed Notices, as soon as possible, but no later than noon of the day after the QIO notifies the hospital of the request. In response to a request, we, and the hospital, must supply all information that the QIO needs to make its determination, including copies of both the IM and the Detailed Notices (if applicable), as soon as possible, but no later than close of business of the day that we notify the hospital of the request for information. At the discretion of the QIO, we, and the hospital, may make the information available by telephone or in writing. A written record of any information not transmitted in writing should be sent as soon as possible.

Providing the member with documentation upon request

At the request of the member, we must furnish the member with a copy of, or access to, any documentation that is sent to the QIO, including written records of any information provided by telephone. We may charge the member a reasonable amount to cover the costs of duplicating the documentation and/or delivering it to the member. We must accommodate the request by no later than close of business of the first day after the material is requested.

Refer to the CMS website for additional information.
www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

Notice of Medicare non-coverage (NOMNC) for skilled nursing facility (SNF) care, comprehensive outpatient rehabilitation facility (CORF) and home health care (HHC)

Effective January 1, 2004, CMS mandates that we provide advance written notification of the termination of service prior to the termination for SNF, CORF and HHC services.

We must ensure that this notice is provided to the Medicare members no later than two (2) days [or two (2) visits] before the proposed end of the services.

Discharge planning and concurrent review

Prior to the actual admission date, our Medical Management department works with the member, physician or other health care professional and hospital to develop a prospective discharge plan. Upon admission, Medical Management will accept concurrent review information provided by the admitting physician or other health care professional and/or the hospital's Utilization Review department. Furthermore, if not already submitted, the hospital will provide us with the discharge plan on the day of admission. If a patient requires an extended length of stay or additional consultations, please call our Medical Management department at **1-800-666-1353** to update the precertification. For Behavioral Health, all calls related to inpatient precertification should be directed to **1-800-201-6991**.

Our concurrent review process uses approved criteria to determine the medical necessity of a member's continued hospitalization; it also allows for changes and updates to discharge plans.

Inpatient concurrent review – day-of-service decision-making program

We provide hospitals with day-of-service decision-making for continued and ongoing care. To achieve this goal, we have refined some of our processes as part of a consistent application of the Milliman Care Guidelines® for inpatient medical and surgical care, home care and recovery facility care. When issuing a precertification for an inpatient admission or concurrent review approval, the number of approved days or other types of services will be based on these guidelines. We provide concurrent and prospective certification for all services via the end-of-day report (EDR). The EDR lists all our members currently known to be in that facility. We must, however, be made aware of each member's admission, and the facility involved must provide timely necessary clinical information to demonstrate medically appropriate covered care. Our intention is to eliminate most, if not all, retroactive denials. The following are more specifics about these processes.

Hospital responsibilities

Concurrent inpatient stays (notification prior to discharge)

- The hospital will verify a patient's status, since no payment will be made for services rendered to persons who are not our members.
- The hospital is required to notify us of any patient that changes level of care, including but not limited to NICU, ICU, etc.
- The member must be enrolled and effective with us on the date the service(s) are rendered; once the hospital verifies a member's eligibility with us, that determination will be final and binding; however, if the Centers for Medicare & Medicaid Services (CMS) or an employer or group retroactively disenrolls the member up to ninety (90) days following the date of service, then we may deny or reverse the claim; if there is a retroactive disenrollment for these reasons, the hospital may bill and collect payment for those services from the member or another payer.
- The hospital must provide a daily inpatient census log by 10 a.m.; the daily inpatient census log will reflect all admits and discharges through midnight the day prior; this will be considered the hospital's official record of our members under its care.
- The hospital must provide notification of all admissions of our members at the time of, or prior to, admission; the hospital must notify us of all emergencies (upon admission or on the day of admission); the hospital must also notify us of "rollovers" (i.e., any patient who is admitted immediately upon receiving a precertified outpatient service); the hospital must also notify us of any transfer admissions of members.
- The hospital must precertify any transfer admissions of members prior to the transfer unless the transfer is due to a life-threatening medical emergency.
- The hospital must communicate necessary clinical information on a daily basis, or as requested by our Case Manager, at a specified hour that allows for timely generation of our EDR.
- If the hospital does not provide the necessary clinical information, the day will be denied and reconsideration will be given only if clinical information is received within 48 hours (72 hours for New Jersey facilities).
- The hospital is responsible for verifying the accuracy of the admission and discharge dates for our members listed on the EDR.
- If we conduct on-site utilization review, the hospital will provide our on-site utilization management personnel reasonable workspace and access to the hospital, including access to members, their medical records, the emergency room, hospital staff, and other information reasonably necessary to:
  - Conduct utilization review activities
  - Make coverage decisions on a concurrent basis
  - Consult in rounds and discharge planning in both inpatient and emergency room settings

It is the responsibility of all physicians and other health care professionals to deliver letters of noncoverage to the member before discharge; this includes hospitals, acute rehabilitation, skilled nursing facilities, and home care.

Please note: *Appeals will be considered if the hospital can demonstrate that the necessary clinical information was provided within 48 hours, but we failed to respond in a timely manner.*

Retrospective review of inpatient stays (notification of admission after discharge)

Commercial members – Upon request from us, the hospital will provide the necessary clinical information to perform a medical necessity review within 45 days of discharge. If the hospital does not provide the necessary clinical information, the day will be denied and reconsideration will only be given if clinical information is

received within 48 hours (72 hours for New Jersey members).

Medicare members – A retrospective review may only be initiated within the above guidelines and when the member is not held financially liable. All information must be received within 10 business days of the initial request for retrospective review.

Enhancing care management through electronic medical records (EMR)

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

Having access to a hospital's EMR system allows for a more timely and accurate understanding of our member's clinical status, thereby facilitating evidence-based dialogue and timely care coordination and management.

There are several direct advantages in allowing us to access your EMR system:

- Reduction in Utilization Management staff time, which allows for reallocation to other utilization review activities or potential full-time employee (FTE) savings
- Fewer interruptions with telephone calls
- Reduction of administrative resources to manage documentation and review activities
- More timely coverage determination decisions
- Real-time clinical information exchange produces faster turnaround times when scheduling aftercare modalities, which results in fewer discharge delays and improved patient satisfaction
- Go Green: EMR access drastically reduces the amount of paperwork required to perform utilization review activities and brand your hospital as eco-friendly

HIPAA compliance and security

We are committed to strict compliance with all security and privacy regulations. Patients' protected health information (PHI) will remain restricted to cases where there is a "need to know" in order to conduct "Treatment, Payment, or Healthcare Operations" (TPO) as outlined in the HIPAA Privacy Rule.

For additional information on granting remote access to your EMR system, please submit your questions, along with your contact information including facility name, city and state and a phone number to: emrcdsa@uhc.com.

Our responsibilities

- We will maintain a system for verifying member eligibility/status.
- We will use reasonable efforts to transmit a decision regarding an emergency/urgent admission to the hospital (to the fax number and contact person designated by the hospital) within 24 hours of making the initial decision; we may also communicate our decision by telephone.
- We will request any necessary clinical information; failure by us to seek such information will result in our liability for that day's service.
- We agree to provide concurrent and prospective certification for all services via a daily EDR when the hospital provides timely necessary clinical information to demonstrate medically appropriate covered care; the EDR will communicate our intention to pay for specific services or a specific plan of care for the member.
- We will assign a first day of review (FDOR) for all elective inpatient services, and all days up to and including the FDOR will be certified; coverage decisions for the next day will be given on the EDR.
- We will notify the hospital and attending physician or other health care professional verbally or by written communication (that is consistent with NCQA requirements and applicable law) of all denied days; our daily EDR will include a report on the decisions for the current day, as well as a preliminary decision for the next day when review is performed on that day; failure by us to communicate a decision to deny precertification will result in our liability for that day's service; if we deny inpatient days due to benefit or medical necessity reasons, the hospital may seek to appeal the adverse determination in accordance with applicable law and our appeal procedures.
- We will perform clinical review of days that fall on the weekend (Saturday and Sunday), holidays for which we or the facility is closed, and days upon which there are unforeseen interruptions in business on the following business day; such reviews will be considered concurrent.

Please note: *We will not deny services retrospectively or reduce the level of payment for services that have been precertified or received concurrent review approval unless:*

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

Neonatal Intensive Care Unit (NICU) level of care

NICU bed levels are based on the intensity of services and identifiable interventions received by the neonate. The NICU bed levels of care are linked to a revenue code that is defined by the National Uniform Billing Committee. We will assign NICU levels for those facilities contracted with more than one level of NICU.

Clinical process definitions

Acute hospital day

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

Alternative level of care*

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

- An acute clinical situation has stabilized.
- The intensity of services required can be provided at less than an acute level of care.
- An identified skilled nursing and/or skilled rehabilitative service is medically indicated.
- ALC is prescribed by the member's physician or other health care professional.

Inpatient ALC must meet the following criteria:**

- The skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech pathologists or audiologists are required; and
- Such services must be provided directly by or under the general supervision of those skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.

* ALC only applies if the facility has a contracted rate.

** Inpatient ALC must meet clinical criteria per clinical guidelines. Failure to satisfy these criteria can result in denial of coverage.

New technology

New technology refers to a service, product, device, or drug that is new to our service area or region. This does not apply to a service, product or device that is new to a hospital but not new to the region. Any new technology must be reviewed and approved for coverage by the Medical Technology Assessment Committee or the Clinical Technology Assessment Committee for Behavioral Health technologies.

Potentially avoidable days

A potentially avoidable day (PAD) arises in the course of an inpatient stay when, for reasons not related to medical necessity, a delay in rendering a necessary service results in prolonging the hospital stay. PADs must be followed by a medically necessary service.

There are several types of PADs:

- **Approved Oxford potentially avoidable day (AOPAD)**: We caused delay in service; the day will be payable.
- **Approved physician or other health care professional potentially avoidable day (APPAD)**: The physician or other health care professional caused delay in service; the day will be payable.
- **Approved mixed potentially avoidable day (AMPAD)**: A delay due to mixed causes not solely attributable to us, the physician, other health care professional, or the hospital; the day will be payable.
- **Denied hospital potentially avoidable day (DHPAD)**: The hospital caused the delay in service; DHPAD is a noncertification code, and the day is not payable.

We will not reverse any certified day unless the decision to certify was based on erroneous information supplied by the physician or other health care professional, or a potentially avoidable day was identified.

Readmissions

When a member is readmitted to the hospital for the same clinical condition or diagnosis within 31 days of discharge, the second hospital admission will not be reimbursed when any of the following conditions apply:

- The member was admitted for surgery, but surgery was canceled due to an operating room scheduling problem.
- A particular surgical team was not available during the first admission.
- There was a delay in obtaining a specific piece of equipment.
- A pregnant woman was readmitted within 24 hours and delivered.
- The patient was admitted for elective treatment for a particular condition, but the treatment for that condition was not provided during the admission because another condition that could have been detected and corrected on an outpatient basis prior to the admission made the treatment medically inappropriate.

In any of the situations noted above, the hospital cannot bill the member for any portion of the covered services not paid for by us.

Diagnosis-related group (DRG) hospitals

DRG is a statistical system of classifying an inpatient stay into groups of specific procedures or treatments. When a hospital contracts for a full DRG, we will reimburse the hospital a specific amount (determined by the contract) based on the billed DRG rather than paying a per diem or daily rate (DRG facility). A DRG is determined after the member has been discharged from the hospital.

When admission information is received through our website, we will consider this to be notification only; first day approval will not be granted to hospitals with a DRG contract. When we receive notification of an admission to a hospital with a DRG contract, our Case Manager will review the admission for appropriateness. If the Case Manager cannot make a determination based on the admitting diagnosis, the Case Manager will request an initial review to determine whether the admission is medically necessary. If the admission is denied, the hospital will not have the reconsideration option; they must follow the standard appeal process. The hospital is required to provide admission notification and a daily inpatient census of all our members.

At our discretion, the day-of-service (DOS) process may or may not be applied for DRG hospitals. Therefore, if we choose not to apply the DOS process, end-of-day reports are not generated. Decisions are communicated to DRG hospitals either telephonically and via letters or through an end-of-week report, depending on the agreement established between us and the hospital.

If a member is readmitted into the same hospital/hospital system within 30 days of discharge, then the second readmission will not be reimbursed.

If a member is transferred to a hospital within the same hospital system as the first hospital during one continuous admission, payment will be made only to the hospital the member was transferred to as the final discharge DRG.

Prepayment DRG validation program

We may request a DRG hospital to send the inpatient medical record prior to claim payment so we may validate the submitted codes. After review of all available medical information, the claim will be paid based on the codes that have been substantiated following review of the medical record.

Hospital records may be requested to validate ICD-9 codes and/or revenue codes billed by participating facilities for inpatient hospital claims. If the billed ICD-9 codes or revenue codes are not substantiated, the claim will be paid with the codes that are validated only.

For appeal rights, please refer to Section Nine.

Technical definitions

Disposition determination

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

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

Late and no notification

Late notification is defined as notification of a hospital admission after the contracted 48-hour notification period and prior to discharge. No notification is defined as failure

to notify us of a member's admission to a hospital after discharge, up to and including at the time of submitting the claim.

Urgent care

Urgent care is medical care for a condition that needs immediate attention to minimize severity and prevent complications but is not a medical emergency and does not otherwise fall under the definition of emergency care as previously defined. Members are encouraged to call their PCP if they think they need urgent care. Members may also contact Oxford On-Call for assistance with clinical issues. Oxford On-Call registered nurses may triage the member and recommend an appropriate site of care based on information provided. Our members may also seek urgent care at a contracted urgent care center facility, in which case precertification is not required. For commercial members, use of nonparticipating facilities within and outside our service area requires notification to Customer Service. For Medicare members, use of a nonparticipating facility outside our service area does not require precertification. Any and all follow-up needs related to such urgent care services should be coordinated through the member's PCP and are subject to the standard referral process outlined in Section Four.

Behavioral health care services

Overview

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

The BEH department offers a toll-free, dedicated line, **1-800-201-6991**, that is available to members, Employee Assistance Programs and physicians and other health care professionals, Mon. – Fri., 8 a.m. – 6 p.m. ET. This line can be used to certify care and to obtain referrals for mental health or substance abuse treatments.

If your patient requires behavioral health services, please call the Behavioral Health department at **1-800-201-6991**.

The BEH department recognizes the importance and the sensitivity surrounding mental health and substance abuse diagnosis and treatment. We encourage coordination of care between our participating behavioral health physicians and primary care physicians as the best way to achieve effective and appropriate treatment. For this purpose, we developed a Release of Information (ROI) form that is designed to facilitate member consent and to share information with the primary care physician in the presence of his or her behavioral health physician. This form may be downloaded from our website, ***www.oxfordhealth.com*** **> Tools and Resources > Forms**.

Clinical definitions and guidelines

The BEH department uses United Behavioral Health (UBH) Level of Care criteria in determining medical necessity of inpatient psychiatric, partial hospitalization substance abuse treatment and rehabilitation, and outpatient mental health treatment. In addition, Medicare coverage guidelines are utilized for MedicareComplete® members.

Inpatient mental health

A mental health condition is defined as justifying inpatient (or acute) care when it involves a sudden and quickly developing clinical situation characterized by a high level of distress and uncertainty of outcome without intervention. Examples include:

- The patient has been unresponsive to an appropriate course of treatment at a lower level of care and is at significant risk.
- The patient is considered a serious risk to self or others and requires 24-hour supervision.
- The patient is unable to maintain a safe environment for self or others.

Partial hospitalization – mental health

Partial hospitalization* for mental health treatment is defined as day treatment of a psychiatric disorder at a hospital or ancillary facility with the following criteria:

- Primary diagnosis is psychiatric
- The facility is licensed and accredited to provide such services
- The duration of each treatment is four (4) or more hours per day

* Partial hospitalization is only available to members with this benefit.

Residential treatment

Residential treatment services are provided in a facility or a freestanding residential treatment center that provides overnight mental health services for members who do not require acute inpatient care but who do require 24-hour structure.

This benefit is subject to precertification and ongoing medical necessity reviews. Each state has different requirements and benefits should be reviewed.

Outpatient mental health

A psychotherapeutic outpatient treatment is defined as a range of approaches for the treatment of mental and emotional disorders that include methods from different theoretical orientations (i.e., psychodynamic, behavioral, cognitive, and interpersonal) and may be administered to an individual, family or group. Examples include:

- The primary diagnosis/focus of treatment is for a psychiatric condition and is not related to substance abuse or dependence.
- The diagnosis or service is not a benefit exclusion (e.g., sexual disorders, marital counseling, etc.).
- The primary diagnosis is not identified as a V-code – any diagnosis beginning with a V indicates wellness and is not considered a psychiatric diagnosis.
- Treatment is focused on restoring or maintaining function that has been compromised due to mental illness.
- Treatment is goal-oriented and directed to achieve specific outcomes.

Please note: *Under NCQA guidelines and requirements, we strongly support coordination of care between behavioral health physicians and primary care physicians (PCPs). With input from the BEH Quality Improvement Committee, we have developed a Release of Information (ROI) form to facilitate the sharing of treatment information between BEH physicians and PCPs. This form is designed to elicit member consent to such sharing of information in the presence of his or her behavioral health physician. This form may be downloaded from our website,* ***www.oxfordhealth.com > Tools and Resources > Forms****.*

Inpatient detoxification

Inpatient detoxification is defined as the treatment of substance dependence to prevent a life-threatening withdrawal syndrome, provided on an inpatient basis.

Conditions under which inpatient detoxification is medically indicated include:

- The patient is a risk to self and others.
- The patient's medical status is altered by withdrawal syndrome that requires 24-hour monitoring.
- A licensed physician (MD or DO) is available on-site 24 hours per day.
- The DSM-V diagnosis indicates psychoactive substance dependence.
- The facility is a licensed, accredited detoxification facility.

Outpatient substance abuse rehabilitation

Outpatient substance abuse rehabilitation is defined as the treatment of substance abuse or dependence at an accredited, licensed substance abuse facility. Conditions under which outpatient substance abuse rehabilitation is medically indicated include:

- The primary diagnosis and focus of substance abuse treatment is within the DSM-IV range of 303-305.
- An evaluation by a licensed substance abuse physician has resulted in certification by our BEH department.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

As of July 1, 2010, for certain new and renewing groups, benefits are subject to final regulations supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Benefits for mental health conditions and substance use disorder conditions that are covered services must be treated in the same manner and be provided at the same level as covered services for the treatment of any other illness or injury.

MHPAEA requires that the financial requirements for coinsurance and copayments for mental health and substance use disorder conditions must be no more restrictive than those coinsurance and copayment requirements for substantially all medical/surgical benefits.

Changes that result from MHPAEA also affect both prior authorization requirements and excluded services. Prior authorization requirements no longer apply for outpatient mental health and substance abuse services. Exclusions for mental health conditions and substance use disorders that were specific to these conditions, but that were not applicable to other sickness or medical conditions, no longer apply.

Please note: *MHPAEA applies to fully insured and self-funded plans that have 50 or more total employees.*

Groups that are not subject to MHPAEA may be subject to state parity legislation, which is summarized on the following pages.

New Jersey mental health parity (for commercial members)

The State of New Jersey has enacted Biologically Based Mental Health Parity legislation (P. L. 1999, c. 106) that states that biologically based mental illness must be covered under the same terms and conditions as all other medical illnesses and diseases.

The law defines biologically based mental illness as a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness including, but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

This law does not affect coverage for substance abuse or for mental illness that is not biologically based. These latter conditions include mental retardation, learning disorders, motor skills disorder, communication disorders, caffeine-related disorders, relational problems, and additional conditions that may be a focus of clinical attention, but which are not otherwise defined as mental disorders in the most recent edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM)* referenced in this section.

The New Jersey law does not affect Medicare plans. In addition, it does not affect medical necessity, certification or referral requirements. New Jersey members should check their *Certificate of Coverage* for certification and referral requirements.

Connecticut mental health parity (for commercial members)

Connecticut has also enacted Mental Health Parity legislation (Managed Care Act – Public Act No. 99-284). The law states that all Connecticut commercial group products will be required to provide benefits for the diagnosis and treatment of mental or nervous conditions under the same terms and conditions as all other illnesses and diseases.

For purposes of this legislative requirement, mental or nervous conditions means mental disorders, as defined in the most recent edition of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM)*. The definition does not include mental retardation, learning disorders, motor skills disorder, communication disorders, caffeine-related disorders, relational problems, and additional conditions that may be a focus of clinical attention that are not otherwise defined as mental disorders in the DSM referenced above.

Please note: *Parity is also required for disorders related to the complications of alcohol and substance abuse, as defined in the DSM. The Connecticut law does not affect self-funded plans or Medicare plans. In addition, it does not affect medical necessity, precertification or referral requirements.*

New York mental health parity (for commercial members)

As of January 1, 2007, for new and renewing groups, legislation was enacted in New York mandating broad-based coverage for the diagnosis and treatment of mental, nervous, or emotional disorders and ailments. Previously, coverage of mental illness was only a "mandated offer."

Additionally, treatment for biologically based illness and treatment for Children with Serious Emotional Disturbances is mandated for large groups on a parity basis. "Parity" means the benefit must be equal to the coverage provided for other health conditions (i.e., mental health benefits cannot have a higher cost share than is required for other medical services or contain day or visit limits that are lower than medical services). Small groups may elect to purchase this additional level of coverage.

The coverage varies depending on the size of the group and the type of policy. This does not apply to the self-funded, Healthy NY and individual plans.

Mental health services

For purposes of this mandate, "mental, nervous or emotional disorders or ailments" means medically necessary care rendered by an eligible practitioner or approved facility which, in our opinion, is directed predominantly at treatable behavioral manifestations of a condition that we determine:

- is a clinically significant behavioral or psychological syndrome, pattern, illness or disorder; and
- substantially or materially impairs a person's ability to function in one or more major life activities; and
- has been classified as a mental disorder in the current American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders*.

Outpatient mental health services

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

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

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

Please note: *Visits for biologically based services will count toward this limit.*

Inpatient mental health services

Covered services are received on an inpatient or partial hospitalization basis in a facility as defined by subdivision 10 of section 1.03 of the mental hygiene law, as well as by any other network physician or other health care professional we deem appropriate to provide the medically necessary level of care.

If an inpatient stay is required, it is covered on a semi-private room basis. If partial hospitalization is precertified, two partial hospitalization visits may be substituted for one inpatient day. Coverage will be provided for active treatment to the maximum number of days shown on the member's Summary of Benefits.

Please note: *Visits for biologically based services will count toward this limit. Active treatment means treatment furnished in conjunction with inpatient confinement for mental, nervous or emotional disorders or ailments that meet standards prescribed pursuant to the regulations of the commissioner of mental health.*

Certification for mental health, substance abuse and detoxification treatment

Inpatient care

All inpatient behavioral health treatment requires certification.

For initial certification of outpatient mental health services, please call our Behavioral Health department at **1-800-201-6991**.

Partial hospitalization

Partial hospitalization is not a standard benefit for all members and always requires certification through the BEH department. If clinical criteria are met and the member has the benefit, the Case Manager will facilitate certification and management at a contracted facility with a partial hospitalization program; the Case Manager will continue to follow the member's treatment while he or she is in the program. This will not be done unless the member has a benefit that covers partial hospitalization.

Section Six: Ancillary Services

Laboratory

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

Outpatient laboratory policies and procedures

We have made several modifications to our clinical laboratory, anatomical pathology and laboratory patient service center policies and procedures that impact the network. As of January 1, 2007, Quest Diagnostics no longer participates in the network and is a non-participating laboratory.

It is important that you refer your patients and their samples to participating patient service centers and laboratories, as it helps patients avoid unnecessary cost. Given the broad scope of our laboratory network, we believe there is a participating lab that will meet the needs of your practice.

A referral is not required for lab specimens sent to participating laboratories (only a physician's prescription or lab order form is required).

We review laboratory ordering information on a periodic basis in an effort to support full use of our contracted laboratory network; if our data shows a pattern of out-of-network utilization for your practice, we will contact you to share this information and engage you to utilize the contracted network.

A list of available laboratories, an inventory of patient service centers, answers to frequently asked questions and other helpful information can be found at ***www.oxfordhealth.com*** by signing in as a provider or facility and selecting **Practical Resources** > **Laboratory Services**.

In-office laboratory testing and procedures list

The in-office laboratory testing list provides a list of laboratory procedural/testing codes that Oxford will reimburse its network physicians to perform in their offices. This list represents the only procedures/tests that Oxford network physicians can perform in their offices that will be reimbursed by Oxford. All other lab procedures/tests must be performed by one of the participating laboratories in Oxford's network.

For the most up-to-date list, log into our website at ***www.oxfordhealth.com*** as a provider or a facility and select **Practical Resources** > **Laboratory Services** > **In-Office Laboratory Testing List**.

Certain physician contracts allow for additional tests to be reimbursed in the office. Refer to physician contract for additional coverage guidelines.

*Note: Reimbursement for some of the procedures/tests is limited to physician's specialties.

Specimen handling and venipuncture:

If specimen handling and venipuncture codes are billed in conjunction with a lab code, only the lab and venipuncture codes will be reimbursed (and only if that lab code is on the Lab Exception List on ***www.oxfordhealth.com***).

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

Radiology

Participating primary care physicians and specialists will be reimbursed for radiology services rendered in the office or in an outpatient setting. The privileging program does not apply to radiology services performed during an inpatient stay, ambulatory surgery, urgent care, emergency room visit, or pre-operative/pre-admission testing. For the most up-to-date list of services that are payable to participating physicians based on their specialty, log into our website at ***www.oxfordhealth.com*** as a provider or a facility and select **Practical Resources** > **Radiology Information**.

Claims for Medicare members whose care is arranged and managed by a delegated entity under a risk arrangement may be excluded from this requirement. Please check with the delegated entity for applicable policy. Physicians who do not participate in the CareCore National network will continue to submit their Medicare radiology claims directly to Oxford.

The radiology privileging list is applicable to commercial plans (excluding Oxford USA/Choice Plus Network) and Medicare plans.

All X-rays performed at an urgent care facility are payable.

*These procedures require precertification. To precertify a radiology procedure, please contact CareCore National via one of the three options listed below:

Physicians can call CareCore National at 1-877-PreAuth (773-2884)

Physicians can send a fax to CareCore National at 1-845-298-1490

Physicians can log onto **www.carecorenational.com**

For commercial plans: Any study beyond three per member per pregnancy requires precertification. Please call 1-877-PRE-AUTH. For specific guidelines, refer to policy: **Obstetrical Ultrasonography.

Imaging requiring precertification

It is the responsibility of the referring physician or other health care professional, who has access to the patient's complete medical history, to contact CareCore National Management Services, LLC to request precertification and to provide sufficient history to demonstrate the appropriateness of the requested services.

Radiology precertification policy for urgent cases

It is the imaging facility's responsibility to confirm that an authorization number has been issued prior to providing a service. In the case of urgent examinations, in which there is no time to obtain an authorization number and in cases in which, in the opinion of the attending physician or other health care professional, a change is required from the precertified examination, and the CareCore offices are unavailable, the services may be performed, and you may request a new or modified authorization number. Requests must be made within two (2) business days of the date of service through the Imaging Care Management department in the usual manner by calling or faxing your request. If the CareCore offices are available, the request should be made immediately. Clinical justification for the request will be reviewed using the same criteria as a routine request.

Radiology precertification online

CareCoreNational provides a secure, interactive Web-based program where precertification requests can be initiated and determined in real time. If medical necessity is demonstrated during this process an authorization number will be issued immediately. If medical necessity is not demonstrated through the online process, physicians may submit additional information at the conclusion of the session and print a procedure request summary page. Log into **www.carecorenational.com** and the automated system will guide you through a series of prompts to collect routine demographic and clinical data. This eliminates the need for a call to CareCore and allows you to enter multiple clinical certification requests at your convenience.

Radiology utilization review process

The utilization review process involves matching the patient clinical history and diagnostic information with the approved criteria for each imaging procedure requested. Utilization review decisions are made by qualified health professionals including board certified radiologists. Data collection for clinical certification of imaging services may be assigned to non-medical personnel working under the direction of qualified health professionals. You will receive notification of review determinations for non-urgent care by fax/telephone within two (2) business days of receiving all the necessary information. Notification for a determination involving an urgent request is given within three (3) hours of the receipt of information necessary to make a medical necessity determination.

For non-urgent care requests for Medicare members, a determination must be issued within 14 calendar days of the request for service. For commercial members, requests for retrospective clinical certification review of medically urgent care are accepted up to two (2) business days after the care has been given, if the services are performed outside CareCore's hours of operation. Retrospective review decisions are made within 30 business days of receiving all of the necessary information. If your request is not authorized, the review determination will be sent in writing to the member and the requesting physician within five (5) business days of the decision.

For the most current list of imaging CPT codes that require authorization for commercial and Medicare members, please log into our website at ***www.oxfordhealth.com*** as a provider or a facility and select **Practical Resources** > **Radiology Information** > **Procedures Requiring Precertification**. You will be informed of any new procedures or other changes to this list on the Oxford website.

To precertify a procedure, you can call CareCore National Management Services, LLC at 1-877-PREAUTH (1-877-773-2884), fax to 1-800-540-2406 or log into **www.carecorenational.com**.

When you call or fax a request to the Radiology Precertification unit, please provide the following information:

Patient identifiers:

- Health plan name
- The member ID number
- Patient date of birth
- 10-digit patient phone number
- Patient name

Medical identifiers:

- The ordering physician's or other health care professional's ID
- The ordering physician's or other health care professional's full last name
- Ordering physician's or other health care professional's office number
- Ordering physician's or other health care professional's fax number

Clinical information:

- Examination(s) being requested, with CPT codes if available
- Presumptive diagnosis or "rule out," with ICD-9 codes, if available
- Patient's signs and symptoms, listed in some detail, with severity and duration
- Any treatments that have been tried, including dosage and duration for drugs and dates for other therapies
- Any other information that you believe will help in evaluating the request, including prior diagnostic tests, consultation reports, etc.

All authorization reference numbers are issued at the time of approval. CareCore National uses the reference CPT code as the last five (5) digits of the authorization number.

We require the submission of clinical office notes for specific procedures. Clinical notes include the patient's medical record and/or letters received from specialists that indicate:

- Patient symptoms, with duration and severity
- Patient medical history
- Previous imaging studies and findings
- Prior treatment and/or therapy, including surgery, with history
- Drug dosage prescribed and duration

Please note: *Radiopharmaceuticals in excess of $50 will be reimbursed. Submission of an invoice detailing the cost and name of the administered material is still required.*

If you choose to fax your authorization request, please include all of the information mentioned above, including the request form, to CareCore at **1-800-540-2406**.

Radiation oncology

Outpatient radiation oncology services require precertification and medical necessity review

In response to significant observed variation from evidence-based standards and variation among peer practice, UnitedHealthcare has determined the need for medical coverage reviews for radiation therapy.

For Oxford products, we are piloting a precertification and medical necessity review program for all outpatient therapeutic radiology services. UnitedHealthcare requires advance notification for all IMRT services. The UnitedHealthcare IMRT policy and Oxford pilot program details are available online at **UnitedHealthcareOnline.com** and **OxfordHealth.com**, respectively. We expect to combine unique elements over time as we evaluate the results of UnitedHealthcare advance notification requirements and the Oxford medical necessity review pilot.

For both commercial and Medicare Oxford products, the rendering radiation oncology office should request precertification and, guided by the Physician Worksheets*, provide sufficient information to determine the medical necessity of the requested services. If a treating physician does not obtain an authorization number from Oxford for radiation therapy codes, claims may not be reimbursed.

We have partnered with CareCore National, LLC for clinical review of cases based upon their expertise in administering similar programs and their record of working effectively with the physician community. To ensure that the radiation therapy criteria utilized in our program and cases reviewed by CareCore radiation oncologists are consistent with specialty society guidance and current clinical evidence, we have solicited comments from our external oncology expert advisory board, CareCore's radiation oncology board and relevant medical specialty societies. The policies and coverage criteria are available on the websites noted above and at **www.CareCoreNational.com** > **Criteria**. The Oxford pilot program will help us further understand how we

can improve the process of approving coverage for radiation oncology services.

The review process for Oxford products

We have developed the following utilization review process for the administration of outpatient radiation therapy services to commercial and Medicare Oxford members.

CPT Codes requiring authorization for payment may be found on our website at ***www.oxfordhealth.com*** by logging in as a provider or a facility and selecting **Practical Resources** > **Radiology Information** > **Procedures Requiring Precertification** > **Radiation Therapy Procedures Requiring Precertification.**

1. Medical necessity review online or by phone will require the treating physician's office to submit information about their patient's treatment plan as specified in the Radiation Therapy Physician Worksheets*.

*Radiation Therapy Physician Worksheets to guide offices in gathering the information that will be required for the review are available on CareCore National's website, **www.CareCoreNational.com**, under **Physician Resources** > **Physician Tools** > **Oncology** > **Radiation Therapy Physician Worksheets**.

2. Physicians and other health care professionals should submit an authorization request either online at **CareCoreNational.com**, or by calling toll-free at 1-877-773-2884, Monday through Friday, 7 a.m. to 7 p.m. (ET), and Saturday and Sunday, 9 a.m. to 5 p.m. (ET).

3. CareCore National will provide a medical necessity determination response after receipt of all necessary clinical information about the patient's treatment plan as specified in the worksheets.

Clinical criteria consistent with existing UnitedHealthcare and Oxford policies are available at **www.CareCoreNational.com**, and updated medical policies are available at **OxfordHealth.com** > **Physicians** > **Tools & Resources**.

Referrals

Certain Oxford products require referrals for radiation therapy from the patient's primary care physician. If your patient is enrolled in one of these plans, he or she will be required to obtain a referral before seeing you for an initial visit. You can verify your patient's benefit information and whether such a referral is required at: **OxfordHealth.com** > **Providers** > **Transactions** > **Benefits**.

Claims processing

Oxford will continue to process claims from participating physicians and other health care professionals for radiation therapy services. You will receive payment directly from us. Please continue to submit claims electronically, directly to our Payer ID #06111, or by mail to the following address:

Oxford Claims Department
P.O. Box 7082
Bridgeport, CT 06601-7082

If a claim is denied because medical necessity was not demonstrated, contract provisions that prohibit balance billing of members will apply. For any service that is not approved for payment, we will offer all appropriate rights of appeal. If you have questions about this program, please call Provider Services toll-free at 1-800-666-1353, and choose option two; or call CareCore National toll-free at 1-800-918-8924, extension 12217.

Musculoskeletal, physical and occupational therapy services

As of April 1, 2009, ACN Group, Inc. (OptumHealth Services), a UnitedHealth Group company, began administering the physical and occupational therapy benefit for UnitedHealthcare's Oxford products. OptumHealth is a leading physical medicine care management company with significant experience in promoting best practices and evidence-based health care while working with physical and occupational therapists as well as physicians. OptumHealth is our benefit manager for most commercial outpatient physical and occupational therapy services.

Utilization review process

Any physical therapy or occupational therapy visits require utilization review. A Patient Summary Form must be submitted to OptumHealth by the treating physician or health care professional. Once the required forms are completed, they can be submitted by fax, mail or through the OptumHealth website at **www.myoptumhealthphysicalhealth.com**.

Fax: 1-866-695-6923

Mail: OptumHealth Care Solutions
P. O. Box 5800
Kingston, NY 12402-5800

Forms can also be obtained through these channels:

Fax: 1-866-695-6923

Mail: OptumHealth Care Solutions
P. O. Box 5800
Kingston, NY 12402-5800

website: **www.myoptumhealthphysicalhealth.com**

Separately, Patient Summary Forms should be sent within three (3) days of initiating treatment and must be received within 10 days from the initial date of service indicated on the Patient Summary Form. Patient Summary Forms received outside of this 10-day submission requirement will reflect an adjustment to the initial payable date. This date will be calculated starting 10 days prior to the date OptumHealth received your Patient Summary Form. Once the forms are received, OptumHealth will review the services requested for medical necessity, and will make any denial determinations. If a patient's care requires additional visits, an updated Patient Summary Form with updated clinical information must be submitted **after** the initially approved visits have occurred.

Referrals

As a reminder, certain Oxford plans require referrals from the member's primary care physician. If your patient has such a plan, the patient will be required to obtain a referral before seeing you for an initial visit. Member benefit information can be found on ***www.oxfordhealth.com*** > **Providers** > **Transactions** > **Benefits**.

Claim processing

The claim submission process has not changed. Please continue to submit your claims electronically, directly to EDI Payer ID #06111, or via mail to:

Oxford Claims Department
P. O. Box 7082
Bridgeport, CT 06601-7082

Oxford will continue to process claims from participating physicians for physical therapy and occupational therapy services delivered to members with an Oxford plan. Under this arrangement, OptumHealth will be responsible for the utilization management of therapy services (when performed on an outpatient basis, including in the home) for commercial fully insured members.

Please note: *The list of CPT codes requiring OptumHealth utilization review may be found on* **www.myoptumhealthphysicalhealth.com**.

Acupuncture guidelines

Acupuncture is covered as a benefit only for those members who have the alternative medicine rider, and we will deny all requests for acupuncture if the rider is not part of the member's benefit package, even if a letter of medical necessity has been submitted. Acupuncture is covered for commercial members only on an in-network basis and must be performed by one of following provider types:

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

Chiropractic guidelines

To receive the standard chiropractic benefit coverage, members must obtain an electronic referral from their PCP. Under our Complementary & Alternative Medicine (CAM) program, choosing a chiropractor is easy, as we have an extensive network of credentialed chiropractors throughout your service area.

To help facilitate referrals for chiropractic care, we have developed the following guidelines, which are based on current medical literature.[1] PCPs should perform the customary initial comprehensive differential diagnosis with the necessary and appropriate work-up.

For patients with conditions that may respond well to chiropractic care, such as acute low-back pain, neck pain or other neuromusculoskeletal problems, you should discuss conventional and chiropractic treatment options with your patient, describing the risks and benefits of each. If a patient requests a referral to a chiropractor and there is no compelling medical contraindication, you can make the referral for an initial evaluation.

For commercial members only: One visit within 180 days (six months) is the maximum number of visits for which a chiropractic referral can be generated. We require all participating chiropractors to submit Patient Summary Forms to OptumHealth Solutions (formerly ACN Group) for services performed. You will need to obtain approval of the plan as a condition of reimbursement.

Form submissions for chiropractic services must be faxed directly to OptumHealth Solutions at **1-866-695-6923**.

[1] Meeker, W.C.; Haldeman, S. Chiropractic: a profession at the crossroads of mainstream and alternative medicine. [Review] [164 refs] [Historical Article. Journal Article. Review, Academic] *Annals of Internal Medicine*. 136(3): 216-27, 2002 Feb 5.

Patient Summary Forms should be submitted to OptumHealth Solutions within three (3) business days and no later than 10 business days following the patient's initial visit or recovery milestone. The submission of the Patient Summary Form must include the initial visit. If OptumHealth Solutions does not receive the required forms within this time frame, your claim will be denied. Once the forms are received, OptumHealth Solutions will review the services requested for medical necessity, and will make any denial determinations. If a patient's care requires additional visits or more time than was requested, you must submit a Patient Summary Form with updated clinical information after the initially approved visits have occurred.

Please note: *According to your contract with OptumHealth, the patient may not be balance billed for any covered service not reimbursed due to the provider's failure to submit the Patient Summary Form, or for those services which do not meet medical necessity or coverage criteria. However, you may file an appeal.*

For Medicare members with a plan underwritten by Oxford Health Plans (NY/NJ/CT), Inc.:

The initial visit does not require a referral or precertification. Coverage of chiropractic care is limited to treatment by means of manual manipulation of the spine for the purpose of correcting an acute subluxation. No other diagnostic or therapeutic service (including but not limited to modalities, laboratory services, radiology) furnished by a chiropractor or under his or her order is covered.

As of the initial visit, the chiropractor will fax a Patient Summary Form to OptumHealth Solutions at **1-866-695-6923**.

Once the forms are received, OptumHealth will review the services requested for medical necessity and will make any denial determinations. If a patient's care requires additional visits or more time than was requested, you must submit an updated Patient Summary Form with updated clinical information after the initially approved visits have occurred.

Absolute contraindications to manipulation

- Vertebral malignancy
- Infection or inflammation
- Cauda equina syndrome
- Myelopathy or severe spondylosis
- Multiple adjacent radiculopathies
- Vertebral bone diseases
- Vertebral bony joint instability (e.g., fractures, dislocations)
- Rheumatoid disease in the cervical region

Relative contraindications to manipulation

- Presence of spinal deformity and most skeletal anomalies
- Systemic anticoagulation, either disease-related or pharmacologic severe diabetes
- Atherosclerosis
- Severe degenerative joint disease
- Vertigo or symptoms and signs of vertebral-basilar artery disease or insufficiency
- Spondyloarthropathies (e.g., psoriatic, ankylosing spondylitis, Reiter syndrome)
- Inactive rheumatoid disease
- Ligamentous joint instability or congenital joint laxity
- Syndromes such as Marfan and Ehlers-Danlos
- Aseptic necrosis
- Local aneurysm
- Osteomalacia
- Osteoporosis

Pharmacy

Pharmacy management programs

The pharmacy benefit plan includes a dynamic medication list, referred to as the Prescription Drug List (PDL), and various clinical drug utilization management programs. These programs are based upon FDA-approved indications and clinical guidelines endorsed by professional medical organizations. This management strategy encourages cost-effective, quality care.

The PDL contains medications within three tiers – Tier 1 is the lowest copayment level and Tier 3 is the highest copayment level. To help make medications more affordable for your patients, consider whether a Tier 1 or Tier 2 alternative is appropriate if they are currently taking a Tier 3 medication. The complete PDL is available online at ***www.oxfordhealth.com*** > **Tools and Resources** > **Practical Resources** > **Prescription Drug Information** > **Oxford's Prescription Drug List**.

The PDL is reviewed on an ongoing basis and updated at least twice per year to reflect advances in pharmaceutical care. Physician medications that require notification or precertification are noted with an "N" and supply limits with "SL."

Medicare plans have a separate PDL from the commercial plans. The Medicare PDL will also be a dynamic listing of medications that is reviewed at least annually and updated quarterly to reflect advances in medical care and requirements by CMS. Also available at **www.securehorizons.com**, the drug list details inclusions, generic and preferred brand drugs, drug quantity limits, and precertification requirements.

Please note: *The PDL is subject to change. When a medication changes tiers, the member may be required to pay more or less for that medication. In addition, the amount allowed for purchase per dispensing or per month may increase or decrease. Visit our website at* ***www.oxfordhealth.com*** *>* ***Tools and Resources*** *>* ***Practical Resources*** *>* **Prescription Drug Information** *>* ***Oxford's Prescription Drug List*** *for the most up-to-date tier placement for a particular medication.*

The listing of a medication product on a PDL does not guarantee coverage, as certain products are excluded due to benefit plan design limitations that are specific to the member's individual or group benefits. This does not apply to New York or New Jersey, as closed formularies are not permitted. In addition, diabetic supplies that are available through the member's base medical benefit are subject to the applicable office visit copayment (out-of-pocket cost) noted on the member's Summary of Benefits.

For New York and Connecticut commercial plans, if a prescription is written for a medication available as an over-the-counter (OTC) product in the identical dosage, form, strength, and active ingredient, the prescription may not be covered. The pharmacist should refer the member to the OTC product. If the member or physician insists on the prescription equivalent product, the member will be responsible for the entire cost of the prescription. A Medical Necessity appeal is the action a member may take to request a review of the individual application of this policy.

PDL management and pharmacy and therapeutics committee

The UnitedHealthcare PDL Management Committee, a group of senior physicians and business leaders, makes tier decisions and changes to the PDL based on a review of clinical, economic and pharmacoeconomic evidence. The Pharmacy and Therapeutics (P&T) Committee is responsible for evaluating and providing clinical evidence to the PDL Management Committee to assist them in assigning medications to tiers on the PDL. The information provided by the P&T Committee includes, but is not limited to, evaluation of a medication's place in therapy, its relative safety and its relative efficacy.

The P&T Committee also determines whether supply limits or notification requirements are necessary.

In addition to medications covered under the pharmacy benefit, the P&T Committee is responsible for evaluating clinical evidence for specialty medications, which require administration or supervision by a qualified, licensed health care professional.

The P&T Committee is comprised of medical directors, network physicians, consultant physicians, clinical pharmacists and pharmacy directors. The P&T Committee meets at least quarterly.

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

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

Concurrent DUR

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

Upon receiving the claim information from the pharmacy, the system performs a number of checks against safety and utilization criteria. When a potential problem is identified, the system either notifies the dispensing pharmacist by sending a soft alert (warning message) or a hard alert (a warning message that also requires the pharmacist to enter an override). The dispensing pharmacist uses his or her professional judgment to determine appropriate interventions, such as contacting the prescribing physician or other health care professional, discussing

concerns with the member and dispensing the medication. In many cases, the pharmacist will quickly address the potential issue and the program impact will be minimal or unknown to the member. The benefits of this program include timely safeguards from medication interactions, improvement in the quality of health care and reduction in the number of inappropriately prescribed medications.

Retrospective DUR

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

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

- Cover letter providing an explanation of the purpose of the mailing
- Patient-specific summary including the clinical guidelines that address the patient's utilization issue
- Prescription claims history that provides a comprehensive list of prescriptions that the patient has received for up to one year.

This combination of clinical guidelines and personalized patient claim history will allow the physician or other prescriber to make an informed decision.

Because this is a retrospective program, there is no immediate effect on whether the member is able to obtain a prescription. The intent is to notify physicians and other prescribers of potential issues and allow the physician or other prescriber to make changes if necessary. The program provides information that the physician or prescriber can use to alter therapy and therefore avoid medication issues.

FDA alerts and product recalls

A formal process is in place to address FDA and manufacturer medication recalls. Members affected by FDA-required or voluntary medication withdrawals are identified and notified by mail. Where possible, physicians or prescribers who have recently prescribed a medication are also notified.

High utilization narcotic program

The high utilization narcotic program identifies members who may be overutilizing narcotic analgesics or potentially seeking narcotics inappropriately from multiple physicians/prescribers.

Member identification and physician outreach

The criteria utilized to identify members includes nine (9) or more narcotic prescriptions filled during a quarter and written by three (3) or more physicians/prescribers and filled at three (3) or more pharmacies. Patient-specific prescription information is provided to each physician/prescriber identified in the review of the pharmacy utilization.

Pharmacy limitation

Members who appear on more than two consecutive quarterly reports may be limited to a single retail pharmacy. The member will receive a registered letter notifying him or her of the limitation. Within 30 days the member is required to select from one of his or her last three (3) pharmacies utilized. If the member does not select a pharmacy, the last retail pharmacy of record will be assigned.

Clinical programs

Medications requiring notification/ precertification

Based on plan designs, selected high-risk or high-cost medications may require notification (also known as precertification or prior authorization) by us in order to be eligible for coverage. Notification criteria have been established by our P&T Committee with input from plan physicians in consideration of the current medical literature. For most members with pharmacy benefit coverage, the medications listed on ***www.oxfordhealth.com*** **> Tools and Resources > Practical Resources > Prescription Drug Information > Drugs Requiring Precertification** (including their generic equivalent, if available) generally require notification.

Notification requires that you submit a formal request and receive advance approval for coverage of certain prescription medications. You may be asked to provide information explaining medical necessity and/or past therapeutic failures. A representative will collect all pertinent clinical data for the service requested. For those requests that do not meet the criteria for approval, you will be informed that the coverage determination requires

further review by our Medical Director. Decisions are communicated within one (1) business day of receipt of the request. If additional information is required to render a decision you will be notified of that need within 24 hours of receipt of the original request.

Please note: *Notification requirements may vary depending on the member's pharmacy benefit plan.*

If you have any questions regarding the medications on this list or any other medications, please call Pharmacy Customer Service at **1-800-905-0201**.

Medications requiring notification/ precertification for commercial and Medicare members (subject to plan design)

The medications (including generic equivalent, if available) requiring notification for commercial and Medicare members with prescription drug coverage through us are listed on our website, ***www.oxfordhealth.com*** > **Tools and Resources** > **Practical Resources** > **Prescription Drug Information** > **Drugs Requiring Precertification**. This list is subject to change without notice.

To obtain notification for commercial members, please call **1-800-753-2851** – available 24/7 including holidays. To obtain precertification for Medicare members, please call Prescription Solutions directly at **1-800-711-4555**.

Supply limits (subject to plan design)

Certain medications may be subject to supply limits (SL). The purpose of the supply limits is to ensure the proper billing of products and/or encourage the use of therapeutically indicated medication regimens. This program focuses on select medications or categories of medications that are high cost and/or are frequently used outside of generally accepted clinical standards. Supply limits can be a quantity level limit (QLL) or a quantity duration limit (QDL). The QLL establishes a maximum quantity per prescription or copayment. A QD establishes a maximum quantity that can be obtained for a defined time period. Supply limits are based on FDA-approved dosing guidelines as defined in the product package insert and the medical literature or guidelines and data that support the use of higher or lower dosages than the FDA-recommended dosage. When a pharmacist submits an online prescription claim, the online claims processing system compares the quantity entered with the allowable limits. If the prescription exceeds the established quantity limits, the claim is rejected and the pharmacist receives a message to that effect. In addition, the current supply limit for the medication is displayed in the message. A subset of medications has coverage criteria available to obtain quantities beyond the established limit. For these medications, the pharmacist receives a message that includes the toll-free number to call for the coverage review.

Affected medications are noted with a SL designation in the PDL, which is available online at ***www.oxfordhealth.com*** > **Tools and Resources** > **Practical Resources** > **Prescription Drug Information** > **Oxford's Prescription Drug List**.

Half Tablet program

Program overview

The voluntary Half Tablet program allows members to save up to half of a copayment when they split eligible medications. Our P&T Committee has determined which medications are eligible based upon set criteria. To qualify, multiple strengths of a medication must be available at a comparable unit price and easily split with no adverse impact on how the medication is released from the tablet. There are currently 17 medications (including their generic equivalent, if available) included in the Half Tablet program.

Once the physician or other health care professional determines that tablet splitting is appropriate for the individual patient, he or she should write the prescription for twice the desired dosage and half the quantity and instruct the patient to take one-half tablet.

Members receive the prescribed dose while reducing the number of dispensed tablets and, therefore, the ingredient cost for the prescription. (Members with a coinsurance plan may save up to 50 percent.) The plan sponsors can also save up to 50 percent through reduced ingredient costs.

One tablet splitter will be provided at no charge to assist members who wish to participate. The complimentary tablet splitter may be obtained by calling the toll-free number, **1-877-471-1860**, or by visiting **www.halftablet.com**.

When processing a prescription for a medication in the Half Tablet program, pharmacists will receive messaging at the point of service informing them of the Half Tablet program.

Medications Included in the Half Tablet program may be found on **www.halftablet.com/faq.html**.

Four-tier pharmacy drug plan – AARP® MedicareComplete, Evercare plan DH and MedicareComplete plans underwritten by Oxford Health Plans (NY/NJ/CT), Inc.

There is a four-tier prescription drug benefit available for all Medicare members enrolled in a plan listed above, except AARP® MedicareComplete Essential™ plans. On January, 2007, we transitioned to Prescription Solutions as our pharmacy benefit manager. The Prescription Drug List for this benefit was carefully designed to promote medically appropriate, cost-effective health care while preserving your ability to prescribe specific drugs of choice for your patients and to comply with the guidelines set forth by the Centers for Medicare & Medicaid Services (CMS) for the Part D benefit. Members covered by the four-tier prescription plan benefit have the following plan design:

For all MedicareComplete plans

There is no deductible. Before the total yearly drug costs (paid by both the member and us) reach $2,510, the member must pay a specified copayment depending upon their plan type and tier of drug. Prescriptions may be obtained via retail pharmacy or through our mail order program at a 30-day or 90-day supply.

Members must use designated retail pharmacies or mail order to get their prescription drugs. After the total yearly drug costs (paid by both the member and us) reach $2,510, the member pays 100 percent of their prescription drug costs. After the member's yearly out-of-pocket drug costs reach $4,050, the member pays the greater of:

- $2.25 or five (5) percent coinsurance for generic (including brand drugs treated as generic)
- $5.60 or five (5) percent coinsurance for all other drugs

You may continue to choose from the many quality drugs available, using your patient's out-of-pocket cost as a consideration when prescribing.

Please review the Prescription Drug List and, where appropriate for your patients, consider changing Tier 3 prescriptions to Tier 1 or 2 drugs. Look for the MedicareComplete drug formulary on **www.securehorizons.com**.

Mail order for commercial members

We offer members the ability to obtain up to a 90-day supply of certain medications within several therapeutic categories of medications by mail. Maintenance medications are prescription medications associated with the treatment of certain chronic conditions, such as diabetes, hypertension and epilepsy. All members whose plans include the mail-order benefit are entitled to use this service.

Please note: *Mail-order coverage may vary depending on the member's benefit. Please refer to the member's Certificate of Coverage or Prescription Drug Rider for specific coverage information. Not all members have a plan that includes mail-order coverage.*

Important Addresses

For Commercial members:

Medco By Mail
P.O. Box 747000
Cincinnati, OH 45274-7000

For Medicare members:

Prescription Solutions
P.O. Box 2975
Shawnee Mission, KS 66201-1375

Section Seven: Quality Management Programs

Overview

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

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

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

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

Important Addresses

Oxford Quality Management Department
Attn: Regional Quality Improvement Director
44 South Broadway
White Plains, NY 10601

Quality management committee structure

The Medical Advisory Committee (MAC) oversees QM activities and addresses specific issues that arise. These issues include review and recommendations regarding clinical practice guidelines, medical policies, service standards, over-utilization and under-utilization of services by physicians and other health care professionals. This committee also makes recommendations regarding the selection of QM studies (based on identified high-volume, high-risk and problem-prone areas in their regions) and develops and implements regional components of the QM work plan.

The Board of Directors has delegated responsibility for the oversight of health plan quality improvement activities to the Regional Quality Oversight Committee (RQOC). The RQOC is the decision-making body responsible for the implementation, coordination and integration of all quality improvement activities for the health plans within its geographic scope.

The Regional Peer Review Committee (RPRC) provides a forum for qualified physicians to investigate, discuss and take action on member cases involving significant concerns about quality of care. The RPRC has been delegated decision-making authority by the National Peer Review Committee (NPRC) to make decisions relating to quality of care and quality of service. Recommendations related to restrictions, suspensions or termination of practitioners or providers are referred to the NPRC for final disposition.

The NPRC provides a forum for qualified physicians to discuss and take disciplinary action on member cases involving significant concerns about quality of care that were unresolved through Improvement Action Plan mechanism administered by the RPRC. The NPRC is a subcommittee of the National UnitedHealthcare Health Services Quality Oversight Committee, which has oversight responsibility for actions taken pursuant to the Quality of Care policy. The NPRC has been delegated decision-making authority for final disposition relating to restrictions, suspensions or termination of practitioners or providers due to unresolved quality of care/ competency issues.

The National Provider Sanctions Committee (NPSC) provides a forum for qualified physicians to discuss and take action on sanction reports that raise issues regarding compliance with UnitedHealthcare's credentialing plan, and/or patient safety concern. Sanctions are monitored from state licensing boards, Office of the Inspector General and other sanctioning bodies or entities. The NPSC has been delegated decision-making authority by the National Quality Oversight Committee (NQOC) to make decisions relating to continued credentialing status as a result of external sanctions imposed to participating physicians and other health care professionals.

Scope of quality management program activities

- **Identifying high-volume, high-risk and problem-prone areas** of care and service affecting our population
- **Developing clinical practice guidelines** for preventive screening, acute and chronic care, and appropriate drug usage, based on the availability of accepted national guidelines, the ability to monitor compliance, and the ability to make a significant impact upon important aspects of care
- **Undertaking quality improvement studies** in clinical areas identified through careful claims data analyses; these include frequency and cost breakdowns by member's age, sex and line of business, episode treatment groups, major medical procedure categories, diagnosis, and diagnosis-related groups (DRGs); additional clinical areas are identified and studied per government contract requirements and health care industry standards

  See **HEDIS Measures** in this section.
- **Utilizing population-based preventive health care audits** to assess the level of preventive care rendered across our membership; separate studies are completed for special risk groups.
- **Conducting regular surveys** to assess member satisfaction, physician and other health care professional satisfaction, employer (client) satisfaction, and reasons for voluntary physician and other health care professional disenrollment.
- **Tabulating adherence to physician service standards** in areas such as wait times for appointments, in-office care and practice size and availability; some measurement methods we use are complaint data, Consumer Assessment of Healthcare Providers and Systems survey information and GeoAccess analysis.
- **Monitoring performance of QM-related functions** for compliance with contract, including activities such as oversight of medical policies and procedures, reporting activities, encounter reporting, and regulatory compliance.
- **Conducting routine medical record audits** to assess physician compliance with the medical record review standards and preventive care guidelines, as well as monitoring coordination and continuity of care between PCPs and specialists.

  Please note: *This is not the only reason we conduct such audits. Audits by the QM department do not review appropriateness of coding of medical claims. Such other audits may have different procedures and processes depending on their purpose and design.*
- **Ensuring medical record documentation** provides the plan for your patients' care, including continuity and coordination of care with other physicians, facilities and health care professionals; proper documentation in the medical record accurately and completely reflects the care provided to your patient and serves as both a risk management and patient safety tool.

  As part of our ongoing clinical quality improvement activities, we review a sample of medical records from primary physicians who practice in the specialties of family/general practice, interal medicine, or pediatrics and use performance standards to measure project results.
- **Reviewing and resolving member complaints** regarding the provision of medical care and services; investigation may include verbal and written contact with the member and the physician or other health care professional, as well as a review of relevant medical records and responses to potential concerns identified.

HEDIS measures

The annual Healthcare Effectiveness Data and Information Set (HEDIS) was developed by the National Committee for Quality Assurance (NCQA). NCQA is an independent group established to provide objective measurements of the performance of managed health care plans, including access to care, use of medical services, effectiveness of care, preventive services, and immunization rates, as well as each plan's financial status. HEDIS measures have become key criteria that employers, consultants, the Centers for Medicare & Medicaid Services (CMS) (Medicare), state regulators (commercial), and prospective members use to evaluate the demonstrated value and quality of different health plans. Disenrollment rates, information on member satisfaction and health outcomes data for Medicare members to CMS are also disclosed.

HEDIS effectiveness of care – our measures

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

Each year we collect data from a randomly selected sample of our members' medical records for HEDIS. HEDIS is mandated by the New York Department of Health, New Jersey Department of Health and Senior Services, Connecticut Department of Health, and the Centers for Medicare & Medicaid Services (CMS). The HEDIS medical record study measures our participating physicians' adherence to nationally accepted clinical practice guidelines.

Patient safety program

A series of initiatives designed to improve the safety and security of our members has been established. The patient safety program involves the measurement, monitoring, trending, and reporting of key indicators. The initiatives include efforts to:

- Improve continuity and coordination of care among physicians and other health care professionals to encourage optimum outcomes for members
- Improve continuity and coordination between sites of care, such as facilities and nursing homes, to increase and encourage timely and accurate communication
- Use visit credentialing reports and recommendations to improve safe practices among physicians, other health care professionals and medical facilities
- Evaluate current clinical practices against aspects of national practice guidelines and recommend changes where appropriate
- Analyze and take action on complaint and satisfaction data that relate to clinical safety

In addition, we are a member of, and support the initiatives of, the Leapfrog Group, which is a coalition of more than 150 public and private organizations that provide health care benefits to employees. Leapfrog is a voluntary program aimed at mobilizing major health care purchasers to alert the health care industry that big leaps in patient safety and customer value will be recognized and rewarded. We encourage the physicians and other health care professionals in our network to complete the Leapfrog Web survey and share information with their communities about their efforts to reduce preventable medical mistakes.

Hospital safety measures

As a member and supporter of The Leapfrog Group, we annually encourage our network hospitals to report their progress on four key factors that affect patient safety. We have identified four hospital safety measures that are a focus for performance comparison in the Leapfrog Group Facility Quality and Safety survey.

Computer Physician Order Entry (CPOE) With the CPOE systems, hospital staff enter medication orders via a computer linked to prescribing-error-prevention software. CPOE has been shown to reduce serious prescribing errors in hospitals by more than 50 percent.

Evidenced-based Hospital Referral Research Consumers and health care purchasers should choose hospitals with extensive experience and the best results with certain high-risk surgeries and conditions. Research indicates that when patients needing certain complex medical procedures are referred to hospitals offering the best survival odds based on scientifically valid criteria – such as the number of times a facility performs these procedures each year or other process of outcomes data – the hospital's risk of patient deaths could be reduced by more than 30 percent by referring patients needing complex medical procedures to hospitals offering the best clinical outcomes based on valid criteria.

Intensive Care Unit (ICU) Physician Staffing (IPS) Staffing ICUs with physicians who have credentials in critical care medicine has been shown to reduce risks of patients dying in ICUs by 40 percent.

Leapfrog Safe Practices Score Quality Index – The National Quality Forum-endorsed 30 Safe Practices covers a range of practices that, if utilized, would reduce the risk of harm in certain processes, systems or environments of care. Included in the 30 practices are the original three Leapfrog leaps.

Additional educational information regarding patient safety is located on our website at ***www.oxfordhealth.com*** and includes the following:

- Questions to ask surgeons prior to surgery
- Information on drug-to-drug interactions
- Up-to-date information on research findings, new treatments, and medications
- Link to FDA alerts for physicians and other health care professionals
- A hospital's discharge program, to help ensure that post-facility services are provided on time, as planned
- Monitoring medical record legibility and in-office procedures for follow-up of laboratory results as part of the medical record review process
- Monitoring of office safety issues for PCPs and institutional safety issues for health delivery organizations

via site evaluations as part of credentialing and recredentialing activities

- Drug utilization program with Medco to prevent drug interactions, overutilization, adverse events, prevent misuse and abuse, and to target populations with special clinical needs
- Adverse outcomes monitoring of individual occurrences, as well as trends at the physician or other health care professional/practitioner and system-wide level, medication assessments and patient-specific education regarding medication adherence as regular components of all disease management programs
- Monitoring of continuity and coordination of care from multiple perspectives

Credentialing and recredentialing

We are dedicated to providing our members with access to effective (medically necessary) health care and, as such, we periodically review the credentials of every network physician and other health care professional in order to maintain and improve the quality of care and services delivered to our members. Our credentialing standards are more extensive than (though fully compliant with) NCQA requirements.

A credentials file is maintained on all participating physicians and other health care professionals. Credentialing decisions are made by the UnitedHealthcare National Credentialing Committee. Recommendations for action are passed to this committee and the Medical Director on a timely basis, and all applicants are notified by a letter of any decision made by the Committee.

Provider types that can be credentialed

- Physicians (MDs)
- Osteopaths (DOs)
- Dentists (DDS or DMDs)
- Podiatrists (DPMs)
- Select health delivery facilities:*
  - Hospitals
  - Home health care agencies
  - Skilled nursing facilities
  - Ambulatory surgery centers
  - Mental health facilities
  - Birthing centers
  - Alcohol/drug rehabilitation facilities
  - Subacute centers
- Physicians and other health care professionals affiliated with freestanding ancillary facilities that do not already have accreditation satisfactory to us
- Non-physician health care professionals:**
  - Social workers (CSWs and MSWs)
  - Marriage and family therapists
  - Psychologists
  - Nurse midwives
  - Physical therapists
  - Occupational therapists
  - Speech therapists/pathologists
  - Speech therapy/pathology physicians
  - Audiologists
  - Optometrists
  - Nurse practitioners
  - Registered dietitians
  - Psychiatric clinical nurse specialists
  - Naturopathic doctors
  - Acupuncturists
  - Chiropractors
  - Massage therapists
  - Nutritionists
  - Yoga instructors
  - Physician assistants
  - Licensed professional counselors

* Credentialing process and requirements may differ depending on specialty of the ancillary or facility.

** Some networks are closed due to network integration activities. Further information can be obtained by calling Provider Services at 1-800-666-1353.

Please note: *Some of the above specialties are credentialed as part of an ancillary program of health care professionals. Such credentialing does not guarantee that we provide coverage for all services that the health care professional renders. Applicable policies and procedures*

or the member's Certificate of Coverage may limit or exclude certain services.

Physicians licensed or double-boarded

A double-boarded physician is a physician who has been certified by the American Board of Medical Specialties to practice in more than one specialty/area of medicine. Physicians who participate in our network can continue to be double boarded as both a PCP and a specialist.

Individual physicians and other health care professionals

Credentialing requirements

The following credentials and documents are required for physicians and osteopaths (MDs, DOs, DDS, DMDs, DPMs):

- Current, valid state license
- Current, valid Drug Enforcement Agency (DEA) registration certificate
- Current, valid Controlled Dangerous Substances (CDS) certificate (NJ only)
- Board certification or satisfactory completion of an approved residency program within the last five (5) years
- Malpractice insurance in the amounts of $1,000,000 per occurrence, $3,000,000 in the aggregate
- Admitting privileges at a participating hospital for all PCPs and most specialists (when applicable)
- History of professional liability claims
- Medicaid and Medicare sanctions history verification
- A work history with explanations of any gaps in employment over the last five (5) years

Non-physician health care professionals

- Current, valid state license
- Certification/registration
- Advanced degree
- Graduation from appropriate school
- Malpractice insurance in the amounts of $1,000,000 per occurrence, $3,000,000 in the aggregate
- History of professional liability claims
- Medicaid and Medicare sanctions history verification
- Collaborative practice agreement, as applicable by specialty
- Post-graduate training, as applicable by specialty
- Documentation of a formal arrangement for psychiatric medication consultation, as applicable by specialty
- A work history with explanations of any gaps in employment over the last five years

Ancillary health care professionals

- Health care professionals affiliated with an accredited facility that is participating with us may not need to be credentialed.

  See **Facilities Credentialing** in this section for a list of approved accreditation agencies.

- Physicians and other health care professionals affiliated with nonaccredited facilities may be credentialed by us following the criteria previously outlined.

Credentialing application

We are a member of the Council for Affordable Quality Healthcare (CAQH) and, as such, utilize the CAQH Universal Credentialing DataSource (UCD) for gathering credentialing data for all the physicians and other health care professionals whose data we made available to CAQH during the initial rollout of the prepopulated database.

CAQH is a not-for-profit alliance of more than 90 national, regional and local health plans and networks. Created in 1999, CAQH member organizations provide and administer health care coverage for more than 100 million Americans. CAQH's UCD promotes collaborative initiatives to help make health care more affordable, to share knowledge to improve the quality of care, and to ease the administrative burden of the credentialing process in order to allow physicians to dedicate more time to patient care.

The UCD employs many features that make a difference and improve the quality of physician and other health care professional data submitted via CAQH, such as:

- Automatic check for errors
- Only asks questions relative to the practice
- Allows physicians and other health care professionals to save a partially completed application and return later
- Enables common data on multiple physicians and other health care professionals to be entered only once
- Assists in quickly locating contact information for colleges, medical schools and facilities

The CAQH process is available to physicians at no charge. Additionally, the process creates cost efficiencies by

eliminating the time necessary to complete redundant credentialing applications for multiple health plans, reduces the need for costly credentialing software and minimizes paperwork by allowing physicians and other health care professionals to make updates online.

We have implemented the CAQH process as our single source credentialing application nationally. All new physicians and other health care professionals applying for participation in our network and those scheduled for recredentialing are instructed on the proper methods for accessing the CAQH UCD.

We encourage physicians and other health care professionals to familiarize themselves with the CAQH Universal Credentialing DataSource prior to being requested to complete an application online. Simply access the UCD demo at **https://upd.caqh.org/OAS/** and click on **Overview**.

For New Jersey physicians and other health care professionals, Universal Physician Applications can be downloaded from the New Jersey Department of Health and Senior Services website at **www.state.nj.us/health** or to request a copy, call Provider Services at 1-800-666-1353. For more information on CAQH, please visit **www.caqh.org** or call CAQH Support at **1-888-599-1771**.

Completed applications include:

- General demographic and practice information
- Educational history, both undergraduate and medical/dental school
- Postgraduate training
- Continuing medical education (CME) [physicians who are not board certified must submit documentation of CME credits obtained within the last three years; we require either 150 CME credits every three years or submission of the American Medical Association (AMA) Physicians Recognition Award]
- Malpractice insurance policy information
- Details of continuous work history with any explanation in gaps over the past five (5) years
- Attestation by the physician or other health care professional alerting us of any malpractice issues or sanctions against the physician or other health care professional by federal or state agencies, facilities or other health care institutions to which the physician or other health care professional has been appointed
- Unaltered and signed Physician Agreement

Credentialing review process for physicians

- We verify state license, postgraduate training, DEA certification, CDS certification (New Jersey only), and board certification.
- We contact the National Practitioner Data Bank (NPDB) concerning malpractice settlements or any reported actions; NPDB reports whether any facility or managed care organization has sought to limit, suspend or abolish your privileges; NPDB also verifies current state and federal listings of physicians and other health care professionals barred from providing Medicare or Medicaid services.
- Site visits are conducted at offices of all PCPs, OB/GYNs and high-volume behavioral health care professionals to evaluate office procedures, safety precautions, emergency protocols, and medical record-keeping.
- We may enter into contracts with third parties to perform services for us in connection with the credentialing review process; we may disclose information to the third party; however, the information is kept confidential; participating physicians and other health care professionals may request a copy of their file at any time. Physicians also have a right to obtain the status of their credentialing or recredentialing application, and to correct any erroneous information in the event that credentialing information we obtain from other sources varies significantly from the information provided by the practitioner. Requests must be submitted in writing to the following address:

Important Addresses

Oxford Credentialing Department
44 South Broadway
White Plains, NY 10601

We will complete credentialing activities and notify physicians within 90 days of receiving a completed application. The notification to the physician will inform them as to whether they are credentialed, whether additional time is needed, or that we are not in need of additional physicians. If additional information is needed, we will notify the physician as soon as possible, but no more than 90 days from the receipt of the application.

Recredentialing

To maintain the integrity of our network of physicians and other health care professionals, all participating physicians and other health care professionals must adhere to credentialing and recredentialing standards. An important standard that NCQA measures for recredentialing is the timeliness of recredentialing. The standard states that managed care organizations should formally recredential their physicians and other health care professionals at least every three (3) years.

To remain in good standing as a network physician or other health care professional, it is imperative that you complete your recredentialing as instructed or update your CAQH application on a quarterly basis.

For New Jersey physicians and other health care professionals, Universal Physician Applications can be downloaded from the New Jersey Department of Health and Senior Services website at **www.state.nj.us/health** or to request a copy, contact Provider Services at **1-800-666-1353**.

Recredentialing review process for physicians

- Verification of state license, DEA certification and board certification through primary source verification
- Verify if there are any malpractice claims liability history through NPDB; this data bank provides us with data on civil judgments related to health care delivery, federal or state criminal convictions against physicians and other health care professionals, actions by federal or state licensing agencies against physicians and other health care professionals, and exclusions of health care physicians and other health care professionals from participation in federal or state health care programs.
- We may enter into contracts with third parties to perform services for us in connection with the recredentialing review process; we may disclose information to the third party; however, the information is kept confidential.
- Various departments contribute quality-related data on each physician or other health care professional undergoing the recredentialing process; the information gathered and the responsible departments are as follows:

Information	Department
Complaint profile	Quality Management
Medical record review data	Quality Management
Results of site evaluations	Provider Relations/Quality Management
Any adverse action	Various departments

Notification

All information compiled during the recredentialing review process will be evaluated by the UnitedHealthcare Credentialing Committee or Regional Quality Improvement Director and Senior Medical Director, whose decision will be communicated to the physician or other health care professional by letter. We maintain documentation of all correspondence in the physician's or other health care professional's credentials file.

Facilities

Credentialing requirements

We require that an initial quality assessment be completed for all newly participating facilities prior to the finalization of a contract relationship. All hospitals, home health care agencies, skilled nursing facilities, ambulatory surgery centers, mental health facilities, birthing centers, alcohol/drug rehabilitation and subacute centers must demonstrate good standing with state and federal regulatory agencies. In addition, we require all facilities to be accredited by a recognized and relevant accrediting agency (please see the following chart). Facilities that do not meet this accreditation standard may be included in our network of physicians and other health care professionals only if they are able to demonstrate compliance with our Standards for Participation.

Facility	Accreditation Required
Hospitals	JCAHO[1]
Home health agency	JCAHO or CHAP[2]
Skilled nursing facility	JCAHO or CARF[3]
Ambulatory surgical center	JCAHO or AAAHC[4] or AAAASF[5]
Mental health facility	JCAHO or CARF
Birthing centers	JCAHO, CABC[6] or AAAHC
Alcohol/drug rehabilitation facility	JCAHO or CARF
Subacute center	JCAHO or CARF or AAAHC

[1] Joint Commission on Accreditation of Healthcare Organizations

[2] Community Health Accreditation Program

[3] Commission on Accreditation of Rehabilitation Facilities

[4] Accreditation Association for Ambulatory Health Care

[5] American Association for Accreditation of Ambulatory Surgery Facilities

[6] Commission for the Accreditation of Birth Centers

Credentialing review process for facilities

The credentialing entity/health plan network management will be responsible for obtaining the following documents from the facility to allow us to perform this initial assessment prior to contracting:

- A completed and signed Hospital and Ancillary Credentialing (Assessment) Program letter attesting to the accuracy of the data provided
- A copy of current licensure, if applicable
- A copy of current general and professional liability coverage
- A copy of the face sheet from the accreditation agency
- Ensuring the appropriate information is forwarded to Network Data Management to create or update a physician identification number for the facility

Recredentialing

- Home health care agencies, ambulatory surgical centers, skilled nursing facilities, and freestanding surgical centers must be recredentialed every three (3) years.
- The UnitedHealthcare Credentialing Committee along with other constituencies such as the credentialing entity/health plan network management, and the Regional Quality Improvement Director and Senior Medical Director will work together to ensure that participating components are assessed according to the UnitedHealthcare Credentialing Plan, NCQA and/or other accreditation standards, and in compliance with any applicable federal and state regulations.
- The facility being credentialed must confirm the information submitted for the original credentialing process and provide updated copies of all credentialed materials.
- Those facilities not accredited will have an on-site review from one of our representatives.
- All documents submitted, as well as documents we may have obtained while verifying the facilities credentials, are added to the file.
- All facilities receive written notification of the status of their recredentialing.

Medical record review

As a participating physician or other health care professional, you are required to provide us with copies of medical records for our members within a reasonable time period following our request for the records. We may request such records for various reasons, including an audit of your practice. Such an audit can be performed at our discretion and for several different purposes, as we deem appropriate for our business needs.

Monitoring the quality of medical care through review of medical records

The purpose of one such medical record audit we may conduct is to review the quality of medical care, as reflected in medical records. A well-documented medical record reflects the quality and completeness of care delivered to patients. Regular review of medical records can provide data that helps physicians and other health care professionals improve preventive, acute and chronic care rendered to patients. Accreditation and regulatory organizations, such as your state Department of Health and CMS, include review of medical records as part of their oversight activities. We require medical records to be maintained in a manner that is current, detailed and organized, and which permits effective and confidential patient care and quality review.

Such review does not focus on coding for services, but rather on the quality issues rendered to the services documented in the medical records. In addition to these standards, medical records are also reviewed for compliance with nationally recommended preventive and

chronic care measures, as well as selected HEDIS measures. Reviews of this type are performed on-site at the physician's or other health care professional's office.

Communicating audit results

Results of such quality-based medical record reviews are communicated in a number of ways. Aggregate scores are reported by region to the Medical Advisory Committee as well as via physician newsletters. In addition, interventions to promote improvement in documentation are developed and implemented based on these results.

Individual results of all such reviews are tabulated in a report mailed to each reviewed physician or other health care professional. Each report contains the reviewed physician's or other health care professional's scores, both aggregate and for each measure, indicating levels of passage, areas of strength and opportunities for improvement. Physicians and other health care professionals who fall below established thresholds in such an audit are encouraged to develop a plan of corrective action that addresses deficient areas. Implementation and effectiveness of the plans are re-evaluated within the following year.

Standards for medical records

We have established the following standards for medical record keeping for PCPs in recognition of the importance of maintaining organized, up-to-date and detailed medical records as an aid in the delivery of quality care:

- Charts must be kept for individual patients in a secured area, away from patient access but readily available to practitioners.
- Charts must be legible and organized in a manner that reflects continuity and allows for easy identification of major medical problems.
- The office must have policies in place for maintaining patient confidentiality in accordance with state and federal laws.
- Physicians and other health care professionals must follow applicable professional and clinical guidelines for documenting care provided to members.
- Physicians and other health care professionals must retain patient medical records for a period of at least 10 years or the period required under applicable state and federal laws.

Confidentiality of medical records

We take confidentiality of patient medical information very seriously. Physicians and other health care professionals are required to maintain member confidentiality related to medical records in accordance with current applicable state and federal laws.

Medical records documentation

Medical records should include the following documentation, as well as any other information deemed appropriate or required by applicable standards.

General information

- Patient name on each page
- Address, phone number, or other identifiers
- Name of next of kin
- Date of visit
- Signature of person making the entry

Immunization record

- For all children of school age
- For adolescents
- Record of tetanus-diphtheria (Td) booster, flu vaccine and pneumococcal vaccine for applicable adults

Treatment plan

- Documentation to support that the treatment plan is appropriately carried out through:
  - Diagnostic testing
  - Use of medication
  - Referrals to specialists
  - Surgical interventions

Medical history

- Documentation of past medical, surgical, family, and social history
- Birth history should be noted for children under age 10
- Notation of the chief complaint or reason for each visit with history of the present illness

Preventive screening

- Evidence of appropriate preventive screening, based on clinical guidelines, by sex and age

See **Preventive Care Guidelines** in section three.

Continuity of care

- Evidence of continuity of care in the following areas:
  - Problems of previous visits are addressed
  - Physician reports (dated and initialized) showing review of diagnostic testing results and abnormal results are noted and followed up appropriately
  - Consultation reports or notes made by the physician reflecting the results of specialist referrals with evidence that recommendations are followed through
  - Recent hospitalizations, ER visits, ambulatory surgeries, etc. are recorded and follow-up is completed as needed
  - A complete problem list and medication list are maintained for patients with multiple and/or chronic problems
  - Documentation of communication between PCP and behavioral health physician for those members in ongoing behavioral health treatment

Allergies

- Notation of allergies or lack of allergies on a face sheet or initial visit sheet
- Allergies to medications or any other severe, potentially life-threatening allergic reactions should be flagged (e.g., severe food allergies, bee stings, contrast dye)

Physical exam information

- Documentation of a pertinent physical exam that includes:
  - Height, weight and BMI, as applicable, for pediatrics, obesity, etc.
  - Record of vital signs, including baseline heart rate, respirations and temperature, as applicable, for any complaint indicating possible infection
  - Blood pressure, recorded as appropriate for age and history
  - Immunization history and growth charts
  - Allergies and adverse reactions
- Complete review of systems for a complete physical exam and/or review of pertinent systems for any acute care or follow-up visits
- Notation and revision of a working diagnosis
- Written plan consistent with the diagnosis

Family communications

- Evidence of communication with the patient/family about the following:
  - Patient/family notification of abnormal test results
  - Need for return visit
  - Assessment, counseling or education on nutrition, need for special diet, therapeutic exercise, restriction of activity, or any other special instruction
  - Assessment, counseling or education on risky behaviors and preventive action associated with sexual activity
  - Assessment, counseling or education regarding depression
  - Assessment, counseling or education on risks of tobacco usage and substance abuse (including alcohol)
  - Signed consent form for all invasive procedures
  - Signed release of confidential information as necessary

Medicare medical record standards

Medical records will contain all information necessary and appropriate for quality improvement activities and to support claims for services submitted by you.

In providing care for UnitedHealthcare members, we expect that you have **signed**, **written** policies to address the following (critical elements appear in bold text in this section):

1. Maintain a single, permanent medical record that is current, detailed, organized and comprehensive for each member and is available at each visit.
2. **Protect member records, whether in paper or electronic form, against loss, destruction, tampering or unauthorized use.** For electronic medical records, you must establish security safeguards in order to prevent unauthorized access or alteration of records without leaving an audit trail to identify the breach. Such safeguards must be programmed so that they cannot be overridden or turned off.
3. **Maintain medical records in a confidential manner and provide periodic training to office staff regarding confidentiality processes. Records storage must allow for easy retrieval, be secure and allow access only by authorized personnel.**
4. Maintain a mechanism for monitoring and handling missed appointments.

5. Demonstrate the office does not discriminate in the delivery of health care.

General documentation guidelines

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

- Date all entries, and identify the author and their credentials when applicable. For records generated by word processing software or electronic medical record software, the documentation should include all authors and their credentials. It should be apparent from the documentation which individual performed a given service.
- Clearly label or document subsequent changes to a medical record entry by including the author of the change and date of change. The provider must also maintain a copy of the original entry.
- Generate documentation at the time of service or shortly thereafter.
- Make entries legible.
- **Cite medical conditions and significant illnesses on a problem list and document clinical findings and evaluation for each visit.**
- Documentation that is not reasonable and necessary for the diagnosis or treatment of an injury or illness or to improve the function of a malformed body member (over documentation) should not be considered when selecting the appropriate level of an E&M service. Only the medically reasonable and necessary services for the condition of the particular patient at the time of the encounter as documented can be considered when selecting the appropriate E&M level.
- **Give prominence to notes on medication allergies and adverse reactions. Also, note if the member has no known allergies or adverse reactions.**
- **Make it easy to identify the medical history, and include chronic illnesses, accidents and operations.**
- **For medication records, include name of medication and dosages. Also, list over-the-counter drugs taken by the member.**
- Records reflect all services provided, ancillary services/tests ordered, and all diagnostic/therapeutic services referred by the physician/health care professional.
- Clearly label any documentation generated at a previous visit as previously obtained, if it is included in the current record.

Document these important items:

- Tobacco habits, including advice to quit, alcohol use and substance abuse for members age eleven (11) and older
- **Immunization record**
- Family and social history
- Preventive screenings/services and risk screenings
- Screening for depression and evidence of coordination with behavioral health providers
- Blood pressure, height and weight, body mass index

Goals

- 90 percent of medical records will contain documentation of critical elements. Critical elements appear in bold text in this section.
- 80 percent of medical records will contain documentation of all other elements when those elements are included in quality improvement medical record audits.
- Documentation of allergies and adverse reactions must be documented in 100 percent of the records.

Demographic information

The medical record for each member should include:

- Member name and date of birth, or member name and health care ID number, on every page
- Gender
- Age or date of birth
- Address
- Marital status
- Occupational history
- Home and/or work phone numbers
- Name and phone number of emergency contact
- Name of spouse or relative
- Insurance information

Member encounters

When you see one of our members, document the visit by noting:

- Member's complaint or reason for the visit
- Physical assessment
- Unresolved problems from previous visit(s)

- Diagnosis and treatment plans consistent with your findings
- Growth charts for pediatric members
- Developmental assessment for pediatric members
- Member education, counseling or coordination of care with other providers
- Date of return visit or other follow-up care
- Review by the primary physician (initialed) on consultation, lab, imaging, special studies, and ancillary, outpatient and inpatient records
- Consultation and abnormal studies are initialed and include follow-up plans

Continuity of care

Continuity and coordination of care

Continuity and coordination of care ensures ongoing communication, monitoring and overview by the PCP across each patient's entire health care continuum. Documentation of services provided by specialists such as podiatrists, ophthalmologists and behavioral health practitioners, as well as ancillary care physicians including home care and rehabilitation facilities, help the PCP maintain a medical record that comprises a complete picture of the health care delivered to each individual. To further address the continuum of care, the PCP should note in the medical record any emergent or inpatient care received from facilities or ancillary services, as well as any specialist care received by their patient. The PCP should specifically request this history from their patients.

Please note: *Elements of the chart indicating continuity and coordination of care among practitioners are required by NCQA and state departments of health in the tri-state area (New York, New Jersey and Connecticut).*

We monitor the continuity and coordination of care that members receive through the following mechanisms:

- Medical record reviews
- Adverse outcomes that may develop as the result of disruptions in continuity or coordination of care

Physician and other health care professional termination

Provider and other health care professionals requesting to terminate their participation must do so by calling Physician Services at 1-800-666-1353 or writing to:

Important Addresses

Oxford Network Management
44 South Broadway, 14th floor
White Plains, NY 10601

Network termination guidelines

If we choose to terminate the network participation of a physician or other health care professional, we will give the physician or health care professional a written termination notice. The termination notice will include the reason for the termination, an opportunity for a review or hearing consistent with state and federal requirements, and the effective date of the termination.

If the credentialed practitioner or health care professional disagrees with the termination decision, he or she may request an appeal hearing or review. The hearing panel will be comprised of three physicians or health care professionals who were not involved with the initial determination and have representation from same/similar specialty.

Physicians and other health care professionals will not be terminated or receive a refusal to renew their contract solely because the individual has:

- Advocated on behalf of a health plan member
- Filed a complaint against the health plan
- Appealed a decision of the health plan
- Provided information or filed a report pursuant to PHL4406-c regarding prohibitions of plans
- If you are a Medicare physician and you have been terminated from the Medicare Network for administrative reasons (e.g., lack of response to a recredentialing request, network reconfiguration, etc.), you have the right to appeal this decision.

  You can do this by contacting your Network Management representative at 1-877-842-3210 (request "Other Professional Services") or you may go online to **UnitedHealthcareOnline.com > Contact Us > Network Contacts.**

For information on the reassignment of members in cases of physician and other health care professional termination, please refer to our website, ***www.oxfordhealth.com***, log in as a provider or a facility, and then click on **Tools and Resources** > **Practical Resources** > **Medical and Administrative Policies** > **Administrative Policies**.

Reassignment of members who are in an ongoing course of care or who are being treated for pregnancy

We adhere to the following guidelines when notifying members affected by the termination of a physician or other health care professional.

- All members who are patients of any terminated PCP's panel – internal medicine, family practice, pediatrics, OB/GYN – are notified of our policy and what steps to follow should the member require transitional care; the same notification procedures hold true for patients being seen regularly by a specialist who is terminated.
- Patients of such a PCP's panel are instructed to call the Customer Service department if they choose to select a new PCP, or to request transitional care from their current practitioner; they are also encouraged to request our *Roster of Participating Physicians and Other Health Care Professionals*, if needed, to make their new selection.
- Patients of a terminated specialist are instructed to call the Customer Service department if they need to request transitional care from their current specialist; they are also directed to call their current PCP for an alternate specialist referral.

Disciplinary policies and procedures

Disciplinary actions

Disciplinary action against a participating physician or other health care professional may be taken as a result of any adverse quality-of-care, credentialing, and/or administrative issue.

Potential issues can be identified through a number of sources including, but not limited to, complaint investigation and credentialing issues.

The following entities have the authority to recommend and implement disciplinary action:

- UnitedHeathcare National Physician Sanction Committee
- The National Peer Review Committee (NPRC)
- Oxford Medical Director (in rare situations) may institute immediate disciplinary action in response to imminent threat of patient harm; such action will later be reported and reviewed by the appropriate committee for their region.

Notice of termination for contract and appeal rights

We grant all physicians the right to appeal certain* disciplinary actions imposed by us. The appeals process is structured so that most appeals for terminations, not including non-renewal of the physician's contract with Oxford, can be heard prior to disciplinary action being implemented. In these cases terminations from the plan are effective as follows:

- New York – 60 days after receipt of written notice to the physician
- Connecticut and New Jersey – 30 days after final written notice to the physician

*Exceptions to above notification and termination time frames: In the following scenarios the physician may be terminated immediately whether or not the physician has the right to an appeal.

- Severe quality-of-care issues that may result in imminent harm to a member or members
- Determination of fraud
- Denial of participation for failure to meet recredentialing criteria
- Final disciplinary action by a state licensing board or other governmental agency that impairs the physician's ability to practice

All other sanctions under this policy shall be effective immediately, whether or not the physician has a right to appeal.

Appeal hearings

Physicians are entitled to a hearing before a panel of peers in response to the following action:

- Termination from the health plan as a result of any disciplinary process except:
  - Severe quality-of-care issues that may result in imminent harm to the member(s)
  - Failure to meet recredentialing criteria that results in denial of participation with Oxford that does not

include non-renewal of contract; additional information may be submitted.

- Non-renewal of contract
- Final disciplinary action by a state licensing board or other governmental agency that impairs the physician's ability to practice

Filing an appeal

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

Reporting of disciplinary actions to regulatory agencies

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

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

The following actions are reported:

- Termination due to alleged mental or physical impairment, misconduct or impairment of patient safety or welfare
- Voluntary or involuntary termination of a contract or affiliation to avoid the imposition of disciplinary action
- Termination for determination of fraud
- Knowledge of any information that reasonably appears to show that a health professional is guilty of professional misconduct
- Any disciplinary action imposed for quality reasons that adversely affects the clinical privileges of a physician or other health care professional for a period longer than 30 days

Disciplinary actions are reported to the following state licensing boards within 30 days of obtaining knowledge of any of the above actions.

New York

Office of Professional Medical Conduct
Office of Professions
New York State Education Department
One Park Avenue
New York, NY 10016-5802
1-800-663-6114

New Jersey

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

Connecticut

Connecticut Division of Medical Quality Assurance
150 Washington Street
Hartford, CT 06106
860-509-8000

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

Disciplinary action and appeals process for administrative quality of care/ utilization issues

The severity levels, sanction levels, and administrative disciplinary actions process flow associated with various administrative violations are as follows:

Severity Level 1 when Sanction Level 1
Administrative disciplinary actions taken for issues ranked at Severity Level 1 may include, but are not limited to, any of the following:

- A letter that advises the practitioner of the findings and requests an explanation and/or a plan of corrective action
- Educational discussion relating to the issue and the practitioner's plan for corrective action
- Closure of the practitioner's panel to new members or removal of name from the physician roster
- Require precertification review by Oxford's Medical Management department for procedures or services that do not otherwise require such precertification
- Impose a withhold, fee reduction or other financial penalty

- A requirement that the physician submit notes or other medical records prior to processing of a claim
- Placement on probation with close observation

Severity Level 2 when Sanction Level 2
Administrative disciplinary actions taken for issues ranked at Severity Level 2 may include, but are not limited to, any of the following:

- Any of the actions under Sanction Level 1, with a notation that the action constitutes final notice
- Limitations on reimbursement for certain procedures that are part of the practitioner's practice (e.g. refusal to pay for certain procedures, or only reimbursed for treatment to certain types of patients; in each case, the physician is prohibited from balance billing members), except for quality reasons, which shall be only accomplished by the MAC
- Non-renewal of practitioner's contract with the Plan; or termination from participation with the Plan

  In the case of termination, the practitioner is notified in writing within 30 days of the determination. For non-termination actions, the practitioner is requested to submit a plan of corrective action in addition to having the sanction imposed.

  For sanctions not involving terminations or non-renewal of contract, when informing the physician of the sanction, the Committee will provide guidance as to the time period for remeasurement. After remeasurement, depending on the practitioner's response to the Level 2 sanction, the committee may take one of the following actions:

- Conditionally accept the plan of correction, and establish a follow-up time period for re-evaluation, allowing the sanction to continue in effect during the follow-up period and for a suitable period thereafter; or terminate the practitioner if the plan of correction is unacceptable, or the physician remains non-compliant with the request imposed by Oxford.

For further information on disciplinary action appeals, please refer to our website, ***www.oxfordhealth.com***, log in as a provider or a facility, and then click on **Tools and Resources** > **Practical Resources** > **Medical and Administrative Policies** > **Administrative Policies**.

Section Eight: Claims, Billing and Reimbursement

Claims

Explanation of the claims process

Time frame for commercial and Medicare claims submission

Physicians, other health care professionals and facilities are required to submit claims within 90* days of the date(s) of service. Untimely claims will be denied. The claims filing deadline is based on the date of service on the claim; it is not based on the date the claim was sent or received.

* For claims with dates of service on or after April 1, 2010, the minimum time frame for claims submitted by New York licensed providers for services rendered to members with New York lines of business (New York situs plans) has changed to 120 days from the date of service.

We strive to process all complete claims within 30 days of receipt. Physicians and other health care professionals have a variety of methods available to verify and ensure that claims are received within the filing deadline.

If a physician or other health care professional does not receive a Remittance Advice within 45 days, he or she should check the status of the claim at that time. We offer multiple tools for checking claims status:

- Oxford Express at 1-800-666-1353 (automated self-service system available 24 hours a day, seven days a week)
- Our website at ***www.oxfordhealth.com*** (available 24 hours a day, seven days a week)
- Provider Services at 1-800-666-1353 (Monday – Friday, 8 a.m. – 6 p.m. ET)

Exceptions:

- If a claim is disputed, you have 180 days from the date of the Remittance Advice statement to appeal the claim, with the exception of claims for New Jersey members; in this case, you have 90 days from the date of the Remittance Advice statement for such claims.
- If an agreement currently exists between you and Oxford or UnitedHealthcare containing specific filing deadlines, the health plan's agreement will govern.
- If coordination of benefits has caused a delay, you will need to provide proof of denial from the primary carrier and will have 90 days from the date of the primary carrier Explanation of Benefits to submit the claim to us.
- If the member has a health benefits plan with a specific time frame regarding the submission of claims, the time frame in the member's *Certificate of Coverage* will govern. Claims submitted after the 90-day filing deadline that do not fit one of these exceptions will not be reimbursed; the reason stated will be "filing deadline has passed" or "services submitted past the filing date."
- For claims submitted after April 1, 2010, if a claim is submitted past the filing deadline due to an unusual occurrence (e.g., provider illness, provider's computer breakdown, fire, or flood) and the provider has a historical pattern of timely submissions of claims, the provider may request reconsideration of the claim.

Clean and unclean claims

Because we process claims according to state and federal requirements, a clean claim is defined as a complete claim or an itemized bill that does not require any additional information to process it.

A clean claim includes at least the following:

- Patient name and Oxford member ID number
- Provider ID number
- Provider information, including federal tax ID number (FTIN)
- Date of service
- Place of service
- Diagnosis code
- Procedure code
- Individual charge for each service
- Physician or other health care professional signature

An unclean claim is defined as an incomplete claim, a claim that is missing any of the above information or a claim that has been suspended in order to get more information from the physician or other health care professional. If you submit incomplete or inaccurate information, we may reject the claim, delay processing or make a payment determination that must be adjusted later when complete information is obtained (e.g., denial, reduced payment).

Reimbursement

Appropriate state and federal guidelines are applied to determine whether the claim is clean.

See **Required information for all claims submission** in this section.

Submission of CMS-1500 form drug codes

Attach the current NDC (National Drug Code) 11-digit number for all claims submitted with drug codes. The NDC number must be entered in the 24D field of the CMS-1500 form or the LINo3 segment of the HIPAA 837 electronic form.

Prepayment anesthesia and surgical claim validation program

Physicians and other health care professionals may be requested to submit surgical notes and anesthesia records to validate the billed ICD-9 and CPT codes on surgical claims submitted. After clinical review, the claim will be paid based on the codes that have been substantiated in the medical record.

Prepayment DRG validation program

Diagnosis Related Group (DRG) facilities may be requested to send the inpatient medical record prior to claim payment in order to validate the submitted codes. After review of all available medical information, the claim will be paid based on the codes that have been substantiated following review of the medical record.

For **appeal rights**, please refer to Section Nine.

EDI claims submission policy

Electronic claims submission is a critical step in our ongoing process to simplify and automate the entire payment process. We have made significant investments in technology to facilitate the transmission and processing of electronic claims. As part of this effort, reimbursement of electronic claims is prioritized.

Please note: *All physicians and other health care professionals can submit electronic claims – regardless of whether or not they participate with Oxford.*

Benefits of this process include:

- Faster claims turnaround time and reimbursement of clean claims
- Lower outstanding receivables
- Claims tracking at the point of submission
- Fewer errors and fewer subsequent delays in processing time
- Overall reduction in administrative expenses

In accordance with our claim submission guidelines, all claims can be submitted electronically with the exception of the following:

- Claims that were processed by another commercial carrier as the primary payer*
- Claims submitted with unspecified CPT and Healthcare Common Procedure Coding System (HCPCS) procedure codes
- Claim resubmissions

See **Paper Claims** in this section for more information.

*Medicare primary claims are now submitted automatically by electronic crossover. Please refer to Other Information for Coordination of Benefits in the Billing section for more details.

For more information or support on electronic claims, please call the eSolutions support team at **1-800-599-4334**.

Submitting electronic claims

Required information for electronic claims

To expedite payment on electronic claims, we must receive complete and accurate information from your office. Complete and accurate information includes the Payer ID, which is 06111, and the required information listed in this section. Additionally, you will need to include information which is listed in the section called **Required information for all claims submissions**.

Required provider information

- **Provider ID number and/or NPI (National Provider Identifier)** – Identification numbers assigned to the physician or other health care professional and the NPI enumerator, respectively
- **Federal tax ID number/Employer Identification Number (FTIN/EIN)** – Identification number assigned to the provider by the IRS
- **Physician or other health care professional name** – Complete first name and last name of the physician or other health care professional rendering services (correct spelling assists us with validation)

Required patient information*

Please note: *Prior to submitting a claim, please confirm the patient's current eligibility information through our website at* ***www.oxfordhealth.com****,* Oxford Express *or an EDI vendor.*

- **Patient's name and member ID number** – Be sure to accurately enter the patient's name and member ID

number as it appears on the patient's member ID card or the electronic eligibility transaction (correct spelling assists us with member validation); do not include the asterisk or space when entering the ID number; however, the last two bold numbers must be included (Example: 12345602)

- **Patient's date of birth** – Be sure to confirm that this date is correct

* For information regarding placement of required information in the HIPAA 837 transaction format, please refer to the 837 Health Care Claim: Professional ASC X12N (004010X98) Implementation Guide, ADDENDA 837 Health Care Claim: Professional ASC X12N (004010X98A1) Implementation Guide, 837 Health Care Claim: Institutional ASC X12N (004010X96) Implementation Guide, or the ADDENDA 837 Health Care Claim: Institutional ASC X12N (004010X96A1) Implementation Guide, which can be obtained from the Washington Publishing Company's website at **www.wpc-edi.com**. Oxford Companion Guides to the HIPAA Implementation Guides can be obtained by contacting our eSolutions support team at 1-800-599-4334.

Covering physician information

It is essential that the covering physician be included in the Remarks/Comments field of electronic claims being submitted. This information should be included in the event that the member's selected physician is unavailable at the time services are performed, requiring an alternate/covering physician:

"Covering for Dr. (First Name, Last Name)"

To help ensure correct payment, the provider ID number of the physician being covered should also be included.

Durable medical equipment (DME) claims

Because we no longer require providers to send scripts with their DME claims, you can send these claims electronically. In order to ensure correct and timely payment, the following information must be included on your electronic DME claims:

- The referring physician or other health care professional's name
- The words "Script on File" in the EDI Remarks field

Anesthesia claims

The following information must be included on your electronic anesthesia claims to ensure correct and timely payment:

- Total number of minutes
- Number of units (one unit equals 15 minutes)
- Actual start time and end time in the Remarks/Comments field

Ambulance claims

Information about the "point of pickup" for ambulance services rendered to our commercial and Medicare members is required. Point of pickup refers to the complete address of the starting point where the ambulance service begins.

For more information on electronic claims, please call our eSolutions support team at **1-800-599-4334**.

Clearinghouses for electronic solutions

Ingenix® EDI Solutions (IEDIS)

Ingenix is the preferred clearinghouse for the submission of claims for all Oxford plans. Ingenix offers a secure, easy-to-use path to virtually all commercial and government payers through the UnitedHealthcare Online All-Payer Gateway™. You have the option to submit claims for Oxford plans directly through Ingenix or indirectly through your current clearinghouse or gateway.

Ingenix is dedicated to transforming organizations and improving health care with a portfolio of services to:

- Prevent erroneous claims submission
- Increase claims and payment efficiency with connectivity and automation
- Optimize revenue cycle management by streamlining coding, compliance, and reimbursement
- Control costs and improve health through data-driven disease prevention
- Improve health care decisions with innovative tools
- Ensure efficiency with comprehensive consulting and implementation services

For more information about Ingenix solutions and services, visit **www.ingenix.com** or call **1-888-445-8745** today.

Electronic claims can be submitted directly to us at no cost via Oxford Direct Connect. For information, log in to ***www.oxfordhealth.com*** as a provider or facility. Click on

the **Transactions** tab and then on **Claims** in the Submit column.

Understanding your electronic claim reports

When your electronic claims are submitted, they are transmitted to a clearinghouse that checks for errors. If a clearinghouse does not find errors, the claim is sent on to us. If we detect errors, the claim is returned to the clearinghouse with an explanation of what was submitted incorrectly. Your clearinghouse is responsible for relaying this information to you. You should then correct the errors and resubmit the claim. This process greatly reduces claim denials and expedites the correction process. The reports you receive from a clearinghouse are crucial for maintaining control over your electronic claims. These reports are designed to help you understand the status of your claims, showing which claims have been accepted and forwarded, as well as which claims need to be resubmitted with corrections.

The format and content of electronic claim reports varies by clearinghouse. Many send two reports:

- The first type of report contains information regarding the total number of claims submitted, accepted and rejected by your clearinghouse; rejected claims will have detailed error explanations to assist you in understanding what information will be needed to resubmit your claim.

Claims that are rejected by a clearinghouse are not forwarded for processing.

- The second type of report identifies claims that have been forwarded to us but cannot be processed; you must then correct any errors and resubmit the claims electronically.

Electronic remittance advice (ERA) and electronic funds transfer (EFT)

ERA and EFT payment solutions are available at no cost to you and include online presentment of remittances and straightforward reconciliation of payments to reduce payment processing costs and improve cash flow.

With ERA/EFT, funds are electronically transferred directly to your bank account. You are also able to choose the method in which you receive remittance information:

- Electronic remittance advice presented online and printed on location
- Electronic remittance files for download directly to your accounting system

There are immediate benefits to signing up for ERA/EFT:

- **Reduce accounting expenses** – ERAs can be imported directly into your accounting systems, eliminating the need for manual input.
- **Improve cash flow** – Electronic payments may mean faster payments, leading to improvements in cash flow.
- **Maintain control over bank accounts** – You keep total control over the destination of claim payment funds; multiple accounts are supported.
- **Match payments to ERAs quickly** – You can associate electronic payments with ERAs quickly and easily.
- **Maintain control over remittance formats** – You can choose from a large library of formats for the remittance advice you will receive.

If you would like more information, simply log in to ***www.oxfordhealth.com*** as a provider or facility. Click on the **Transactions** tab and then on **Remittance Advice** in the Check column. If you have any questions, please call eSolutions at **1-800-599-4334**.

eSolutions support team

We have a team of professionals dedicated to assisting you with electronic solutions for your administrative needs. They can also provide you with helpful information and assist you with a variety of topics related to EDI.

For more information on electronic claims, please call the eSolutions support team at **1-800-599-4334**.

Paper claims

Claims submitted with the commercial carrier's coordination of benefits (COB) information* or unspecified CPT and HCPCS codes are exceptions to the electronic claim requirement and should continue to be submitted on paper CMS-1500 or UB-04 forms.

See Section One on **Claims Submission Addresses** for a list of claim addresses.

*Medicare primary claims are now submitted automatically by electronic crossover. Please refer to Other Information for Coordination of Benefits in the Billing section for more details.

Time frame for processing claims

We strive to settle all complete claims within 30 days of receipt. If you have not received payment within 45 days, and have not received a notice from us about your claim, please use the contact information below to verify that we have received your claim.

To check the status of unpaid claims, log in to our website at ***www.oxfordhealth.com***, call Oxford Express at **1-800-666-1353** or the Provider Services department at **1-800-666-1353**.

State time frames for claims payment

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

New York – 45 days (paper), 30 days (electronic)

Connecticut – 45 days (paper and electronic)

New Jersey – 40 days (paper), 30 days (electronic)

Paid or denied claims

When a claim is paid or denied, you will receive a check and/or an explanation that we refer to as a Remittance Advice statement. This will explain the payment in detail. Physicians and other health care professionals must accept our fee schedules and reimbursement as payment in full. You may appeal a claims payment decision if you disagree with the determination. See Section Nine on **Appeals** for a full explanation.

In addition to your Remittance Advice, you may also check on the status of your claims using one of our electronic solutions. You can check the status of your claims on our website, ***www.oxfordhealth.com***, using Oxford Express (our automated phone system) or through an EDI vendor.

Corrected/resubmitted claims (reconsideration) policy

To ensure a prompt response when resubmitting a claim, you must include the following:

Physicians and other health care professionals

- A completed CMS-1500 or UB-04 claim form with the corrected or resubmitted information
- The words "Corrected Claim" or "Resubmitted Claim" written or stamped in Field 19 (Reserved for Local Use) of the CMS-1500 form or Field 84 (Remarks) of the UB-04 form
- A copy of our Remittance Advice or claim number written on the claim form in Field 19 (Reserved for Local Use) of the CMS-1500 form or Field 84 (Remarks) of the UB-04 form

Facilities

* For facility EDI, use payer ID 06111 and include appropriate bill type.

Corrected/Resubmitted Claims (not requested by Oxford)

Oxford Correspondence Department
P.O. Box 7081
Bridgeport, CT 06601-7081

Please note: *Do not use a highlighter or red ink to communicate the issue in question,* **please use blue or black ink only**. *Also, please keep copies of all Remittance Advice documents from us for your records.*

Requests for additional information

There are times when we will request additional information to process a claim. The request will either appear on the Remittance Advice or a separate communication. The requested information must be submitted promptly. If the information is not submitted within 45 days, an appeal must be submitted with the information.

Corrected/Resubmitted Claims (requested by Oxford)

Oxford Corrected Claims Department
P.O. Box 7027
Bridgeport, CT 06601-7027

Payment appeals

See Section Nine on **Appeals** for more information.

Claim status inquiry and response

Benefits of the transactions include:

- **Flexibility (Web and EDI)** – You have more search options for retrieving claim status information; the search capability allows physicians and other health care professionals to narrow searches by selecting from a range of optional inquiry data including claim ID numbers, extended date range, bill type, billed amount,

CPT code and more; additionally, inquiries by member Social Security number return all claims for all member ID numbers associated with the requested Social Security number.

- **Increased efficiency in practice administration (Web and EDI)** – Office administrators have the ability to inquire about submitted claims listed under the same federal tax ID number, allowing the user to conduct searches for all physicians or other health care professionals in a practice without having to log in using multiple passwords.
- **A global view** – Claim status responses include all claims that have been received by and forwarded to our third-party vendors.
- **More detailed claim status and code sets** [Web, EDI and interactive voice response (IVR)] – Claims show all relevant detailed statuses of a claim, both at the claim detail level and at the claim header level; this allows a full view of how claims are processed from beginning to end; HIPAA claim status codes consist of a combination of the following three code types:
  - **Status Category Code** – Defines the category of the status; claims are "Acknowledged," "Pended" or "Finalized"
  - **Status Code** – Identifies the reasoning behind the category location of a claim; for example, if a claim was paid at a contracted rate, the claim is in the "Finalized" category
  - **Entity Code** – Rarely used in the claim status response, this is used when business conditions apply or under error conditions, such as when a member or procedure code is not found; these codes further clarify the status category and status codes; status category and status codes will be used in most cases

Performance highlights include:

- **Timely information** – Claim inquiries are retrieved and returned within HIPAA-mandated time frames, 60 seconds for individual and multi-claim searches and 24 hours for batch inquiries.
- **Consistent response** – All of our electronic mediums (including Web, Oxford Express, our automated IVR system, and EDI) communicate a consistent and HIPAA-compliant claim status response; additionally, we support Batch EDI claim status inquiry transactions.
- **Fax-back option available for IVR claims** – The IVR claim status response offers you the ability to request and receive a faxed copy of the claims requested.

Claims recovery policy (for individual physicians and other health care professionals)

In situations resulting from isolated mistakes or where the physician or other health care professional is in no way at fault, we will not pursue collection of overpayments with individual participating physicians and other health care professionals that were made more than one year prior to the date of notice of the overpayment (the one-year period runs from the date of payment to the date we provide notice to the physician or other health care professional). Discussions and actions to collect overpayments for which a physician or other health care professional is given notice within the one-year period are appropriate under this policy. We will not use extrapolation, unless the situation fits into items 1, 2 or 3 below. This would include, but would not be limited to, situations involving duplicate claims, overpayments related to fee schedule issues, isolated situations of incorrect billing/unbundling, and situations where we were not the primary insurer.

This policy does not apply to facilities or ancillaries.

1. Reasonable suspicion of fraud exists or there is a sustained or high level of billing error.
2. A physician or other health care professional affirmatively requests additional payment on claims or issues older than one year, whether through suit, arbitration, or otherwise.
3. The Centers for Medicare & Medicaid Services (CMS) makes a retroactive change to enrollment or to primary versus secondary coverage of a Medicare member. We will pursue collection of past overpayments beyond one year and utilize statistical methods and extrapolation.

Cases involving a reasonable suspicion of fraud or a sustained or high level of billing error would include extensive or systemic upcoding, unbundling, misrepresentation of services or diagnosis, services not rendered, frequent waiver of member financial responsibility, misrepresentation of physician or other health care professional rendering the services or licensure of such physician or other health care professional, and similar issues.

ICD-9-CM, CPT, HCPCS, and place codes

We use the International Classification of Diseases, 9th Revision, Clinical Modification Diagnosis and Procedure

* For information on additional HIPAA Code Sets, please refer to Appendix C of the 837 Health Care Claim: Professional ASC X12N (004010X98) Implementation Guide or the 837 Health Care Claim: Institutional ASC X12N (004010X96) Implementation Guide.

Codes (ICD-9-CM), Current Procedural Terminology (CPT), and the Healthcare Common Procedure Coding System (HCPCS) to determine payment. Physicians and other health care professionals must correctly use these codes on their claims in order to receive payment. Some codes are included in this manual; however, you can obtain complete lists of these codes by contacting St. Anthony's Publishing:

St. Anthony's Publishing
11410 Isaac Newton Square
Reston, VA 20190
1-800-632-0123, ext. 5814

In addition to the codes mentioned above, we use the bill type, occurrence codes and revenue codes, when applicable, to determine payment. You can obtain complete lists of these codes* by contacting the Centers for Medicare & Medicaid Services (CMS).

If any of the information is not submitted correctly, the clearinghouse will return the claim to you so that you can correct the error(s) and resend the claim electronically.

Required information for all claims submissions

Using the correct fields on the CMS-1500 form

The following information is required for claims processing. If this information is not provided, the claim will be suspended and payment withheld until you resubmit the claim with the necessary information.

Information	CMS-1500 Line Number	Description
Patient name	2	Name of the patient receiving service
Member ID number	1a	The patient's Oxford ID number
Date of service	24a	Date on which service was performed
Other insurance coverage	9a	Coverage in addition to Oxford
Provider name/address	33	Name/address of treating physician or other health care professional
Provider number	33	Treating provider's Oxford ID number
Provider FTIN	25	Federal tax ID number
Diagnosis code	24E	ICD-9-CM code(s) for the primary and secondary diagnoses for which patient is being treated
Services/procedures	24D	Service(s) itemized by CPT-4 code and/or HCPCS code and modifiers, if applicable (i.e., per service or procedure)
Number of days and units	24G	Days or units of service as appropriate; must be whole numbers
Total charge	28	Sum of all itemized charges or fees
Certain conditions	10	If a visit is related to employment or accident
NPI number	17b	National Provider Identifier (NPI) number of the referring provider
Rendering provider	24J	NPI number of the rendering provider

Using the correct place codes

To ensure timely and accurate payment of claims, Oxford uses the place codes created by the Centers for Medicare and Medicaid Services (CMS) and mandated by the Health Insurance Portability and Accountability Act (HIPAA) for electronic transactions. All claims are required to be submitted with the correct CMS place code. These place codes must be used for services provided to commercial members. The CMS place codes include the following:

Code	Description
11	Office
12	Home
15	Mobile diagnostic unit
20	Urgent care facility
21	Inpatient facility
22	Outpatient facility
23	Emergency room facility
24	Ambulatory surgical center
25	Birthing center
26	Military treatment facility
31	Skilled nursing facility
32	Nursing facility
33	Custodial care
34	Hospice
41	Ambulance – land

Code	Description
42	Ambulance – air or water
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse
56	Psychiatric residential treatment center
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
65	End stage renal disease facility
71	State or local public health clinic
72	Rural health clinic
81	Independent lab
99	Other unlisted facility

Required information for submission of hospital/facility claims

Required information	Description
Billing FTIN	Federal tax identification number of the organization requesting reimbursement
Facility ID/NPI number	Oxford-assigned provider identification number and NPI number of the facility requesting claim reimbursement, e.g., HO1234, ANC123
Billing facility name	Name of the organization requesting claim reimbursement
Billing facility city, state, ZIP code	City, state and ZIP code of the organization requesting claim reimbursement
Billing address	Street address of the organization requesting claim reimbursement
Patient Oxford ID number	Oxford member identification number of person to whom services are being rendered (do not use a space or an asterisk when entering the Member ID number, e.g., 17935801)
Patient last name	Last name of the patient
Patient first name	First name of the patient
Patient gender	Sex of the patient
Patient date of birth	Date of birth of the patient (eight spaces are provided for the date of birth, e.g., 01011957 not 010157)
Revenue code(s)	Code that identifies a specific accommodation, ancillary service or billing calculation
Diagnosis code(s)	The ICD-9-CM code describing the principal diagnosis (i.e., the condition determined after study to be chiefly responsible for admitting the patient for care)
Date(s) of service	Date(s) on which service was performed ("From-To" dates are accepted for inpatient charges only; outpatient charges must be entered line-by-line for each date of service)
Place code(s) or place of service	Code(s) used to indicate the place where procedure was performed
Requested amounts	Total billing amount requested by the provider
CPT/HCPC code(s)	The charge or fee for the service itemized by each HCPC or CPT-4 code (i.e., per service or procedure; inpatient charges do not require CPT codes; outpatient charges require CPT codes)
Units of service	As appropriate – A quantitative measure of services rendered by revenue category to or for the patient to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc.
Condition code(s)	As appropriate – Code(s) used to identify relating conditions that may affect Oxford's processing
Occurrence code(s)	As appropriate – Hospital/facility codes and associated dates defining a significant event relating to this bill that may affect Oxford's processing
Occurrence span code(s)	As appropriate – Hospital/facility codes and the related dates that identify an event that relates to the payment of the claim
Assignment of benefits	As appropriate – Authorization for claim reimbursement to be made to billing provider
Coordination of benefits	As appropriate – Coverage in addition to Oxford

Required information for submission of hospital/facility claims (continued)

Required information	Description
Statement covers date	The beginning and ending service dates of the period included on this claim
Covered days	The number of days covered by the primary insurer, as qualified by that organization
Non-covered days	Days of care not covered by the primary insurer
Coinsurance days	The inpatient Medicare days occurring after the 60th day and before the 91st day, or inpatient skilled nursing facility swing bed days occurring after the 20th and before the 101st day in a single period of illness
Lifetime reserve days	Under Medicare, each beneficiary has a lifetime reserve of 60 of additional days of inpatient facility services after using 90 days of inpatient facility services during a period of illness
Patient marital status	The marital status of the patient at date of admission, outpatient service or start of care
Admission/start of care date	The date the patient was admitted to the provider of inpatient care, outpatient service or start of care
Admission hour	The hour during which the patient was admitted for inpatient or outpatient care
Admission type	Hospital/facility code indicating the priority of this admission
Admission source	Hospital/facility code indicating the source of this admission
Discharge hour	Hour that the patient was discharged from inpatient care
Patient (discharge) status	Hospital/facility code indicating patient status as of the ending service date of the period covered on this bill, as reported in field 6 of the form
Medical/health record number	The number assigned to the patient's medical/health record by the provider
Treatment authorization codes	A number, hospital/facility code, or other indicator that designates that the treatment covered by this bill has been authorized by Oxford
Admitting diagnosis code	The ICD-9-CM diagnosis code provided at the time of admission, as stated by the provider
External cause of injury code	The ICD-9-CM code for the external cause of an injury, poisoning or (E-code) adverse effect

If you require assistance entering provider or patient information while completing a claim form, please call your software vendor or call the eSolutions support team at **1-800-599-4334**.

Billing

Requirements for inpatient and outpatient billing

All claims must be submitted within 90 days of completed services or payment for that service may be reduced or denied.

In addition:

- Claims must be submitted electronically or on a completed CMS-1500 or UB-04 form.
- Claims must be submitted with the appropriate CPT codes as established by the American Medical Association or Healthcare Common Procedure Coding System (HCPCS) as established by the Centers for Medicare and Medicaid Services (CMS).
- The Health Insurance Portability and Accountability Act (HIPAA) transaction and code set rule requires usage of the medical code set that is valid at the time that the service is provided; CMS will no longer permit a 90-day grace period to use discontinued codes for services rendered in the first 90 days of the year; to help promote prompt and timely payment of claims, the new CPT/HCPCS codes rendered must be used for services beginning on or after January 1 of each year.

Balance billing policy

Physicians and other health care professionals in our network may not bill members for unpaid charges above their specific member cost sharing (i.e., copayment, deductible, coinsurance excess, or charges over UCR), except when services are determined by us to be non-covered services (i.e., services that are excluded from coverage in the "Exclusions and Limitations" section of the member's *Certificate of Coverage (COC)/Evidence of Coverage (EOC)* and for which the member is responsible for payment, or services incurred when the member was not eligible for coverage) or when the member has exceeded or exhausted a benefit limit.

If you are uncertain whether a service is covered, you must make reasonable efforts to contact us and obtain coverage determination before seeking payment from a member. Our network of physicians and other health care professionals may not bill a member for:

- Any difference between our payment to you for a covered service and your billed charges
- The entire amount or partial amount of a claim that was denied by us because you failed to obtain a required precertification or a referral for those plans that require a referral

Exception: Commercial Freedom Plan® and Liberty Plan℠ members may access specialist services on an out-of-network basis without a referral. In such cases, plan members may be billed for deductible and coinsurance amounts by you. However, you may not bill the member for any difference between your billed charges and our fee schedule.

- The entire amount or partial amount of a claim that was denied solely because the service was determined to be not medically necessary
- Any line item in a claim for covered services that was included in, or excluded from, a more comprehensive payment code in accordance with our claims processing procedures
- Any line item that is adjusted in accordance with a reimbursement policy
- Fees for all or part of covered services before services are rendered (except for applicable copayments, coinsurance, and deductibles)
- Administrative services (e.g., faxing, mailing referrals, completing forms, or other standard office functions)

In those cases that require a referral, if you perform the service without a referral, the claim will be denied or paid out-of-network based on your contracted rate. In accordance with your Provider Agreement, the member is held harmless, and you cannot balance bill the member except for possible deductible and coinsurance, dependent upon member's benefit. Physicians and other health care professionals in our network who repeatedly violate these restrictions for billing members will be subject to discipline, which may include termination of your Agreement.

Any notices to members that advise them that a bill has been forwarded to us must clearly state that no money is due.

If you have any questions regarding balance billing, please call **1-800-666-1353**.

Billing address, physician or other health care professional/practice information or tax ID number change

We want to be sure the physician/other health care professional information in our database is as accurate as

possible. Your correct practice address and telephone numbers are needed so that we may list you correctly in our roster and for you to receive important mailings. An accurate billing address is also necessary for all claims logging and payment. Additionally, it is important that you notify us of any changes, such as retirement, relocation, closure of secondary office, or change of practice.

When submitting an address change form or tax ID change, you must include the following:

- A completed Provider Demographic Update Form or a letter on your letterhead
- A signed W-9 form (needed for tax ID changes only)

When submitting changes on your letterhead, you must include the following:

- A description of the change (new or additional address, telephone number or tax ID number change)
- The old and the new billing address
- The old and the new practice address
- Phone number change (if applicable)
- The tax ID number and your physician or other health care professional ID number
- The effective date of change

All documentation should be faxed to 1-866-561-3966 or e-mailed to **Ox_Hpodemo@uhc.com**. It's easy to change your practice address electronically; log in to your personalized page at ***www.oxfordhealth.com*** and click on **change address**.

The W-9 and Provider Demographic Update forms are available online at ***www.oxfordhealth.com*** or by calling **1-800-666-1353**.

National Provider Identifier (NPI) requirement

We accept NPIs on all Health Insurance Portability and Accountability Act (HIPAA) electronic claims and real-time transactions. A valid NPI is required on all covered claims (paper and electronic) in addition to the tax identification number (TIN). We are also requesting the billing provider National Uniform Claim Committee (NUCC) taxonomy code be submitted on institutional claims. As of May 23, 2008, Medicare and many state Medicaid agencies require the use of your National Provider Identifier (NPI) on all electronic and paper claim submissions. If you have not already begun to do so, you must include a valid NPI on all Medicare and Medicaid claims. Providers who have not already done so can submit their NPI to us on their letterhead or by completing a Provider Demographic Update form.* The form is available on ***www.oxfordhealth.com***. Simply log in to the provider or facilities site, then go to **Tools & Resources** and click on **Forms** under **Manage Your Practice**. Select and download the appropriate form. Please send completed forms and correspondence to us by e-mail or fax:

OX_HPDemo@uhc.com.

Fax: 1-866-561-3966

When submitting NPI information on your letterhead, please be sure to include the following:

- Practice/organization name
- Current tax identification number (TIN)
- National Provider Identifier and issue date
- NUCC taxonomy code(s) and basis for NPI (if you are an organization)
- Name and telephone number of the individual submitting NPI information to us
- If you have multiple NPIs representing your practice or organization, please refer to section III of the Provider Demographic Update form and use the grid to supply your organization or sub-part name, NPI and taxonomy code(s) associated with that NPI.

Providers and organizations who have already notified UnitedHealthcare of their NPI do not need to also inform us. NPI information received will be updated by both Oxford and UnitedHealthcare by the compliance date. Please go to ***www.oxfordhealth.com*** for additional NPI information, answers to frequently asked questions and more.

* For purposes of informing us of NPI, only sections I and III of the Provider Demographic Update form are necessary. If you have not begun to submit your NPI on claims, please work with your software vendor or clearinghouse to establish a timetable for doing so. The NPI information that you report to us now, and on all future claims, is essential in allowing us to efficiently process claims to avoid delays or denials.

Coordination of benefits (COB)

Under COB, the primary plan pays its normal plan benefits without regard to the existence of any other coverage. The secondary plan pays the difference between the allowable expense and the amount paid by the primary plan, provided this difference does not exceed the normal plan

benefits which would have been payable had no other coverage existed.

Claim submission

Before submitting a claim for processing, you must first determine if the patient has other coverage. If Oxford is secondary, you should bill the primary insurance company first and when you receive the primary carrier's explanation of benefits (EOB), submit it to us along with the claim information. See **Coordination of benefits rules**.

We now participate in Medicare Crossover for all of our members who have Medicare primary. This means Medicare will automatically pass the EOB to us electronically after the claim has been processed. We can then process the claim as secondary without a claim form or EOB from your office. When you receive your EOB from Medicare, it should indicate that the claim has been forwarded.

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

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

1. **Copy of the claim**. For a HCFA claim, fields 10 a, b and c should contain the other carrier information (only) including any policy numbers; for a UB-04 claim, field 50 should be populated with the other carrier information; for a complete list of required claim fields, please refer to Section Eight, **Claims, billing and reimbursement**.
2. **Legible copy of the primary carrier's EOB**, including the primary carrier's allowed amount, how much was paid by the primary carrier and the member's responsibility. In cases where the primary carrier has denied a service, an explanation of the denial must be included.

If information in our file does not match the COB information submitted with a claim, we will proceed accordingly:

1. If the claim indicates services are related to a work-related injury or a motor vehicle accident, we will validate the information, determine responsibility and release the claim for processing; claims with other coverage information that cannot be validated will be suspended and the provider will be notified of the claim's suspended status.
2. Claims may be suspended for up to 30 days.
3. If the COB department receives a response within the 30-day period, the member's file will be updated and the claim will be released for processing; if the member does not respond to the COB department within the 30-day period, the claim will be denied.

Referral and authorization guidelines

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

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

Balance billing

In accordance with your agreement, you are not allowed to balance bill a member for those amounts in excess of your contracted rates. Balance billing of members is subject to disciplinary procedures as defined in Section Eight, **Balance billing policy**. Please also refer to **Disciplinary policies and procedures**.

Release of information

Under the terms of HIPAA, we have the right to release to, or obtain information from, another organization in order to perform certain transaction sets. This information is used for the purpose of coordinating and paying a member's claims. Failure to release requested information can result in a delay in processing or denial of claim payment.

Right of recovery

We have the right to recover amounts paid in error. The Accounts Receivable team is responsible for collecting overpayments that have been identified by our audit teams.

We use three (3) primary collection vendors to manage provider recoveries: JRP, Creditek and Allied Interstate. These vendors are responsible for sending initial letters, assessing refund status (telephone calls and letters), partnering with us to resolve overpayment disputes/ appeals, using automated processes to exclude claims included in closed settlement time period and, pending

settlement discussions, excluding claims beyond the state compliance time frame.

Physicians and other health care professionals should follow the instructions outlined in the letter from the vendor.

Physicians or other health care professionals have 30-45 days to refund or appeal. Claims can be "down-adjusted" if still open after 90 days.

> Please refer to Section Eight, **Claims recovery policy** for further information regarding this process.

Coordination of benefits rules:

Primacy is determined based upon model regulations established by the National Association of Insurance Commissioners (NAIC).

1. **COB provision rule**: The plan without a COB provision is primary.
2. **Dependent/non-dependent rule**: The plan that covers the individual as an employee, member or subscriber or retiree is primary over the plan that covers the individual as a dependent.
3. **Birthday rule**: The "birthday rule" applies to dependent children covered by parents who are not separated or divorced. The coverage of the parent whose birthday falls first in the calendar year is the primary carrier for the dependent(s). If the parents have the same birth date, then the primary coverage is the health plan that has covered the individual for the longest continuous period.
4. **Custody/divorce decree rule**: If the parents are divorced or separated, the terms of a court decree will determine which plan is primary. If no specific terms are available, benefits are determined in this order; the plan of the parent with custody of the child, the plan of the spouse of the parent with custody of the child, the plan of the parent not having custody of the child and finally the plan of the spouse of the parent not having custody of the child.
5. **Active or inactive coverage rule**: The plan that covers an individual as an employee (not laid off or retired) or as that employee's dependent is primary over the plan covering that same individual as a laid off or retired employee or as that employee's dependent.
6. **Longer/shorter length of coverage rule**: If the preceding rules do not determine the order of benefits, the plan that has covered the person for the longer period of time is primary.

Coordinating with Medicare plans

We will coordinate benefits for members who are Medicare beneficiaries according to federal Medicare program guidelines.

When the member is insured by Oxford on a commercial plan, we have primary responsibility if the member is:

- 65 or older, actively working and his or her coverage is sponsored by an employer with 20 or more employees;
- Disabled, actively working and his or her coverage is sponsored by an employer with 100 or more employees;
- Eligible for Medicare due to end stage renal disease (ESRD) and services are within 33 months of the first date of dialysis

When the member is insured by Oxford with a Medicare Advantage plan, we have primary responsibility if the member is:

- 65 or older and retired;
- 65 or older, actively working and his or her coverage is end stage renal disease (ESRD) sponsored by an employer with less than 20 employees;
- Disabled, actively working and his or her coverage is sponsored by an employer with less than 100 employees;
- Eligible for Medicare due to end stage renal disease (ESRD) and services are after 33 months of the first date of dialysis

Reimbursement

Commercial products

PCP/specialist reimbursement – When joining our network, all PCPs and specialists agree to accept our fee schedule and the payment and processing policies associated with the administration of these fee schedules. All fees paid by us, together with the patient's copayment, deductible and/or coinsurance (if applicable), are to be accepted as payment in full. Physicians and other health care professionals must not balance bill members for in-network covered services. If physicians or other health care professionals fail to precertify services, they may not balance bill the member.

Hospital reimbursement – We will reimburse hospitals for services provided to members at the rates established in the fee schedule or in schedule or attachment of the hospital contract. Payment rates shall include payment for all professional services by physicians and other health care professionals covered by a facility's tax identification

number or who have a principal practice location at the hospital's address. All fees paid by us, together with the patient's copayment, deductible and/or coinsurance (if applicable), are to be accepted as payment in full.

Ancillary facility reimbursement – We will reimburse ancillary health care professionals for services provided to members at the rates established in the fee schedule or in attachment or schedule of the ancillary contract. Ancillary health care professionals must not balance bill members for in-network covered services. If ancillary health care professionals fail to precertify services, they may not balance bill the member.

AARP® MedicareComplete, Evercare Plan DH and MedicareComplete plans underwritten by Oxford Health Plans (NY/NJ/CT), Inc.

PCP reimbursement – If you receive fee-for-service reimbursement from us for services provided to Medicare members you must submit claims to us electronically or on a CMS-1500 form. You will be reimbursed at agreed-upon rates, less the applicable Medicare member copayment/out-of-pocket cost. If you are a capitated PCP, you must submit claims to us as if under a traditional fee-for-service billing arrangement.

Specialist reimbursement – Medicare members should pay the appropriate copayment/out-of-pocket cost to the specialist when applicable. The specialist bills us directly. We will reimburse at agreed upon rates. Physicians and other health care professionals should not bill federal Medicare.

Hospital/facility reimbursement – The physician or other health care professional must precertify services or must submit an electronic referral if applicable, in accordance with our policies for hospital and facility services.

See Section Four on **Precertification** for more information.

The Medicare member may be responsible for a copayment/out-of-pocket cost. The facility bills us directly. We will reimburse at agreed-upon contracted rates. Do not bill federal Medicare; you will not be reimbursed, and it may delay your payment.

General reimbursement guidelines

We reimburse claims for medically necessary covered services in accordance with our medical and administrative policies, the contracted fee schedule that is applicable to the network in which you participate, and the member's copayment, deductible and coinsurance, where applicable. The following is a list of commonly requested administrative policies related to reimbursement of claims. All of the medical and administrative policies for Oxford products are available for your reference on ***www.oxfordhealth.com*** and can be accessed from the provider or facility home page via the **Tools & Resources** tab under **Practical Resources** > **Medical & Administrative Policies**.

Please note: *Our medical and administrative policies are subject to change. A monthly policy update bulletin is posted on* ***www.oxfordhealth.com*** *on the first business day of each month. By accessing this communication, you can view a list of recently approved and revised policies, in their entirety, 30 days prior to their implementation date.*

- Add-on codes
- After-hours and weekend care
- Assistants at surgery (assistant surgeon)
- Bilateral surgery
- Contrast agents for radiology procedures
- Cosurgeons/team surgery
- Credentialing guidelines for participation in the radiology network for radiologists and cardiologists
- Distinct procedural service (Modifier -59)
- Evaluation and management codes
- Global surgical package
- In-office laboratory testing and procedures list
- Maximum frequency
- Modifiers
- Modifier -25
- Modifiers -54, -55, -56
- Multiple imaging rules
- Multiple procedures (Modifier -51)
- Multiple surgery
- Obstetrical care
- Obstetrical ultrasonography
- Prolonged services
- Radiology privileging list
- Radiology procedures for CareCore National arrangement

- Radiology procedures requiring precertification
- Reduced services
- Reimbursement for comprehensive and component CPT codes
- Same day/same service
- Technical component and professional component (TC/PC)
- Telephone calls, e-mail and other non-personal communications
- Therapeutic and diagnostic injection policy
- Unusual services
- Vision services

Correct coding and IntelliClaim system

All claims submitted to us must be correctly coded using the appropriate CPT code(s) or HCPCS code(s). According to the American Medical Association and the Healthcare Common Procedure Coding System (HCPCS), when both a CPT and a HCPCS Level II code have virtually identical narratives for a procedure or service, the CPT code should be used. If, however, the narratives are not identical, the Level II HCPCS code should be used.

As set forth in our current reimbursement methodology for comprehensive and component codes policy, the process of assigning a code to a procedure or service depends on both the procedure performed and the documentation that supports it. When multiple procedures are performed on a patient during a single session or visit, the claim is submitted with multiple codes instead of one comprehensive code that fully describes the entire service, we will reimburse the claim based upon the comprehensive procedure and adjust the separately billed component, incidental or mutually exclusive procedures that were performed during the same session. If a claim is incorrectly coded, we will correct the coding error by adding a new claim line with the correct comprehensive code.

To rebundle a claim, our claim system utilizes a software package assembled by IntelliClaim (owned by McKesson Health Solutions). IntelliClaim's product provides a platform on which two off-the-shelf and widely-used products (referenced below) are combined with a flexible environment that allows us to develop, customize and update our payment guidelines as necessary. The efficiency, accuracy and speed with which edits can be applied, the detailed documentation supporting the logic behind the rules, and the clear explanations for claim adjustments result in more automated claim processing as well as quick turnaround. As part of the IntelliClaim package, IntelliClaim has incorporated two software packages to rebundle codes. These software packages are the Correct Coding Initiative software by the National Technical Information Service (NTIS) and ClaimsXten™ by McKesson.

The NTIS software provides us with the correct coding rules used by the Centers for Medicare and Medicaid Services (CMS). This software is the same software product used by fiscal intermediaries that process Medicare fee-for-service claims for CMS. The correct coding rules can be found on CMS's website at **www.cms.hhs.gov**. The IntelliClaim software incorporates the quarterly updates that CMS makes to the correct coding rules into our claims processing system. ClaimsXten™ contains KnowledgePacks consisting of rules that, among other things, characterize coding relationships on provider medical bills. ClaimsXten™ provides information that allows claims submitters, claims processors and adjudicators to identify potentially incorrect or inappropriate coding relationships by a single provider, for a single patient, on a single date of service. Examples of the rules include incidental, mutually exclusive, unbundling and visit edits. Sources of the KnowledgePacks include the AMA and CPT publications, CMS, specialty societies, and McKesson physician consultants. Senior medical directors will review certain categories of code pairs encompassed in the McKesson KnowledgePacks, which are not currently implemented in our system. In certain clinical circumstances, the medical directors may deem that certain code pairs should deviate from the default rules for comprehensive procedures. The implementation of ClaimsXten™ is scheduled to be phased in as the review is completed. In light of the changes to our policy on modifiers -25 and -59, future updates to the NTIS and ClaimsXten™ software may be installed without review by medical directors and will follow our regular update schedule.

Please be aware that this reimbursement policy is subject to other reimbursement policies and rules including, but not limited to, the following policies:

- Modifiers
- Modifier -25
- Modifiers -54, -55, -56
- Global surgical package
- Distinct procedural services (Modifier -59)

Please note: *Information about correct coding rules can be found on the CMS website at* **http://www.cms.hhs.gov/physicians/**.

Modifiers

We only recognize the use of modifiers under the specific circumstances listed in our administrative policies (which are available on our website). We will reimburse correctly coded claims with modifiers only as indicated in these policies, including after a review of clinical notes. All other uses of modifiers will not be reimbursed.

Evaluation and management on same day as surgery

When you perform an established evaluation and management (E&M) or inpatient/outpatient consultation procedure on the same day a surgical procedure is performed, the reimbursement for the E&M procedure will be included in the fee for the surgical procedure. The fee for certain supplies associated with the procedure is also included in the reimbursement for the surgical procedure. The list of surgical procedures that we consider exempt is located in the global surgical package policy. In addition, refer to the modifier -25 policy for additional information on E&M codes and same-day surgery.

Multiple surgical procedures performed during same operative session

We utilize the CMS multiple procedure indicators one, two and three as set forth in the NPFS relative value file to determine which procedures are eligible for multiple procedure reductions. When you perform two or more surgical procedures during the same operative session, for reimbursement purposes, we will consider the procedure with the highest CMS-based relative value unit the primary procedure. All other procedures performed during the operative session are multiple procedures and should be billed with a multiple surgery modifier (-51).

A secondary procedure that is not billed with the -51 modifier will be adjusted, and an identical new claim line(s) will be added with a -51 modifier appended to the code. The fee for these secondary procedures will be 50 percent of the fee schedule amount. This policy does not apply if the surgical procedure is considered exempt according to the most current CPT Code Book list of procedures exempt from modifier -51 payment rules.

Global surgical package (GSP)

A global period for surgical procedures is a long-established concept under which a "single fee" is billed and paid for all services furnished by a surgeon before, during and after the procedure. According to CMS, the services included in the global surgical package (GSP) may be furnished in any setting (e.g., hospital, ambulatory surgery center, physician's office).

Our GSP policy applies the CMS time frames assigned to each global surgical procedure. All procedures with an entry of 1, 10, 90, or MMM days in the Medicare Fee Schedule Database (MFSDB) are subject to our GSP policy.

Under the GSP policy, the fee for any evaluation and management procedure performed within the follow-up period is included in the reimbursement for the surgical procedure. The fee for certain supplies associated with the procedure is also included in the reimbursement for the global surgical procedure if used within the follow-up period. If you bill for such supplies and services separately, we will indicate on the claim that such services are inclusive and reimburse for the global surgical code.

Please note: *The modifiers may only override the GSP time frames as authorized by and under the specific circumstances listed in our policies on modifiers.*

Correct coding of office visits and consultations

When you bill for a new patient office visit, outpatient visit, preventive E&M, or ophthalmology visit, the patient's claims history will be checked to determine if the patient has been seen by you or your group within the last three (3) years. In accordance with the 2008 CPT code guidelines, if the patient has been seen within the last three (3) years, the claim line on which the new patient E&M code appears will be adjusted, and an identical new claim line will be added with an established E&M visit code, at the same level as the new patient code that was billed.

Availability of policies and fees

All of our clinical, reimbursement, and administrative policies are available for your reference on ***www.oxfordhealth.com*** and can be accessed from the provider or facility home page via **Tools & Resources** > **Practical Resources** > **Medical & Administrative Policies**.

Copies of our policies can also be obtained by sending a written request to:

Important Addresses

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

Although our entire fee schedule is proprietary and cannot be distributed, we will, upon request, provide our current fees for the top codes you bill. Fees are adjusted periodically, and we will use reasonable efforts to notify you of fee changes applicable to your practice. Provider Services is available to provide this information and to answer questions regarding claims payment.

To request information regarding our fees, please call **1-800-666-1353**.

Notice of changes or revisions to our medical and administrative policies

A Policy Update Bulletin summarizing all recently approved and/or revised policies is available on ***www.oxfordhealth.com*** on the first business day of every month. By accessing the bulletin, you may view new and/or updated policies, in their entirety, 30 days prior to implementation. We encourage you to view this information in its entirety to determine the guidelines and criteria that will be applied to each policy. This communication serves as your 30-day prior notification of new and revised policies and may be accessed from the provider or facility home page under **Tools and Resources** > **Practical Resources** > **Medical and Administrative Policies** > **Policy Update Bulletin**.

New York state-regulated process for notice of adverse reimbursement changes

Under New York law, if we implement an adverse reimbursement change to your contract, we will give health care professionals at least 90 days' prior written notice of the change. An adverse reimbursement change is a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. A health care professional is defined as a health care professional licensed, registered or certified in accordance with Title Eight of the Education Law. Title Eight includes professionals only and does not include facilities.

If you object to an adverse reimbursement change, you may terminate your contract by providing written notice within 30 days of the date of the notice. Your termination will be effective on the implementation date of the adverse reimbursement change.

We are not required to give you notice where:

- the change is required by law, regulation or applicable regulatory authority
- the change is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by a government agency or by the AMA CPT codes, reporting guidelines and conventions
- the change is expressly provided for under the contract terms by inclusion of, or reference to, a specific fee or fee schedule, reimbursement methodology or payment policy indexing mechanism

These requirements do not create a private right of action on behalf of a health care professional against us for violations of these requirements.

Section Nine: Payment Appeals and Grievances

Appeals

Participating physician and other health care professional appeals

Our administrative procedures for members with an Oxford product require facilities, physicians or other health care professionals participating in our network to file an internal appeal before proceeding to arbitration under their contract. If, as a participating physician or other health care professional, you want to dispute a claim payment determination or a medical necessity determination, your dispute is eligible for an individual one-step internal appeal process. You must file your appeal request within 180 days of the date noted on the initial determination notification. On appeal, you must include all relevant clinical documentation that you wish to submit for consideration, including the entire medical record related to the service along with a Participating Provider Review Request Form. If the appeal is for a Medicare member and the initial denial may result in member liability for services (i.e., not a covered benefit, benefit exhausted, etc.), the Medicare member appeals process must be used.

See **Medicare appeals** in this section.

To avoid delays in processing your appeal request, please refer to the appeals process outlined in the denial letter or Explanation of Benefits (EOB) to appropriately route your appeal to the correct department. Time frames for appeal reviews do not begin until they are received by the appropriate department.

- **Decision-maker** – For decisions involving medical judgment, the appeal will be reviewed and decided by a different clinician than the reviewer who made the initial determination; for decisions involving payment disputes, the appeal will be reviewed and decided by a different decision-maker than the decision-maker who made the initial determination.
- **Untimely appeals** – If you submit an appeal after the appeal time frame has expired, we will uphold the denial for untimely submissions.
- **Pre-appeal claims review** – Before requesting an appeal, if you need further clarification of a payment determination, you may ask a service associate, verbally or in writing, for a review of the claims payment issue; the service associate will make every effort to explain our actions; if you or the member is found to be entitled to additional payment, we will reprocess the claim and remit the additional payment.

To request the review of a claim, please call Provider Services to speak to a Service Associate at **1-800-666-1353**.

Please note: *A participating physician or other health care professional must follow the Medicare member appeal process for all Medicare members where the member may be liable for the service.*

Internal administrative appeals process

Mandatory internal appeals process under your contract for medical necessity determinations

If, as a participating physician or other health care professional, you would like to dispute our payment determination that a service requested for a member is not medically necessary, you may mail a written request, with relevant supporting clinical documentation, that shows why the denial of services should be reversed, to:

Important Addresses

Oxford Clinical Appeals Department
P.O. Box 7078
Bridgeport, CT 06601-7078

If the appeal is for a Medicare member and the initial denial resulted in member liability for the services, the Medicare member appeals process must be used. All pertinent clinical documentation should be submitted with the appeal request. Once the review is complete, we will send written correspondence notifying you of our decision. The Clinical Appeals department will make a reasonable effort to render a decision within 120 days of receiving the appeal and supporting documentation. The decision of the Clinical Appeals department is our final position on the matter and is subject to the post-appeal dispute resolution process explained in this section.

Additional requirements for facilities

- Any requests for reconsideration through the Day of Service program must be made prior to requesting an appeal.
- The entire medical record related to the denied service must accompany the appeal letter; if the medical records are not submitted, the denial will be upheld based on the available information, unless the information already submitted supports a reversal of the decision; under

such circumstances, the facility is prohibited from balance billing the member.

- The Clinical Appeals department will make all reasonable efforts to render a decision within 60 calendar days of receiving the appeal request with supporting documentation.

Please note: *There is a separate appeal process for member appeals.*

Mandatory internal appeals process under your contract for claims payment disputes

If you would like to dispute the payment of a claim that does not involve medical necessity, you should appeal the claim by submitting a Participating Claims Review Request Form for commercial members with the "appeal" box checked to:

Important Addresses

Oxford Physician Appeals
P.O. Box 7016
Bridgeport, CT 06601-7016

To be processed, an appeal* must include:

- Participating Provider Review Request Form for Commercial Members with the "appeal" box checked
- Reason(s) you believe that the claim was processed incorrectly (or the reasons additional reimbursement should be made)
- Member's name
- Member ID number
- Member's copy of the Remittance Advice for the claim (or the claim number) in question
- Any documentation (clinical or otherwise) that you believe supports reversal of our claim payment determination

The Correspondence department will make all reasonable efforts to render a decision within 30 days of receiving the appeal and supporting documentation.

Please note: *There is a separate appeal process for member appeals.*

* A participating provider must follow the Medicare member appeal process for all Medicare members where the member may be liable for services.

Post-appeal dispute resolution process

If you have completed the internal appeals process and are not satisfied with the results of that internal appeal, under your contract with us, you have a right to arbitrate your individual dispute with us. Please consult your contract to determine the appropriate arbitration authority; most contracts provide for arbitration before the American Arbitration Association (AAA). The costs of arbitration are borne equally by the participating provider and the health plan, unless the arbitrator determines otherwise. The arbitrator's award must be in writing and include written factual findings, along with conclusions of law, which must be based upon and consistent with the law of the state identified and governing law section of your contract.

The decision in such arbitration is binding on you and us, pursuant to your provider agreement. To commence arbitration, you must file a statement of claim with the appropriate arbitration authority describing the dispute. In most instances, the arbitration authority will require that you file a specified form with your statement of claims, as well as pay an administrative fee to begin the proceeding. The appropriate arbitration authority, such as the AAA, will have processes in place for the prompt resolution of cases involving time sensitivity.

The AAA address and phone number for New York, New Jersey (excluding commercial members), Connecticut, Pennsylvania, and Delaware products is as follows:

American Arbitration Association
Northeast Case Management Center
950 Warren Avenue, 4th Floor
East Providence, RI 02914
Phone: 1-866-293-4053

Additional information, rules and forms for arbitration before the AAA may be found on the AAA's website at **www.adr.org**.

The claim appeal process for New Jersey commercial members is described in the next section titled "New Jersey state-regulated appeal process for claim payment appeals involving New Jersey commercial members."

New Jersey state-regulated appeal process for claim payment appeals involving New Jersey commercial members

If you have a dispute relating to the payment of a claim for services that were rendered to a New Jersey commercial plan member on or after July 11, 2006, or on a collection matter which commenced after July 11, 2006, your individual dispute may be eligible for a two-step appeal process. Process details, criteria for eligibility and exclusions can be found on the "Health Care Provider Application to Appeal a Claims Determination" form, as promulgated by the New Jersey Department of Banking and Insurance (DOBI) available on the DOBI website **www.state.nj.us/dobi** and on ***www.oxfordhealth.com***. Disputes involving medical necessity may not be appealed through this process. The first step of the claim appeal process allows you to submit a claim appeal through our internal appeal process and, if eligible, the second step allows your dispute to be referred to an independent arbitration entity selected by and contracted with DOBI.

Internal appeal: You must submit an internal appeal to our Correspondence department or our collections vendor within 90 calendar days of receipt of an adverse claim determination. The appeal will be resolved within 30 calendar days from the receipt of your appeal submission. To be eligible for this process, the appeal must be submitted on the "Health Care Provider Application to Appeal a Claims Determination" form ("NJ Internal Appeal Form") and include all required information (listed on form). The NJ Internal Appeal Form is available on our website at ***www.oxfordhealth.com***. For claim appeals, the form and the information must be sent to:

Important Addresses

Oxford Physician Appeals Department
P.O. Box 7016
Bridgeport, CT 06601-7016

For appeals of collection issues, your appeal should be sent to the collection vendor address listed in the collection notice.

Arbitration: In accordance with New Jersey law, disputes may be referred to arbitration when the internal appeal determination is in our favor or when we have not made a timely determination on an eligible claim appeal. To be eligible for the New Jersey arbitration process, the disputed claim amount must be at least $1,000. While you may aggregate your claims to reach this number, you must initiate the arbitration proceeding on a form created by the Department of Banking and Insurance (DOBI) on or before the 90th calendar day following your receipt of this determination. The arbitration will be conducted according to the rules of the arbitration organization (AO). The decision in such arbitration will be binding and will not be eligible for further appeal.

The appeal must be submitted on the application form created by the DOBI, which is available online at **www.njpicpa.maximus.com**. Supporting documentation may be submitted online (if the information is in an electronic format) with your application, or by fax or mail using the case number generated through the online submission process to:

MAXIMUS, Inc.
Attn: New Jersey PICPA
50 Square Drive, Suite 210
Victor, New York 14564
Fax number: 585-425-5296

(MAXIMUS has requested that faxes be limited to 25 pages.)

Fees for the arbitration must be submitted by mail. Physicians and other health care professionals wishing to submit their application by mail should contact MAXIMUS using the contact information on their website, **https://njpicpa.maximus.com**.

New York state-regulated process for external review for participating physicians and other health care professionals treating New York commercial members

This external appeals process applies only to services provided to commercial members who have coverage by virtue of a HMO or insurance plan licensed in New York state. This does not apply to the Medicare or self-funded line of business.

Retrospective review

You may request an external appeal on your own behalf when we have made a retrospective final adverse determination on the basis that the service or treatment is not medically necessary, or is considered experimental or investigational (or is an approved clinical trial) to treat the member's life-threatening or disabling condition (as defined by the New York State Social Security Law). A retrospective adverse determination is one where the initial medical necessity review is requested or initiated after the

services have been rendered. This process does not apply to services where precertification or concurrent review is required.

Internal medical necessity appeal

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

See **Commercial member appeals** in this section for additional information.

After the Clinical Appeals department issues a retrospective final adverse determination, you will be eligible to file an external appeal. All requests for such internal retrospective appeals must be made within 60 days of receipt of the initial retrospective medical necessity or experimental/investigational determination. Retrospective appeals will be resolved within 60 days from the Clinical Appeals department's receipt of the information necessary to review the appeal.

External appeal process

If the Clinical Appeals department upholds all or part of such an adverse determination, you, as the physician or other health care professional, or the member or member's designee has the right to request an external appeal. To do so, you must submit an external appeal form (including member signature), a fee and the notice of the retrospective final adverse determination to the New York State Insurance Department within 45 days of receiving such a notice from a first-level appeal.

Please send external appeal requests to:

New York State Insurance Department
P.O. Box 7209
Albany, NY 12224-0209
Phone: 1-800-400-8882
Fax: 1-800-332-2729

Concurrent Review

The right to external appeal has been expanded to allow you to initiate the external appeal process in connection with concurrent services. Previously, external appeal rights were only available to you in cases of retrospective adverse determinations. If the Clinical Appeals Department upholds all or part of a concurrent review adverse determination, you may submit an appeal on your own behalf.

Providers requesting external appeals of concurrent adverse determinations (including when done as the member's designee) may not balance bill the member for the service. In other words, you are prohibited from pursuing reimbursement from the member for services determined to be not medically necessary by the external appeal agent (except with respect to copayments, deductibles, or coinsurance).

Payment of the fee for concurrent external appeal reviews has been revised as follows:

- If our determination is upheld in whole, payment for the external appeal is your responsibility. Payment must be made within 45 days from the date the determination is received (interest will begin to accrue after the 45-day period).
- If our determination is upheld in part, payment will be divided evenly between us and you. Payment must be paid within 45 days from the date the determination is received (interest will begin to accrue after the 45-day period). A hardship request may be made to the Department of Insurance once regulations have been adopted.
- For appeals you submit acting as the member's designee, the party responsible for paying the fee will depend on whether the appeal is accepted as a member appeal. If the appeal is accepted as a member appeal, we will be responsible for paying for the appeal. When you seek to submit an external appeal acting as the member's designee, the New York Department of Insurance has the authority to confirm the designation by requesting additional information from the member in writing on two separate occasions. The member has two weeks to respond to each request. If the member does not respond to the requests within the designated time frames, the DOI will make two written requests to you asking you to to submit the external appeal on your own behalf. You will have two weeks to respond to each request. If the DOI does not receive your response within the designated time frame, the appeal will be rejected. If you respond to the request, payment for the external appeal will be made as outlined above.

To submit an external appeal, you must submit a completed external appeal form, a fee and the notice of the concurrent final adverse determination to the New York State Insurance Department within 45 days of receiving such a notice from a first-level appeal. Please send external appeal requests to:

New York State Insurance Department
P.O. Box 7209
Albany, NY 12224-0209
Phone: 1-800-400-8882
Fax: 1-800-332-2729

Commercial member appeals

Appeals may be filed by a member or on a member's behalf by his or her representative, or physician or other health care professional, with the member's written consent. If a representative files an appeal on a member's behalf, he or she must provide the member's name, the claim number, an authorization or ID number, and a written designation signed by the member after the denial of services. This written designation permits the representative to appeal on the member's behalf. Our appeal designation form is available on our website at ***www.oxfordhealth.com***.

If you appeal a claim decision or a clinical decision on behalf of a New Jersey member, you may use the state-approved consent form to appeal. Although the consent form is valid for two years, in order for the appeal to be considered a request on behalf of the New Jersey member, a copy of the form must be submitted with each subsequent request.

For appeals of benefit determinations concerning urgent care, a physician or other health care professional with knowledge of the member's medical condition shall be permitted to act as the member's authorized representative without written consent. A benefit determination concerning urgent care is defined as a determination which, if subject to the standard appeal time frames, could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or in the opinion of a physician with knowledge of the member's condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the determination.

Medical necessity appeals

Standard medical necessity appeals process for commercial members

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

Important Addresses

Oxford Clinical Appeals Department
P.O. Box 7078
Bridgeport, CT 06601-7078

Members can fax their request to 1-877-220-7537

All pertinent clinical information should be sent with the appeal request. Verbal appeals can be submitted; however, we encourage the use of written submissions to help ensure that all issues are identified.

In the event that only a portion of the pertinent clinical information is received, our appeals department will request the missing information in writing within five (5) days of receipt of the partial information. If information is not received within the requested time frame, we will make a determination based on the information available to meet the appeal response deadlines.

Expedited medical necessity appeals process for commercial members

Members have the right to request an expedited appeal, and a physician or other health care professional may request an expedited appeal when requested to do so by the member.

In order to request an expedited appeal, the member or physician or other health care professional must:

- Request an expedited appeal verbally or in writing, and hand deliver, mail or fax the request (if in writing) to the address previously listed
- State specifically that the request is for an expedited appeal

Based on the following criteria, the Clinical Appeals department will determine whether or not to grant an expedited request:

- If the time frame involved in reaching a decision through the standard appeal process would seriously jeopardize the member's life or health
- If the standard time frame involved in reaching a decision would jeopardize the member's ability to regain maximum function

If the Clinical Appeals department determines that the request does not meet expedited criteria, then the member will be notified verbally and in writing that the request will be handled through the standard appeal process. The appeal request will be reviewed within the standard time frame required by state regulations.

Benefit appeals for commercial members

Appeals of benefit denials issued by the Medical Management, Disease Management or Behavioral Health departments are handled by the Clinical Appeals department.

See **Medical necessity appeals** in this section.

Administrative appeals for commercial members

Administrative appeals (benefit appeals that do not involve a medical necessity determination for commercial members) of decisions issued by the Claims or Customer Service department without the Medical Management department's involvement are handled by the member appeals unit.

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

Important Addresses

Oxford Member Appeals
P.O. Box 7073
Bridgeport, CT 06601-7073

Verbal appeals may be submitted; however, written submissions are encouraged to help ensure that all issues are identified. Verbal appeals from a third party will not be accepted without written authorization from the member.

The request must be filed within 180 days of the member's receipt of the adverse claim determination notice.

Second-level member appeals for commercial members

Members have the right to take a second-level appeal* to our Grievance Review Board (GRB). If the member remains dissatisfied with the first-level appeal determination, the member or their authorized representative may appeal the first-level medical necessity, benefit or administrative determination to the GRB for further consideration. Requests for a second-level appeal must be made within 60 business days of receipt of the first-level appeal determination letter. Second-level appeal requests for Connecticut members involving a benefit or administrative issue must be filed within 10 business days of receipt of the first-level appeal determination letter. The request for appeal and any additional information must be submitted to:

Important Addresses

Oxford Grievance Review Board
48 Monroe Turnpike
Trumbull, CT 06611

The member or their authorized representative must include all information requested previously by us (if not already submitted), and include any additional facts or information that the member believes to be relevant to the issue. The member or their representative may send us written comments, documents, records, or other information regarding the claim.

* In New York, a second-level appeal is not required by us in order to be eligible for an external appeal.

Member external appeal process for commercial members

New York, New Jersey and Connecticut members have the right to appeal a medical necessity determination to an external review agent. Information concerning the appropriate external appeals process will be detailed in the appeals attachment included with the initial determination and appeals determination.

Consumer complaints sent to regulatory bodies

Members can file a consumer complaint with one of the following applicable regulatory bodies. The applicable regulatory body is determined by the state in which the member's certificate of coverage was issued, not where the member resides:

Connecticut

State of Connecticut Insurance Department
153 Market Street
P.O. Box 816
Hartford, CT 06142-0816
1-860-297-3862

New Jersey

Division of Insurance Enforcement and
Consumer Protection
20 West State Street
P.O. Box 329
Trenton, NJ 08625-0329

Consumer Protection Services
Dept. of Banking and Insurance
P.O. Box 329
Trenton, NJ 08625-0329
1-800-446-7467 (in NJ only)
609-292-5316
fax 609-292-5865

New York

Consumer Services Bureau
State of New York
Insurance Department
25 Beaver Street
New York, NY 10004-2349
212-480-6400

Office of Managed Care
Certification and Surveillance
New York Department of Health
Corning Tower, Room 1911
Empire State Plaza
Albany, NY 12237
518-474-2121

Medicare member appeals

The Centers for Medicare & Medicaid Services (CMS) has implemented a specific set of regulations for initial organization determinations, complaints, appeals, and grievances for Medicare members. Medicare member appeals are defined as those appeals resulting from an adverse determination that may result in member liability. To determine whether or not there may be member liability, please refer to the denial notice issued for the request for service or payment. All disputes that are not related to a denial of service or payment or are related to enrollment or hospice care are addressed through the Medicare grievance process. We will make all efforts to help this process run smoothly. In return, we ask for your cooperation. We are responsible for gathering all necessary medical information. The Medicare member's enrollment form is an implied consent to the release of patient medical records; therefore, it is critical that when we contact you for information related to an appeal, you provide us with the necessary information in a timely fashion. We also give members the opportunity to provide additional information about their case in support of their position. All Medicare member appeals must be submitted within 60 days of the initial adverse determination.

Assistance with Medicare appeals/reconsiderations

If a Medicare member decides to appeal and would like assistance, he or she may have a friend, an attorney or other designee help with the appeal. There are several groups that can assist in submitting appeals, such as a local Agency on Aging, the Senior Citizens Law Center, the member's state ombudsman, or the Insurance Counseling and Assistance Program.

A third party may file an appeal on a member's behalf. If so, the party must complete the Representative of Appointment/Acceptance form or provide proof that he or she represents the Medicare member by providing the member's name, the claim/reference number, the member's Medicare member ID number, and a signed statement from the member authorizing the third-party representation.

Please note: *We are not authorized to process the appeal without this documentation. (This rule does not apply in the case of a physician requesting an expedited 72-hour appeal.)*

To the extent provided under applicable law, a court-appointed legal guardian or an agent under a health care proxy may also file an appeal. Non-participating facilities may file an appeal; however a Waiver of Liability statement must be completed, and the waiver must state that the physician or other health care professional will not bill the Medicare member in the event the denial is upheld. Members may supply additional information for their appeal at any time.

We can supply both the Appointment of Representative Statement and Waiver of Liability Form upon request.

Types of appeals

- Expedited appeals*
- Standard service appeals
- Denials of Skilled Nursing Facility, Home Health Care or Comprehensive Outpatient Rehabilitation Facilities appeals
- Payment (Claims) appeals
- Part D pharmacy appeals

If you have any questions as to whether or not a service is covered, or regarding a claim payment, please call Provider Services at 1-800-666-1353 and, if applicable, follow the in-office denial protocol. To file an expedited appeal request verbally, please call the Medicare Customer Service department at the number listed on the back of the member ID card. Please indicate to the Service Associate that you are requesting an expedited appeal.

* The Medicare member's enrollment form is an implied consent to the release of patient medical records, therefore it is critical that when we contact you for information related to an appeal, you provide us with the necessary information in a timely fashion.

A Medicare member who would like to file an expedited, standard or payment appeal request in writing must hand-deliver or mail the appeal to:

Important Addresses

Mail:

UnitedHealthcare
Attention: Medicare Complaints,
Appeals and Grievances Department
P.O. Box 6106
Cypress, CA 90630

Hand-deliver:

UnitedHealthcare
13621 NW 12th St.
Sunrise, FL 33323
Fax: 1-866-950-5158

Expedited appeal process for Medicare members*

When we (or our designated agent) have determined that a requested service will not be covered, members and/or their physicians and other health care professionals have the right to request an expedited appeal. A Medicare member (or his designee), who would like to file an expedited appeal, must hand-deliver, mail or fax a written request to us or verbally request an expedited appeal by specifically stating, "I want an expedited reconsideration," or "I believe that my (or the member's) health could be in jeopardy by waiting for a standard reconsideration."

Such an appeal can only be expedited if requested and if the case is one in which the standard time frame could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or if the request is supported by a physician or other health care professional. If a member's request for an expedited reconsideration is denied, the request for appeal will be processed within the standard time frame and the member will be notified.

Expedited appeals that are filed by physicians or other health care professionals are deemed to be expedited. As such, these requests should be limited to those cases in which the standard time frame could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

If you, as a physician or other health care professional, request us to review your appeal as expedited, we will grant that review and process the case within 72 hours.

Please note: *If additional information is needed to complete the review, you will be responsible for submitting that information in a timely manner to enable the review to be processed within 72 hours.*

If the request is submitted in writing, the 72-hour expedited appeal time frame will begin when our Medicare department receives the written request. The member or member's designee may present additional information via telephone or in person at our Sunrise, Florida office.

Time extension – An extension of up to 14 calendar days is permitted for an expedited reconsideration if the extension will benefit the member. An example would be if the member were required to have additional diagnostic tests performed to confirm a diagnosis.

* An expedited appeal must be concurrent or prior to services being rendered.

Standard service appeal process for Medicare members

When we (or our designated agent) have issued an adverse determination (denial) for a service that has not yet occurred or for a concurrent service with member liability, the member, or his or her designee, can file a standard service appeal. Standard service appeals must be submitted in writing and must be filed within 60 days of the initial denial determination notice. Standard service appeals are reviewed and determinations are made within 30 days of receipt of the appeal request.

Appeals for denials of skilled nursing facility (SNF), home health care (HHC) or comprehensive outpatient rehabilitation facility (CORF)

When we (or our designated agent) have determined that a request for a SNF, HHC or CORF will be discontinued, the member, his or her designee and/or physician or other health care professional has the right to request a fast-

track appeal through the Quality Improvement Organization (QIO), an independent review entity, upon receipt of the Notice of Medicare Non-Coverage. If a member, or designee on behalf of a member, would like to file a fast-track appeal, he or she must hand-deliver, mail or fax a written request to the QIO in their state, or verbally request a fast-track appeal by specifically stating, "I want a fast-track appeal," by noon of the day after he or she receives the initial denial notice from us. The appeal can be filed with us directly at any time or in the event that the noon deadline is missed. If filed with us, the expedited 72-hour appeal or standard service appeal process must be followed.

The QIO differs for each state, as follows:

Connecticut

QUALIDIGM
100 Roscommon Drive, Suite 200
Middletown, CT 06457
1-800-553-7590 or 860-632-2008

New Jersey

PRONJ
557 Cranbury Road, Suite 21
East Brunswick, NJ 08816-4026
1-800-624-4557 or 732-238-5570

New York

IPRO
1979 Marcus Avenue, 1st Floor
Lake Success, NY 11042-1002
1-800-331-7767

Payment (claims) appeal process for Medicare members

When our Claims department (or our designated agent) has issued a denial on a claim which results in member liability, the member or his or her designee can file a payment appeal. Payment appeals must be submitted in writing and must be filed within 60 days of the denial determination notice.

Part D pharmacy appeals

When we or our pharmacy benefit manager have issued a denial on a request to cover a prescription drug, the member or member's designee can file an appeal. Appeals must be submitted in writing and must be filed within 60 days of the denial determination notice. These appeals can be submitted via mail or fax.

Medicare member adverse determinations on appeal

We are responsible for processing an expedited appeal within 72 hours, a standard Part D pharmacy appeal within seven (7) days, a standard service appeal within 30 days, and a payment (claims) appeal within 60 days of the date we receive the request.

If we do not rule fully in the member's favor, we will forward the appeal request to the CMS contractor, which is MAXIMUS Federal Services, Inc. [formerly the Center for Health Dispute Resolution (CHDR)]. MAXIMUS will then render a decision and will send the member a letter informing him or her of its decision within 30 business days for standard service appeals, within 60 days for payment appeals, and within 10 business days for expedited appeals, of receiving the case from us.

MAXIMUS may request additional information from your office prior to making a reconsideration decision. MAXIMUS will notify our Medicare Complaints, Appeals and Grievances department, which will in turn notify your office. Your timely attention to this request is required. Upon issuing a reconsideration determination, MAXIMUS will advise the member (and/or representative) of the decision, the reasons for the decision and, if applicable, the right to a hearing before an administrative law judge of the Social Security Administration. In the event of an adverse determination from MAXIMUS, Medicare members may request a hearing before an administrative law judge by writing to MAXIMUS or to a Social Security office within 60 days of the date of notice of an adverse reconsideration decision. This 60-day notice may be extended for good cause. A hearing can be held only if the amount in controversy is over the amount specified each year by Medicare (as determined by the administrative law judge).

The administrative law judge's adverse decision can be reviewed by the Appeals Council of the Social Security Administration, either by its own action or as the result of a request from the member or the health plan. If the amount involved is over the amount specified each year by Medicare, either the member or we can request that a decision made by the Appeals Council or administrative law judge be reviewed by a federal district court.

An initial, revised or reconsideration determination made by us, MAXIMUS, the administrative law judge, or the Appeals Council can be reopened:

- Within 12 months
- Within four (4) years, with just cause

- At any time for clerical correction or in cases of fraud

Grievances

Commercial member complaints and grievances

If we do not fully grant a member's appeal or services, the member can file a grievance with:

Important Addresses

Oxford Grievance Review Board
48 Monroe Turnpike
Trumbull, CT 06611

A member's right to go to external review is contingent on the plan type and relevant state law. Information on conducting the external process will be provided with appeal determination letters.

Medicare member complaints and grievances

Medicare members have the right to file grievances regarding us or our contracted physicians and other health care professionals. The Medicare grievance procedure provides for the meaningful, dignified, confidential, and timely resolution of those grievances. A Medicare member has the right to file a complaint/grievance about:

- Quality-of-care issues
- Office waiting times
- Physician behavior
- Premiums
- Involuntary disenrollment
- A request for expedited determination or appeal that has been denied and transferred to the standard process
- Any other issues concerning the quality of care or service received as a Medicare member
- Balance billing issues

Filing a grievance

We encourage the informal resolution of member complaints (i.e., over the telephone), especially if such a complaint is the result of misinformation, misunderstanding or lack of information. If the member's complaint cannot be resolved quickly by telephone, it will be handled through our formal grievance procedure. A formal Medicare grievance will be handled in a timely manner by the appropriate department.

We will provide a written resolution within 30 days.

Members who choose to submit a grievance in writing should use the following addresses:

For Oxford commercial member complaints about contracted physicians and other health care professionals (e.g., quality of care, office waiting time, physician behavior, adequacy of facilities):

UnitedHealthcare
Attn: Quality of Care Department
P.O. Box 400046
San Antonio, TX 78229

For Oxford Medicare member complaints about contracted physicians and other health care professionals (e.g., quality of care, office waiting time, physician behavior, adequacy of facilities); balance billing, or any other member complaints (e.g., disenrollment, premiums, policies, or services):

UnitedHealthcare
Attention: Medicare Complaints, Appeals, and Grievances Department
P.O. Box 6106
Cypress, CA 90630

For any other member complaints (e.g., disenrollment, premiums, policies, or services):

UnitedHealthcare
Attention: Medicare Complaints, Appeals, and Grievances Department
P.O. Box 6106
Cypress, CA 90630

Please note: *The Medicare member's enrollment form is an implied consent to the release of patient medical records, therefore it is critical that when we contact you for information related to this type of grievance, you provide us with the necessary information in a timely fashion.*

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710-1031

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