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NetworkBulletin

An important message to health care professionals and facilities

Please route as appropriate to UnitedHealthcare contracted physicians and health care professionals in your office.

In This Issue

UnitedHealthcare®

UnitedHealthcare respects the expertise of the physicians and health care professionals who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost effective care, and to support practice staff with a simple and predictable administrative experience. The Network Bulletin was developed to share important updates regarding UnitedHealthcare procedure and policy changes*, as well as other useful administrative and clinical information. The complete bulletin is also available on our web site at www.UnitedHealthcareOnline.com, where you will find additional materials and information regarding many of the subjects addressed here.

*To the extent that this bulletin conflicts with applicable state law, UnitedHealthcare will follow such applicable state law.

Reimbursement Policy

Note Regarding Reimbursement Policies

Unless otherwise noted below, these reimbursement policies apply to services reported using the 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent or its successor form. UnitedHealthcare reimbursement policies do not address all issues related to reimbursement for services rendered to UnitedHealthcare members, such as the member's benefit plan documents, UnitedHealthcare medical policies and the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide. Meeting the terms of a particular reimbursement policy is not a guarantee of payment. Likewise, retirement of a reimbursement policy affects only those system edits associated with the specific policy being retired. Retirement of a reimbursement policy is not a guarantee of payment. Other applicable reimbursement policies, medical policies and claims edits will continue to apply.

Once implemented, the policies may be viewed, in their entirety, on *UnitedHealthcareOnline.com > Tools & Resources > Policies and Protocols > Reimbursement Policies*. In the event of an inconsistency or conflict between the information provided in the Network Bulletin and the posted policy, the provisions of the posted reimbursement policy will prevail.

New

Once in Lifetime Procedures Policy

Effective for dates of service on or after September 1, 2010, UnitedHealthcare will implement a new policy for Once in a Lifetime Procedures, supported by the Centers for Medicare & Medicaid Services (CMS) publications related to this concept. Once in a Lifetime Procedures are those procedures, by the nature of their description, that can be performed only once in a patient's life due to the patient's anatomy.

Once in a Lifetime Procedures will not be separately reimbursed on subsequent dates of service after the original service was performed, except when reported with modifier 53 (Discontinued Procedure), modifier 55 (Postoperative Management Only), modifier 56 (Preoperative Management Only), or modifier 58 (Staged or Related Procedure or Service by the Same Physician During the Postoperative Period).

Please refer to the appendix of this Network Bulletin for a list of Current Procedural Terminology (CPT®) codes for Once in a Lifetime Procedures.

Updates

Anesthesia Policy

Bundling Revisions

UnitedHealthcare's Anesthesia Policy currently identifies specific procedural or pain management services that are not separately reimbursable with anesthesia management services (CPT codes 00100-01999 excluding 01996 and 01953).

Effective in the third quarter of 2010, UnitedHealthcare will revise the Anesthesia Policy to adopt the Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative (NCCI) edits when considering procedural or pain management services that are an integral part of anesthesia management services (CPT codes 00100-01999) and anesthesia management services that are an integral part of procedural or pain management services. The CMS NCCI edits will be managed under the NCCI Editing Policy found online at UnitedHealthcareOnline.com.

The Anesthesia policy will be revised to only address procedural or pain management services that are not separately reimbursable with anesthesia management services (CPT codes 00100-01999 excluding 01996 and 01953) for the following :

- Procedural or pain management services in the CMS National Physician Fee Schedule that have a status indicator of B (Bundled code) or T (Injections).
- Procedural or pain management services that are not separately reimbursed with anesthesia management services per the NCCI Policy Manual.
- Transesophageal echocardiography (TEE) (CPT codes 93312-93318) billed in conjunction with anesthesia management services (CPT codes

00100-01999 excluding 01996 and 01953) when the modifier 59 (Distinct Procedural Service) is **not** appended to the TEE code.

- Nerve Block codes (CPT codes 62310-62311,62318-62319, 64400-64450, 64505-64530, 64479-64484 and 64490-64495) billed in conjunction with anesthesia management services (CPT codes 00100-01999 excluding 01996 and 01953) when the modifier 59 (Distinct Procedural Service) is **not** appended to the nerve block code.

The Anesthesia policy will also address procedural or pain management services that are separately reimbursable with anesthesia management services (CPT® codes 00100-01999 excluding 01996 and 01953) for the following:

- TEE (CPT codes 93312-93318) billed in conjunction with anesthesia management services (CPT codes 00100-01999 excluding 01996 and 01953) when the modifier 59 (Distinct Procedural Service) **is** appended to the TEE code.
- Nerve Block codes (CPT codes 62310-62311,62318-62319, 64400-64450, 64505-64530, 64479-64484 and 64490-64495) billed in conjunction with anesthesia management services (CPT codes 00100-01999 excluding 01996 and 01953) when the modifier 59 (Distinct Procedural Service) **is** appended to the nerve block code.

The above described changes are currently scheduled to take effect in the third quarter of 2010.

Modifier 47

The 2010 CPT Manual states: "Regional or general anesthesia provided by the surgeon may be reported by adding the modifier '47' to the basic service. (This does not include local anesthesia.) Note: Modifier 47 would not be used as a modifier for anesthesia procedures."

Effective in third quarter of 2010, UnitedHealthcare will revise the Anesthesia Policy to not reimburse for anesthesia management services (CPT® codes 00100-01999 excluding 01996) when a modifier 47 is appended.

Anesthesia Policy and Transesophageal Echocardiography

UnitedHealthcare's Anesthesia Policy currently states that the American Society of Anesthesiologists (ASA) guidelines indicate that placement of the TEE probe, image acquisition, interpretation and report of the information are medical services provided by anesthesiologists or other qualified physicians. Indications for TEE are usually based on the individual patient's condition rather than the specific surgical procedure. Therefore, the TEE procedure is not considered part of the routine anesthesia care and is considered a separately reimbursable service. As a result, TEE procedures (CPT codes 93312-93318) will be separately reimbursed from anesthesia management services (CPT codes 00100-01999 excluding 01996 and 01953).

The 2010 ASA Relative Value Guide® revised its guidelines to state, "If the TEE is performed for diagnostic purposes by the same anesthesiologist who is providing anesthesia for a separate procedure, modifier 59 should be appended to the TEE code to note that it is distinct and independent from the anesthesia service. "

UnitedHealthcare will revise the Anesthesia Policy to only separately reimburse TEE (CPT codes 93312-93318) billed in conjunction with anesthesia management services (CPT codes 00100-01999 excluding 01996 and 01953) when the modifier 59 (Distinct Procedural Service) is appended to TEE code. These changes are targeted to take effect in the third quarter of 2010.

Moderate Sedation Policy

According to the American Medical Association (AMA), the reporting of anesthesia services (CPT codes 00100-01999) should not be reported by the same physician reporting diagnostic or therapeutic procedures cited in Appendix G of the 2010 Current Procedural Terminology (CPT®) Manual.

Effective in the third quarter of 2010, UnitedHealthcare will not separately reimburse for anesthesia management services (CPT codes 00100-01999 excluding 01996) when reported on the same date of service by the same individual physician or health care professional also reporting a

diagnostic or therapeutic procedure cited in Appendix G of the 2010 CPT® Book and not addressed in the Anesthesia Reimbursement Policy.

For the list of the CPT codes for the diagnostic or therapeutic procedures referenced, please refer to the Appendix of this Bulletin.

Reminder

Facility and Professional Reimbursement Policy on Wrong Surgery or Other Invasive Procedure Events

Patient safety is among the highest priorities for all stakeholders in health care. As you are aware, in January 2009, the Centers for Medicare & Medicaid Services (CMS) decided to not cover surgical or other invasive procedures to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. CMS will also not cover the costs of related hospitalizations and other services.

Effective July 1, 2010, UnitedHealthcare will align its policies to be consistent with CMS. As such, our Facility and Professional Reimbursement Policy on Wrong Surgery or Other Invasive Procedure Events means that UnitedHealthcare will not reimburse for a surgical or other invasive procedure when the physician erroneously performs:

- A different procedure altogether;
- The correct procedure, but on the wrong body part; or
- The correct procedure, but on the wrong patient.

UnitedHealthcare also will not provide reimbursement for facility or professional services related to these wrong surgical or other invasive procedures. Related services that will not be reimbursed include:

- **All** services provided in the operating room related to the error;
- **All** charges from physicians and other providers in the operating room when the error occurs, who could bill individually for their services; and,
- **All** related services provided during the same hospitalization in which the error occurred.

This policy, like all UnitedHealthcare reimbursement policies, are posted at *UnitedHealthcareOnline.com > Tools & Resources >Policies & Protocols > Reimbursement Policies* on the effective date of the policy.

Surgical Procedures Performed In-Office

When performing surgical procedures in a non-facility setting, the physician reimbursement is all-inclusive. Our payment covers all of the services, supplies, and equipment needed to perform the surgical procedure when a member receives these services in your office. Please note the physician reimbursement includes surgical equipment which may be owned or supplied by an outside surgical equipment or Durable Medical Equipment (DME) vendor. Claims from the vendor will be denied based on the fact that the global physician reimbursement includes staff, supplies and equipment. Any agreement to use a vendor is between the physician and the surgical or DME vendor. Facility claims submitted by vendors for services in an office setting will likewise be denied.

Medical Policy

Intensity Modulated Radiation Therapy (IMRT)

As of November 1, 2009 UnitedHealthcare required advance notification for all members receiving IMRT services. Advance notification was required for the CPT codes 77301 (Intensity modulated radiotherapy plan), 77418 (intensity modulated treatment delivery, single or multiple fields / arcs, per treatment session) and 0073T (Compensator-based beam modulation treatment delivery).

Over the past months we have evaluated the advance notification requirement and have determined that effective immediately, we will **no longer require advance notification for CPT code 77301 (IMRT treatment plan)**. If UnitedHealthcare receives a request for IMRT services for an unproven condition, we will send the submitted clinical information to a

radiation therapist for an expert opinion. We believe the availability of the IMRT treatment summary will provide the radiation therapists with information that has the opportunity to speed the review process.

Additionally, we are not requiring advance notification for CPT code 77338 (multi-leaf collimator device for intensity modulated radiation therapy).

IMRT Policy

The UnitedHealthcare policy states the use of IMRT is proven for the following conditions:

- Primary Bone and Articular Cartilage Cancer of the skull and face, vertebral column, sacrum, and coccyx
- Anal cancer
- Esophageal cancer
- Prostate cancer
- Trachea cancer
- Head and neck cancer
- Malignant (primary and secondary) and benign nervous system neoplasms of the brain (including cranial nerves and cerebral meninges) and spinal cord (including spinal meninges)

Use of IMRT for conditions not listed above would be considered unproven and therefore not a covered health service. However, IMRT may be indicated for an unproven diagnosis when at least one of the following conditions is present:

- The target volume is in close proximity to critical structures that must be protected OR
- An immediately adjacent area has been previously irradiated and abutting portals must be established with high precision

Key Points:

- UnitedHealthcare continues to require advance notification for IMRT services. This includes CPT codes 77418 and 0073T.
- UnitedHealthcare **no longer requires** advance notification for CPT code 77301, Intensity modulated radiotherapy plan
- IMRT services that are not considered proven will be reviewed by a radiation therapist. Clinical information and the IMRT radiotherapy plan are necessary for the review.
- **Cases considered unproven and submitted WITHOUT the IMRT radiotherapy plan may require additional time for review. If the information is not submitted timely, we may not have sufficient information to provide a complete and accurate review.** Submitted information needs to support why the case meets one of the above listed conditions where IMRT maybe indicated.
- Requests for IMRT for members insured by UnitedHealthcare should have a completed IMRT notification form faxed to 866-756-9733.
- The UnitedHealthcare IMRT policy is available for your review at *UnitedHealthcareOnline.com > Tools & Resources > Policies & Protocols > Medical Policies*
- **A revised UnitedHealthcare IMRT Data Collection form is available for your use. It can also be found at UnitedHealthcareonline.com > Clinical Resources > Cancer – Oncology > IMRT.**

NCCN Reviews for Use of Bevacizumab (Avastin)

In 2008 UnitedHealthcare and Oxford Health Plans (Oxford) announced the use of the National Comprehensive Cancer Network (NCCN) Compendium for reviewing outpatient chemotherapy drug coverage requests. The UnitedHealthcare Oncology Medication Clinical Coverage policy outlines the use of the NCCN compendium in our decision making process.

The Compendium recommendations list the specific cancer stage, the treatment regimen and/or the line of therapy for bevacizumab (Avastin). UnitedHealthcare and Oxford will continue to reimburse for bevacizumab for conditions with NCCN Categories of Evidence and Consensus of 1, 2A, and 2B as proven and we will extend our review to the cancer stage, treatment regimen and/or line of therapy. If the administration of bevacizumab does not follow the NCCN Compendium specifics regarding treatment regimen and/or line of therapy,

services will not be eligible for coverage and will be denied as unproven.

Implementation

UnitedHealthcare and Oxford will implement a bevacizumab review process in the Fall 2010. Additional details regarding this process will be available in future additions of the Network Bulletin and on our physician portals.

Other entities

At this time, the process for reviewing bevacizumab claims has not been changed for benefits issued or administered by AmeriChoice®, Evercare®, Neighborhood Health Plan, Mid Atlantic Health Plan, PacifiCare, the River Valley entities, and SecureHorizons® Any changes will be announced in future issues of Network Bulletin and on our Web sites.

Oncology Coverage: Proton Beam Radiation Therapy Policy

UnitedHealthcare and its affiliates have recently reviewed the clinical evidence regarding Proton Beam Radiation Therapy (PBT) and concluded that PBT is proven for the treatment of:

- arteriovenous malformations (AVMs) and
- melanoma of the uveal tract.

PBT is proven non-preferentially as one form of external beam radiation therapy for the treatment of:

- intracranial and skull base tumors
- prostate cancer

Clinical evidence supporting the use of PBT for the treatment of prostate and intracranial and skull base tumors is limited and conflicting. UnitedHealthcare will continue to review clinical evidence surrounding the use of PBT for the treatment of these cancers and may modify this conclusion at a later date based upon the evolution of the published clinical evidence.

Clinical studies have examined the use of PBT for treating other cancers. The literature review demonstrates inadequate clinical evidence of safety and/or efficacy in published, peer-reviewed medical literature. Therefore, UnitedHealthcare has determined there is insufficient data to conclude that PBT is safe or effective for treating the cancers not listed above; coverage requests for treating these cancers will be denied as unproven.

The PBT policy is available for your review at *UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols, Administrative Guides > Medical Policies > Proton Beam Radiation Therapy*.

Implementation

UnitedHealthcare will implement a post service claim review for PBT services rendered on or after September 1, 2010. Additional details regarding this process will be available in future additions of the Network Bulletin and on our physician portal.

Other entities

At this time, the process for PBT claims for benefits issued or administered by AmeriChoice, Evercare, Neighborhood Health Plan, Mid Atlantic Health Plan, PacifiCare, UnitedHealthcare of River Valley Inc, and SecureHorizons® have not been changed. Any changes will be announced in future issues of Network Bulletin and on our Web site(s).

Updates

UnitedHealthcare has recently reviewed the clinical evidence supporting the safety and effectiveness of certain medical technologies. The following tables outline the medical policy updates resulting from this review. The appearance of an item or procedure in the summaries below indicates only that UnitedHealthcare has recently adopted or revised a medical policy; it does not imply that UnitedHealthcare provides coverage for the item or procedure listed. Note that most UnitedHealthcare benefit plan documents exclude from benefit coverage health services identified as investigational or unproven. Physicians and other health care professionals may seek and collect payment from a UnitedHealthcare member for services not covered by the applicable benefit plan, provided they first obtain the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.

Unless otherwise noted, the policy updates outlined below will be effective on **July 1, 2010**. Once implemented, the policies may be viewed, in their entirety, on *UnitedHealthcareOnline.com > Tools & Resources > Policies and Protocols > Medical & Drug Policies and Coverage Determination Guidelines*. In the event of an inconsistency or conflict between the information provided in the Network Bulletin and the posted policy, the provisions of the posted medical policy will prevail.

Policy Title	Summary of Changes	Revised Coverage Rationale
Chelation Therapy *The revised policy is effective on July 1, 2010*	• Revised statement of proven indications: – Added language to indicate chelation therapy is proven for the treatment of heavy metal overload conditions – Replaced reference to "heavy metal poisoning" with "heavy metal toxicity" – Added list of specific heavy metal toxicity and overload conditions for which treatment with chelation therapy is proven • Revised statement of unproven indications for chronic, progressive diseases: – Added language to indicate chelation therapy is unproven for the treatment of non-overload conditions – Replaced reference to "heavy metal poisoning" with "heavy metal toxicity"	Chelation therapy is proven for the treatment of heavy metal toxicity and overload conditions (e.g., iron, copper, lead, aluminum). Specific conditions include: • Iron overload – Secondary hemochromotosis from blood transfusions to treat conditions such as hemoglobinopathies or bone marrow replacement disorders • Copper overload – Wilson's disease • Lead overload • Aluminum overload caused by dialysis necessitated by end-stage renal disease Chelation therapy is unproven for the treatment of chronic, progressive diseases (not involving heavy metal poisoning or non-overload conditions) and other disorders including but not limited to: • Alzheimer's disease • apoplectic coma • autism spectrum disorder • cancer • cardiovascular disease • chronic fatigue syndrome • chronic renal insufficiency • defective hearing • diabetes • diabetic ulcer • cholelithiasis • gout • erectile dysfunction • multiple sclerosis • osteoarthritis • osteoporosis • Parkinson's disease • Raynaud's disease • renal calculus • rheumatoid arthritis • schizophrenia • scleroderma • snake venom poisoning • varicose veins • vision disorders (glaucoma, cataracts, etc.)

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Policy Title	Summary of Changes	Revised Coverage Rationale
Chelation Therapy **(continued)**		Much of the evidence supporting chelation treatment for other chronic progressive disease is based on testimonials and single-case studies. Thus, there still is no scientific evidence that demonstrates any benefit from this form of therapy. Chelation therapy is unproven for the treatment of "mercury toxicity" from dental amalgam fillings. Randomized controlled trials do not identify a causal association between amalgam fillings and various systemic symptoms and disorders attributed to mercury.
Deep Brain Stimulation *The revised policy is effective on July 1, 2010*	• Revised statement of proven indications for the treatment of idiopathic Parkinson's disease, essential tremor, chronic intractable primary dystonia, and cervical dystonia; – Removed language indicating deep brain stimulation is proven for the treatment of these conditions when standard recognized medical therapy has either failed to relieve the symptoms or the side effects of the medications prohibit their continued use – Added language to indicate deep brain stimulation is proven for the treatment of these conditions when used according to U.S. Food and Drug Administration (FDA) indications • Removed 86.09 and 86.99 from list of ICD-9 Procedure codes • Updated description for ICD-9 Procedure code 02.93	Deep brain stimulation is proven for treating idiopathic Parkinson's disease when used according to U.S. Food and Drug Administration (FDA) indications. Deep brain stimulation is proven for treating essential tremor when used according to FDA indications. Deep brain stimulation is proven for treating chronic, intractable primary dystonia (occurs on its own, apart from any illness), including generalized and/or segmental dystonia, hemidystonia and cervical dystonia (torticollis) when used according to FDA indications. Deep brain stimulation is unproven for treating secondary dystonia (occurs with illness, after trauma or following exposure to certain medications or toxins). There is inadequate evidence of the safety and efficacy of deep brain stimulation for treating secondary dystonia. Deep brain stimulation is unproven for treating conditions other than those listed above.

Policy Title	Summary of Changes	Revised Coverage Rationale
Epidural Steroid and Facet Injections for Spinal Pain	• Effective July 1, 2010: – Removed 0213T-0218T from list of applicable CPT codes for facet joint injections • Effective August 13, 2010: – Removed 337.21, 353.2, 353.3, 354.4, 354.8, 354.9, 722.0, 722.11, 722.4, 722.71, 722.72, 722.81, 722.82, 723.0, 723.3, 723.4, 724.00, 724.01, 805.00, 805.02-805.08, 805.2, and 953.0 from list of proven ICD-9 Diagnosis codes for lumbosacral epidural steroid injections – Removed list of ICD-9 Procedure codes	• **Facet Joint Injections** Diagnostic facet joint injection and/or facet nerve block (e.g., medial branch block) is proven to localize the source of pain to the facet joint in persons with spinal pain. Therapeutic facet joint injection is unproven for the treatment of chronic spinal pain. Clinical evidence about the very existence of facet joint syndrome is conflicting, and evidence from studies is inadequate regarding the superiority of periodic facet joint injections compared to placebo in relieving chronic spinal pain. **Epidural Steroid Injections** Epidural steroid injection is proven for the treatment of acute and sub-acute sciatica or radicular pain of the low back caused by disc herniation or degenerative changes in the vertebrae. Epidural steroid injections have a clinically established role in the short-term management of low back pain when the following **two** criteria are met: • The pain is associated with symptoms of nerve root irritation and/or low back pain due to disc extrusions and/or contained herniations; and • The pain is unresponsive to conservative treatment, including but not limited to pharmacotherapy, exercise or physical therapy Epidural steroid injection is unproven for all other indications of the lumbar spine. There is a lack of evidence from randomized controlled trials indicating that epidural steroid injections effectively treat patients with lumbar pain not associated with sciatica or radicular pain. **Note:** This policy does not apply to obstetrical epidural anesthesia utilized during labor and delivery.

Policy Title	Summary of Changes	Revised Coverage Rationale
Fecal Calprotectin Testing *The revised policy is effective on July 1, 2010*	• Changed policy title; previously titled Testing for the Diagnosis and Management of Inflammatory Bowel Disease • Revised coverage rationale; – Removed language indicating the use of serologic assays for the diagnosis and management of inflammatory bowel disease (IBD), including ulcerative colitis and Crohn's disease, is unproven – Added language to indicate fecal measurement of calprotectin is unproven for the diagnosis and management of all conditions including, but not limited, to: • inflammatory bowel disease (IBD) including ulcerative colitis and Crohn's disease • colorectal cancer • Removed list of applicable ICD-9 Diagnosis codes • Removed 83516, 86255, 86256, 86671, and 88347 from list of applicable CPT codes	Fecal measurement of calprotectin is unproven for the diagnosis and management of all conditions including but not limited to the following: • inflammatory bowel disease (IBD) including ulcerative colitis and Crohn's disease • colorectal cancer There is insufficient evidence that fecal calprotectin is effective as a biomarker for the diagnosis and management of intestinal disease. Before fecal calprotectin can be incorporated into routine clinical practice, studies in larger and diverse groups of patients will be needed to further clarify its role in clinical decision making and its effect on the outcome of treatment of the condition for which it is being used.
High Ligation at the Saphenofemoral or Saphenopopliteal Junctions *The revised policy is effective on August 1, 2010*	• Changed policy title; previously titled *Surgical and Minimally Invasive Treatment for Varicose Veins of the Leg* • Removed coverage guidelines for the following procedures*: – Vein ablation, including stripping, radiofrequency ablation and endovenous laser ablation – Sclerotherapy – Stab avulsion and ambulatory phlebectomy – Subfascial endoscopic perforator surgery (SEPS) *The documentation requirements and evaluation criteria to be utilized when rendering a coverage decision for these procedures are now outlined in the Coverage Determination Guideline titled Ablative Procedures for Venous Insufficiency and Varicose Veins. See below for details. • Added language to indicate ligation at the saphenofemoral junction, as an adjunct to radiofrequency ablation or	Ligation of the greater saphenous vein at the saphenofemoral junction, as a stand-alone procedure, is unproven for treating venous reflux. Ligation performed without stripping or ablation is associated with high long-term recurrence rates due to neovascularization. Ligation of the small saphenous vein at the saphenopopliteal junction, as a stand-alone procedure, is unproven for treating venous reflux. Ligation performed without stripping or ablation is associated with high long-term recurrence rates due to neovascularization. Ligation at the saphenofemoral junction, as a stand-alone procedure, is proven, when used in patients with ascending superficial thrombophlebitis, to prevent the propagation of an active clot from the superficial system to the deep venous system. Ligation at the saphenofemoral junction, as an adjunct to radiofrequency ablation or endovenous laser ablation of the main saphenous veins, is unproven.

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Policy Title	Summary of Changes	Revised Coverage Rationale
High Ligation at the Saphenofemoral or Saphenopopliteal Junctions ***(continued)***	endovenous laser ablation of the main saphenous veins, is unproven • Removed 36468, 36470, 36471, 36475, 36476, 36478, 36479, 37250, 37251, 37500, 37718, 37722, 37765, 37766, 37785, 93970 and 93971 from list of applicable CPT codes • Updated list of proven ICD-9 Diagnosis codes: – Removed 451.0, 451.2, 459.11, 459.12, 459.13, 459.19, 459.31, 459.33, 707.10, 707.11, 707.12, 707.19, 448.0, 448.1, 448.9, and 454.9 – Added 459.81 • Removed list of unproven ICD-9 Diagnosis codes • Removed list of applicable ICD-9 Procedure codes	Published clinical evidence has not demonstrated that the addition of saphenofemoral ligation to endovenous ablation procedures provides an additive benefit in resolving venous reflux or preventing varicose vein recurrence. Endovenous ablation is a clinically effective therapy for treating venous reflux. Adding ligation to the procedure adds clinical risk without adding clinical benefit.
Manipulation Under Anesthesia *The revised policy is effective on July 1, 2010*	• Updated list of unproven indications to include treatment of the toe • Removed list of unproven ICD-9 Diagnosis codes	Manipulation under anesthesia is proven for treatment of the: • Elbow joint for arthrofibrosis following elbow surgery or fracture • Knee joint for arthrofibrosis following total knee arthroplasty, knee surgery, or fracture • Pelvis for acute traumatic fracture or dislocation • Shoulder joint for adhesive capsulitis (e.g., frozen shoulder) Manipulation under anesthesia is unproven for treatment of the: • Ankle • Finger • Hip joint or adhesive capsulitis of the hip • Knee joint for any condition other than for arthrofibrosis following total knee arthroplasty, knee surgery, or fracture • Pelvis for diastasis or subluxation • Shoulder for any condition other than adhesive capsulitis (frozen shoulder) • Spine • Temporomandibular joint (TMJ) • Toe • Wrist Manipulation under anesthesia is unproven for serial manipulations for any body part or multiple body joints for the management of acute or chronic pain conditions.

Policy Title	Summary of Changes	Revised Coverage Rationale
Occipital Neuralgia and Cervicogenic Headache *The revised policy is effective on July 1, 2010*	• Revised statement of unproven indications; added language to indicate occipital nerve blocks are unproven for: – the diagnosis and treatment of occipital neuralgia or headaches including migraine and cervicogenic headaches – the treatment of headaches including migraine and cervicogenic headaches • Added 64626, 64627 and 64722 to list of applicable CPT codes	Injection of local anesthetics and/or steroids, used as occipital nerve blocks, is unproven for the diagnosis and treatment of occipital neuralgia or headaches including cervicogenic headache. There is insufficient evidence that greater occipital nerve blocks can be used as a specific diagnostic test for occipital neuralgia or headaches. The efficacy of local injection therapies for occipital neuralgia or cervicogenic headache and other headaches has not been established in well designed clinical trials. Surgery including but not limited to the following is unproven for the treatment of occipital neuralgia or cervicogenic headache: • Occipital neurectomy • Partial posterior intradural C1-C3 rhizotomy • Rhizotomy of C1-C3 spinal dorsal roots • Surgical decompression of second cervical nerve root and ganglion • Surgical decompression of the greater occipital nerve The available evidence is insufficient to conclude that surgery is an effective treatment for occipital neuralgia or cervicogenic headache. The long-term efficacy of surgical procedures for occipital neuralgia or cervicogenic headache has not been established in well designed clinical trials. Radiofrequency ablation or denervation is unproven for the treatment of occipital neuralgia or cervicogenic headache. The available evidence from published studies is not sufficient to conclude that radiofrequency ablation or denervation is an effective treatment for occipital neuralgia or cervicogenic headache. Neurostimulation or electrical stimulation of the occipital nerve is unproven for the treatment of occipital neuralgia or cervicogenic headache. The available studies were limited and had significant methodological flaws, making it difficult to draw conclusions regarding the efficacy of electrical stimulation for the treatment of cervicogenic headache or occipital neuralgia.

Policy Title	Summary of Changes	Revised Coverage Rationale
Omnibus Codes *The revised policy is effective on July 1, 2010*	• Added language to indicate: – Use of ultrasound guidance for facet joint and epidural steroid injections (CPT codes 0213T-0218T, 0230T and 0231T) is unproven – Use of computer-aided electronic auscultatory devices (CPT codes 0223T-0225T) is unproven – Use of advanced glycation end products as a diagnostic or predictive test (0233T) is unproven – Use of dermal fillers such as Radiesse or Sculptra (Q2026 and Q2027) is proven for vocal fold insufficiency and to correct facial defects due to facial lipidatrophy in persons with human immunodeficiency virus (HIV)	Refer to the policy on UnitedHealthcareOnline.com for the coverage rationale for Omnibus Codes.
Platelet Derived Growth Factors for Treatment of Wounds *The revised policy is effective on July 1, 2010*	• Revised coverage rationale to indicate autologous platelet rich plasma is unproven for the treatment of all wounds (language previously specific to "chronic nonhealing" wounds only) • Added statement of coding clarification for treatment related to diabetic ulcers	**Platelet Derived Growth Factors** When used according to U.S. Food and Drug Administration (FDA) approved indications, becaplermin (Regranex® Gel) is proven for the treatment of lower extremity diabetic neuropathic ulcers. **Platelet Rich Plasma** Autologous platelet rich plasma (e.g., Procuren®, AutoloGel®, or SafeBlood®) is unproven for the treatment of wounds. The better designed studies do not demonstrate that autologous platelet rich plasma such as Procuren, AutoloGel or SafeBlood improves health outcomes in patients with wounds.
Prolotherapy for Musculoskeletal Indications *The revised policy is effective on July 1, 2010*	• Revised statement of unproven indications; added language to indicate treatment with prolotherapy is unproven for the treatment of: – joint or ligament instability conditions – lateral epicondylosis	The use of prolotherapy for the treatment of joint or ligament instability conditions such as chronic low back pain, osteoarthritis of the knee, thumb, and finger joints, and lateral epicondylosis is unproven. The available studies are limited to those that include short to medium–term follow-up with no significant functional improvement compared to placebo. Additional studies are needed to further define treatment parameters and to determine whether a clinically significant improvement is achieved.

Policy Title	Summary of Changes	Revised Coverage Rationale
Thermal Capsulorrhaphy/ Thermal Shrinkage Therapy *The revised policy is effective on July 1, 2010*	• Changed policy title; previously titled Thermal Shrinkage Therapy For Joint Capsules, Ligaments And Tendons • Revised coverage rationale; added language to indicate thermal capsulorrhaphy/ thermal shrinkage is unproven for the treatment of joint instability or ligamentous laxity of the shoulder	Thermal capsulorrhaphy/thermal shrinkage is unproven for the treatment of joint instability or ligamentous laxity of the shoulder. Well designed randomized trials are needed to compare thermal capsulorrhaphy/thermal shrinkage with surgical or other treatment options. Thermal capsulorrhaphy/thermal shrinkage is unproven for the treatment of joint instability or ligamentous laxity in joints (other than the shoulder) such as the shoulder, knee, hip, and ankle. Clinical evidence does not support the use of thermal capsulorrhaphy or thermal shrinkage for the treatment of joint instability or ligamentous laxity in any joint. Well designed randomized trials are needed to compare thermal capsulorrhaphy/ thermal shrinkage with surgical or other treatment options.

Retirement

The following medical policies were retired on the dates noted below. In most circumstances, the procedural codes and/or services previously outlined in a retired policy are no longer being managed or are considered to be proven and are therefore not excluded as unproven services, unless coverage guidelines or criteria are otherwise documented in another policy or coverage determination guideline.

Note: The absence of a policy does not automatically indicate or imply coverage. As always, coverage for a service or procedure must be determined in accordance with the member's benefit plan and any applicable federal or state regulatory requirements. Additionally, UnitedHealthcare reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

Policy Title	Retirement Status	Retirement Date
Breast Reconstruction	• Medical Policy retired and replaced with Coverage Determination Guideline titled *Breast Reconstruction*	March 26, 2010
Cryopreservation of Reproductive Tissue	• Medical Policy retired: – Coverage criteria for cryopreservation of reproductive tissue added to Medical Policy titled *Infertility Diagnosis and Treatment* – Applicable benefit interpretation guidelines added to Coverage Determination Guideline titled *Reproduction Services Including Cryopreservation of Reproductive Tissue and Termination of Pregnancy*	May 1, 2010
Orthognathic Surgery	• Medical Policy retired and replaced with Coverage Determination Guideline titled *Orthognathic/Jaw Surgery*	March 26, 2010

Coverage Determination Guidelines

UnitedHealthcare's Coverage Determination Guidelines (CDG) provide assistance in interpreting certain standard benefit plans, describe the clinical criteria we apply in determining whether a service is determined to be reconstructive or cosmetic, and outline the clinical information we will seek from you in making that determination. The terms of a member's document (e.g., Certificates of Coverage, Schedules of Benefits, or Summary Plan Descriptions) may differ greatly from the standard benefit plan upon which these guidelines are based. In the event of a conflict, the member's specific plan document supersedes these guidelines.

Similar to prior years,, under the UnitedHealthcare Physician, Health Care Professional,Facility and Ancillary Provider Administrative Guide for 2010 you are required to provide advance notification for a variety of reconstructive/potentially cosmetic procedures, including ablation, ligation and vein stripping services. Notice is required whether the services are performed on an inpatient or outpatient basis, in order to confirm coverage for these services. An administrative reimbursement reduction will be applied if notification is not received prior to the service being rendered.

Additionally, the UnitedHealthcare Administrative Guide provides that you must cooperate with all requests for information, documents or discussions from UnitedHealthcare for purposes of a clinical coverage review including, but not limited to, pertinent medical records, imaging studies/reports and appropriate assessments for determining degree of pain or functional impairment.

Beginning August 1, 2010, UnitedHealthcare will be conducting more detailed clinical coverage reviews for ablative procedures for the treatment of venous insufficiency and varicose veins. As outlined in detail in the CDG for these services, you will need to provide the following clinical documentation in order for UnitedHealthcare to *render a coverage decision for services to be performed on or after August 1, 2010:*

- Contemporaneous physician office notes describing the history of the member's chief complaint, previous treatment, relevant signs on physical exam, and the member's functional impairment
- Duplex ultrasonography with color flow Doppler results and physician interpretation report demonstrating reflux, duration of reflux, and vein size
- High-quality color photographs documenting the size and location of veins that account for the symptoms
- Treatment plan outlining the proposed procedures and the expected outcome for improvement of the functional deficit
- Completed questionnaire documenting the degree and severity of functional impairment and results from trial use of compression stockings (This requirement applies to patients with a functional impairment of pain, heaviness or aching only. Refer to the CDG for a copy of the questionnaire.)

The Coverage Determination Guidelines, titled *Ablative Procedures for Venous Insufficiency and Varicose Veins*, will be available for your reference on UnitedHealthcareOnline.com > Tools & Resources > Policies and Protocols > Medical & Drug Policies and Coverage Determination Guidelines beginning June 1, 2010. Please review the guidelines in their entirety for complete details on the documentation requirements and evaluation criteria to be utilized when rendering a coverage decision for these services **beginning August 1, 2010**, as well as the list of vein ablation, ligation and stripping codes requiring prior notice. In the event of an inconsistency or conflict between the information provided in the Network Bulletin and the posted Coverage Determination Guidelines, the provisions of the posted Coverage Determination Guidelines will prevail.

CDG Title	Ablative Procedures for Venous Insufficiency and Varicose Veins
Effective Date	August 1, 2010

INDICATIONS FOR COVERAGE

Required Documentation

The decision regarding whether the requested procedure will be covered as reconstructive or excluded from coverage as cosmetic will require review of the following required clinical information/documentation:

A. Contemporaneous physician office notes with the history of the medical condition(s) requiring treatment or surgical intervention documenting:
   1. The patient has venous insufficiency and valvular reflux that is consistent with the nature of the complaint that results in a functional deficit that is recurrent or persistent in nature; **and**
   2. The condition is causing the functional impairment (include the nature of the impairment)

B. Duplex ultrasonography, with color flow Doppler results, and a formal, written report signed by the physician who interpreted the test, that demonstrates reflux, duration of reflux and documentation of vein size (hand-held ultrasound is insufficient for these purposes)

C. A completed questionnaire addressing the degree and severity of functional impairment and the results of compression stockings trial (refer to the Coverage Determination Guidelines on *UnitedHealthcareOnline.com* for a copy of the questionnaire form)

D. High-quality color photographic prints documenting the size with ruler and location of veins that account for the condition. These include close up photographs of any ulcers and/or skin changes as well as an anatomical landmark such as the ankle or knee to identify side

E. Treatment plan outlining the proposed procedures and the expected outcome for the improvement of the functional deficit

Coverage Determination Criteria

A. Varicose vein ablation (surgical excision, radiofrequency ablation or endovenous laser ablation) of the greater saphenous vein, small saphenous vein or principle branches (posterior accessory vein, anterior accessory vein and the cephalad extension of the small saphenous vein (vein of Giacomini)) is considered reconstructive when all of the following criteria are present:

   1. Condition is caused by venous insufficiency

   2. Vein size by ultrasound
      a. If the planned ablation involves the greater saphenous vein, the vein must be 5.5 mm or greater in diameter, as measured by duplex ultrasonography at several locations along the thigh (proximal, mid, distal).
      b. If the planned ablation involves the small saphenous vein, the vein must measure 5 mm or greater just below the saphenopopliteal junction.
      c. If the planned ablation involves the named principle branches, the vein must measure 5 mm or greater.

   3. Duration of reflux, as measured by duplex ultrasonography with color flow Doppler that meets the following parameters:
      a. Greater saphenous vein – ≥ 500 milliseconds (ms) with measurements taken at the saphenofemoral junction, mid thigh and below the knee
      b. Small saphenous vein – ≥ 500 ms with measurements taken just below the knee
      c. Principle branches - ≥ 500 ms
      d. Perforating veins - > 350 ms

   4. High-quality color photographic prints that document either:
      a. Skin pigmentation changes of venous stasis dermatitis; or
      b. Skin ulcerations; or
      c. In cases where painful varicosities are described as the cause of impairment, the photographs must document veins of sufficient size, and in a location that explains the degree and severity of functional impairment

CDG Title	Ablative Procedures for Venous Insufficiency and Varicose Veins (continued)
Effective Date	August 1, 2010

INDICATIONS FOR COVERAGE

Coverage Determination Criteria (continued)

5. For the member whose only functional impairment is pain, heaviness or aching, there must be a documented trial of a minimum of two weeks use of compression stockings, 30 - 40 mmHg or greater, that resulted in significant improvement in symptoms.

6. Member must have one of the following functional impairments:
   a. Skin ulceration; or
   b. Documented episode(s) of frank bleeding of the varicose vein due to erosion of or trauma to the skin; or
   c. Documented history of superficial thrombophlebitis; or
   d. Documented venous stasis dermatitis; or
   e. Moderate or severe pain and/or limitation of activities as documented on the questionnaire form (refer to the Coverage Determination Guidelines on UnitedHealthcareOnline.com for a copy of the questionnaire form)

B. Ablation of perforator veins is considered reconstructive when the following criteria are present:

1. Evidence of perforator venous insufficiency measured by duplex ultrasonography (see criteria above); and
2. Perforator vein size is 4 mm or greater; and
3. Presence of venous stasis ulceration(s) due to the insufficiency.

C. Endovenous ablation (radiofrequency or laser) of either reticular or telangiectatic veins is not considered reconstructive

D. Ligation of the greater saphenous vein at the saphenofemoral junction as a standalone procedure is unproven as a treatment for venous reflux. Therefore, it is not a covered service. This code is proven as a covered service only when used to prevent the propagation of an active clot from the superficial system to the deep venous system (see related Medical Policy titled High Ligation at the Saphenofemoral or Saphenopopliteal Junctions for details)

E. Ligation of the small saphenous vein at the saphenopopliteal junction as a standalone procedure is unproven as a treatment for venous reflux. Therefore, it is not a covered service. This code is proven as a covered service only when used to prevent the propagation of an active clot from the superficial system to the deep venous system (see related Medical Policy titled High Ligation at the Saphenofemoral or Saphenopopliteal Junctions for details)

COVERAGE LIMITATIONS AND EXCLUSIONS

Cosmetic Procedures are excluded from coverage:

1. Procedures that correct an anatomical Congenital Anomaly without improving or restoring physiologic function are considered Cosmetic Procedures. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Sickness or Congenital Anomaly does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure

2. Any procedure that does not meet the reconstructive criteria/indications for coverage listed above

CDG Title	Ablative Procedures for Venous Insufficiency and Varicose Veins (continued)
Effective Date	**August 1, 2010**

COVERAGE LIMITATIONS AND EXCLUSIONS (continued)

The codes listed in this guideline are for reference purposes only. Listing of a service code in this guideline does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document.

CPT Code	Description
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites (list separately in addition to code for primary procedure)
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in a single extremity, each through separate access sites (list separately in addition to code for primary procedure)
36479	Ligation, division, and stripping, short saphenous vein
37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below
For CPT codes 37700 and 37780 (for treatment of venous reflux), refer to the Medical Policy titled *High Ligation at the Saphenofemoral or Saphenopopliteal Junctions.* These codes are proven as a covered service only when used to prevent the propagation of an active clot from the superficial system to the deep venous system	
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)

REFERENCE SUMMARY

The Coverage Determination Guidelines apply only to ablative procedures for the treatment of venous insufficiency and varicose veins. Please refer to UnitedHealthcare's Medical Policy titled *High Ligation at the Saphenofemoral or Saphenopopliteal Junctions* for the clinical coverage criteria for high ligation procedures. This policy will also be available for your reference on UnitedHealthcareOnline.com > Tools & Resources > Policies and Protocols > Medical & Drug Policies and Coverage Determination Guidelines **beginning June 1, 2010.**

CDG Title	Ablative Procedures for Venous Insufficiency and Varicose Veins (continued)
Effective Date	August 1, 2010

RELATED GUIDELINES FOR UNITEDHEALTHCARE AFFILIATES

The following UnitedHealthcare affiliates will also be implementing the guidelines noted above beginning August 1, 2010. See below for the plan-specific details and/or reference sources.

- **Neighborhood Health Partnership:** Refer to the UnitedHealthcare Coverage Determination Guidelines on UnitedHealthcareOnline.com > Tools & Resources > Policies and Protocols > Medical & Drug Policies and Coverage Determination Guidelines.
- **PacifiCare:** Refer to the Medical Management Guideline titled *Procedures for Ablation of Varicose Veins* on PacifiCare.com > User ID and Password > Provider user ID > Library > Resource Center > Guidelines & Interpretation Manual > State > Commercial Med Mgmt_Clinical Guideline.
- **Optimum Choice Incorporated (OCI) and M.D. Individual Practice Association (MDIPA):** The guidelines will be applied in accordance with the precertification requirements for cosmetic and reconstructive surgery as outlined in the *Mid-Atlantic Regional Supplement to the Physician, Health Care Professional, Facility and Ancillary Provider 2010 Administrative Guide* on UnitedHealthcareOnline.com > Tools & Resources > Policies and Protocols > UnitedHealthcare Administrative Guide 2010 > Mid-Atlantic Regional Supplement > Preauthorization and Precertification Requirements. The guidelines are available on UnitedHealthcareOnline.com > Tools & Resources > Policies and Protocols > Medical & Drug Policies and Coverage Determination Guidelines > *Ablative Procedures for Venous Insufficiency and Varicose Veins*.
- **Oxford:** Refer to the Medical Policy titled *Procedures for Ablation of Varicose Veins* on OxfordHealth.com > Tools & Resources > Medical & Administrative Policies > Clinical Policies.
- **UnitedHealthcare of the River Valley:** Refer to the Coverage Policy titled *Procedures for Ablation of Varicose Veins* on UHCRiverValley.com/10Provider > Coverage Policy Library.

Drug Policy

Claims

July 1, 2010 Update to Facility Outpatient Procedure Grouper Mapping

Each year, UnitedHealthcare reviews the outpatient procedure grouper (OPG) mapping used in reimbursing outpatient procedures in hospitals and ambulatory surgery centers contracted under this methodology. Annual updates reflect additions, deletions and changes to the CPT/HCPCS codes assigned to specific grouper levels.

The updated UnitedHealthcare outpatient procedure grouper mapping defining the CPT/HCPCS code assignment to grouper level will be effective July 1, 2010. Of the codes that are the same from the 2009 OPG (with code updates January 1, 2010), 96% are assigned to the same grouper level, 1.5% have decreased in level assignment and 2.5% have increased in level assignment.

Included in this mapping are five CPT/HCPCS codes that the Center for Medicare and Medicaid Services (CMS) considers reimbursable on an inpatient basis only. Regardless of CMS' decision to reimburse solely on an inpatient basis, UnitedHealthcare reviewed these codes against national guidelines and determined that they could be appropriate as outpatient procedures when ordered by a physician. The five codes are 43279, 43400, 51980, 58548 and 60270.

Effective July 1, 2010, reimbursement for outpatient procedures will be based on this revised mapping.

Please remember to include the appropriate CPT/HCPCS codes in addition to the revenue codes when billing for outpatient procedures. Consistent with standard billing requirements, the use of CPT/HCPCS codes is required for reimbursement purposes.

Pharmacy Updates

Commercial

Announcing UHCSpecialtyRx.com: Specialty Pharmacy's New Web Site Launched March 15, 2010

We are excited to introduce UHCSpecialtyRx.com - your central source for information about specialty medications, Clinical and Condition Management Programs, and the Specialty Pharmacy Program. The Web site is designed to provide you with access and information and ultimately, to save you time, reduce overall costs and help your patients make the most of their benefits to achieve better outcomes.

As a health care professional, visit UHCSpecialtyRx.com to learn about:

- Vendors and cost-effective sourcing options
- Medication guidelines
- Disease state information
- Initiatives
- Clinical Management Programs

Created to empower your patients to optimize their benefits and live healthier lives, UHCSpecialtyRx.com can help members to:

- Find a specialty pharmacy or home health care provider
- Get detailed condition and medication information

We will continue to evolve and update the new site to serve you and your patients as a central source for information.

HPV Vaccine Coverage Clarification

There are currently two licensed human papillomavirus vaccines available, each with approval in differing patient populations.

- Bivalent (types 16 and 18) HPV vaccine – Cervarix® – approved for use in females 10 through 25 years of age.

- Quadrivalent (types 6, 11, 16, and 18) HPV vaccine – Gardasil® – approved for use in males and females 9 through 26 years of age.

UnitedHealthcare covers immunizations for members whose benefit document covers preventive services in a physician office, including immunizations. The UnitedHealthcare Vaccines drug policy allows coverage for vaccines that are: (1) approved by the US Food and Drug Administration (FDA); (2) have final recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) published in the Morbidity & Mortality Weekly Report (MMWR); and (3) are not explicitly excluded from coverage in the benefit document.

UnitedHealthcare began to cover HPV vaccine for females in 2007 with publication of ACIP recommendations. Recent permissive recommendations for use in males were released in 2009. Today we will continue to cover HPV vaccine for females. Should ACIP expand its definitive recommendations in MMWR, UnitedHealthcare will align our coverage with those recommendations.

Frequently Asked Questions:

Does UnitedHealthcare cover HPV vaccine?
Yes.

Does UnitedHealthcare cover HPV bivalent (90650) Cervarix? If yes, what gender & ages?
Yes. Effective April 1, 2010, standard UHC plans will cover HPV2 (CPT 90650) only for females ages 9-26.

Does UnitedHealthcare cover HPV quadrivalent (90649) Gardasil? If yes, what gender & ages?
Yes. Standard UnitedHealthcare plans cover HPV4 / Gardasil (CPT 90649) only for females ages 9-26.

Does UnitedHealthcare cover either of the HPV vaccines for males? If not, why?
No. While Gardasil is now FDA approved for boys and men ages 9-26, the definitive ACIP recommendations for HPV vaccine have not been revised. Furthermore, the ACIP provisional recommendation on Gardasil for males indicates that physicians may (not must) immunize. Coverage would not change based on a "permissive" recommendation.

Does UnitedHealthcare cover HPV vaccine after the 27th birthday?
No.

For 90650 Cervarix, is coverage available prior to April 1, 2010? If not, why?
No. We have a long established policy that new coverages and expansions of coverage are effective the date of implementation. That includes coverage of vaccines. We are aware that there may be a lag between ACIP publication in MMWR and our loading of a code into our claim system, but we do not cover retroactively.

For additional information please refer to:

UnitedHealthcare Vaccine Policy or
UnitedHealthcareOnline.com > Tools & Resources > Policies and Protocols > Medical & Drug Policies and Coverage Determination Guidelines > Vaccine Policy

Current ACIP Recommendation
http://www.cdc.gov/mmwr/PDF/rr/rr5602.pdf

Recent ACIP Provisional Recommendation
http://www.cdc.gov/vaccines/recs/provisional/downloads/hpv-vac-dec2009-508.pdf

Notification Program Update – Oral Oncology
Effective September 1, 2010

Notification Program

Selected medications may require notification and review to determine eligibility for coverage under the member's pharmacy benefit plan. Effective September 1, 2010, 13 oral oncology drugs will be added to this program. The increasing number of oral oncology medications being developed, the potential for expanded off label use of oncology medications in the future, and the associated toxicity and cost of these medications has led UnitedHealthcare to further review the category. Our Notification Program will utilize the National Comprehensive Cancer Network (NCCN) Compendium to help determine coverage of oral oncology medications. This is consistent with our approach for medical coverage of physician administered oncology medications. Patients who are currently on one of these medications will continue to have coverage as long as they are insured under their current plan; new

prescriptions after September 1, 2010 will require review. Notification applies to all 13 medications. Most UnitedHealthcare benefit plans require that these medications be provided by specialty pharmacies (Prescription Solutions and IVP/Walgreens Specialty Pharmacy) participating in our Specialty Designated Network and providing clinical management programs and resources that help our members achieve optimal outcomes with their drug therapy.

To start a review process for a patient, please call 800-417-1764.

Prescription Drug List and Coverage

Notification (Effective 9/1/10)	
Category	**Medication Name**
Oral Oncology (cancer)	Afinitor®
	Votrient™
	Gleevec®
	Hycamtin®
	Nexavar®
	Revlimid®
	Sprycel®
	Sutent®
	Tasigna®
	Tarceva®
	Temodar®
	Thalomid®
	Tykerb®

Updates Effective July 1, 2010

UnitedHealthcare strives to make prescription medications accessible and affordable to our members through our pharmacy benefit programs. One of the ways we accomplish this is through the use of a Prescription Drug List (PDL). Tier decisions and changes to the PDL are made by the UnitedHealthcare PDL Management Committee, a group of senior level UnitedHealth Group physicians and business leaders.

Changes to the PDL are based on clinical, economic and pharmacoeconomic factors. The UnitedHealthcare National Pharmacy and Therapeutics (P&T) Committee provides clinical guidance to assist the PDL Management Committee in the decision making process. As the periodic reviews of the PDL are performed, medications may move to different tiers or coverage status may be changed. As a reminder, when a medication changes tiers, your patient may be required to pay more or less for that medication. Tier 1 represents the lowest copay option.

Note: This is not a comprehensive list of changes. Your patients should call the phone number on the back of their health care ID cards for more information about their benefit plan design. Some changes may affect patients differently depending on their benefits. The changes described may not apply to members in benefit plans insured or administered by PacifiCare or government programs such as AmeriChoice, SecureHorizons or Medicare Advantage.

PDL – Tier Changes

Beginning July 1, 2010 all changes will go into effect. Changes to this effective date are noted.

Proton Pump Inhibitors – PPI Class

With the availability of several over-the-counter (OTC) options including Prilosec OTC® (omeprazole), Prevacid® 24HR (lansoprazole) and Zegerid OTCTM (omeprazole/sodium bicarbonate), the PPI class was evaluated. The PPI coverage and tiering changes will help encourage the use of OTC and lower cost alternatives. Aciphex® (rabeprazole), Protonix® (pantoprazole) and Zegerid® (omeprazole/sodium bicarbonate) are moving from Tier 2 to Tier 3. Dexilant™, formerly named Kapidex™ (dexlansoprazole), will now be in Tier 3. Pantoprazole (generic Protonix), currently in Tier 3, will be excluded from coverage while brand Protonix, as noted above, will be our covered pantoprazole product. The pharmacies will dispense brand Protonix in place of generic pantoprazole for your patients currently receiving the generic product.

High Cholesterol Class

We are moving Vytorin® (ezetimibe/simvastatin) from Tier 2 to Tier 3. There are several lower tier alternatives available including generic Zocor® (simvastatin) in Tier 1, Crestor® (rosuvastatin) and Lipitor® (atorvastatin) in Tier 2.

A summary of these changes as well as additional up-tiers is provided in the table below.

Down-Tier Updates

Down-tiering refers to medications that move from a higher tier to a lower tier, making them more affordable for your patients. Down-tiering can occur at any time through the year so your patients can take advantage of the savings as soon as possible. Down-tiering changes were made in several therapeutic categories and are summarized in the table below.

Summary of PDL Changes for 3-Tier Benefits

Category	Medication Name	Change in Coverage Status*	Lower Cost Alternatives for Medications Moving to Tier 3
Acne	Tazorac® cream and gel	Tier 2 to Tier 3	tretinoin cream and gel, Retin-A-Micro®
Acromegaly	Somatuline® Depot	Tier 3 to Tier 2	N/A
Attention Deficit Hyperactivity Disorder	Intuniv	Excluded at launch to Tier 2	N/A
Growth hormone	Nutropin AQ® NuSpin	Tier 3 to Tier 2	N/A
High Cholesterol	Vytorin	Tier 2 to Tier 3	simvastatin, Crestor, Lipitor
Inflammatory Bowel Disease	Dipentum®	Tier 2 to Tier 3	sulfasalazine, Apriso®, Lialda®
Opioids	Opana® ER	Tier 3 to Tier 2	N/A
Overactive bladder	Gelnique®	Excluded at launch to Tier 2	N/A
Proton Pump Inhibitors	Aciphex	Tier 2 to Tier 3	omeprazole, Prevacid 24HR, Prilosec OTC, Zegerid OTC
Proton Pump Inhibitors	Protonix®	Tier 2 to Tier 3	omeprazole, Prevacid 24HR, Prilosec OTC, Zegerid OTC
Proton Pump Inhibitors	Zegerid	Tier 2 to Tier 3	omeprazole, Prevacid 24HR, Prilosec OTC, Zegerid OTC
Wake-Promoting Agents	Nuvigil®	Excluded to Tier 3	N/A

Benefit Exclusions

In addition, effective July 1, 2010, several medications will no longer be covered under most of our pharmacy benefit plans.

Some of our pharmacy benefit plans exclude a medication if it includes an active ingredient(s) available in and therapeutically equivalent to another covered drug or which is (are) a modified version of and therapeutically equivalent to another covered drug. Plans may also exclude a medication if it is therapeutically equivalent to an over-the-counter (OTC) medication. The table below provides a summary of these exclusions and information on the alternatives available that will continue to be covered.

A summary of the benefit plan exclusions is noted in the table below.

Summary of Benefit Plan Exclusions

Category	Medication Name	Change in Coverage Status*	Alternatives for Excluded Medications
Acne	NeoBenz® Micro, NeoBenz Micro SD	Excluded at launch to permanent Exclusion	OTC benzoyl peroxide
Acne	Triaz® Foaming Cloths	Excluded at launch to permanent Exclusion	OTC benzoyl peroxide
Acne	Ziana®	Tier 3 to Excluded	clindamycin gel, tretinoin gel, Retin-A-Micro, Duac®
Analgesic	Ryzolt	Excluded at Launch to permanent Exclusion	tramadol extended-release (generic Ultram ER), tramadol immediate-release (generic Ultram)
Antidepressant	Aplenzin™	Excluded at launch to permanent Exclusion	bupropion hydrochloride SR (generic Wellbutrin SR®), bupropion hydrochloride XL (generic Wellbutrin XL®)
Antiepileptic	Lamictal® ODT™ and Lamictal XR™	Excluded at launch to permanent Exclusion	lamotrigine, (generic Lamictal®), Lamictal
Proton Pump Inhibitors	pantoprazole (generic Protonix)	Tier 3 to Excluded	Protonix brand
Sedative/hypnotic	Edluar™	Excluded at launch to permanent Exclusion	zolpidem (generic Ambien®), zaleplon (generic Sonata®), Ambien CR®
Wake-Promoting Agents	Provigil®	Tier 3 to Excluded	Nuvigil
Wake-Promoting Agents	Nuvigil®	Excluded to Tier 3	N/A

This is not a comprehensive list of changes. The changes noted do not apply to all UnitedHealthcare lines of business.
*Tier placements may differ depending on your patients pharmacy benefit. Patients are encouraged to go to visit their member Web sites for the most updated PDL and tier placement information based on their particular pharmacy benefit plan.
This is not a comprehensive list of changes. The changes noted do not apply to all UnitedHealthcare lines of business.

Clinical Program Updates

Supply Limits

Supply Limits establish the maximum quantity of drug that is covered in a specified timeframe or per copayment. The supply limits for Cloderm® pump (30g and 75g), Cloderm tubes (45g and 90g), Luxiq® Foam (50g and 100g) and Xeloda® (150mg) are being implemented effective July 1, 2010. Additional information about these new supply limitations can be obtained at *UnitedHealthcareOnline.com*.

Supply Limits

Category	Medication Name	New Supply Limit
Oral Oncology (cancer)	Xeloda (150mg)	96 capsules per copay
Skin Conditions	Cloderm pump (30g and 75g)	30g per copay
	Cloderm tubes (45g and 90g)	45g per copay
	Luxiq Foam (50g and 100g)	50g per copay

Prevnar 13 Vaccine Coverage Effective April 1, 2010

UnitedHealthcare covers immunizations for members whose benefit document covers preventive services in a physician office, including immunizations. The UnitedHealthcare Vaccines drug policy allows coverage for vaccines that are: (1) approved by the US Food and Drug Administration (FDA); (2) have final recommendations of the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) published in the Morbidity & Mortality Weekly Report (MMWR); and (3) are not explicitly excluded from coverage in the benefit document. As noted in our Vaccine drug policy, implementation typically occurs within 60 days of MMWR publication of ACIP recommendations.

On February 24, 2010, FDA granted approval for Prevnar 13™, a 13-valent pneumococcal conjugate vaccine. Prevnar 13 includes the seven serotypes (4, 6B, 9V, 14, 18C, 19F and 23F) in Prevnar (Pneumococcal 7-valent Conjugate Vaccine) – the first pneumococcal conjugate vaccine introduced in 2000 – plus six additional serotypes (1, 3, 5, 6A, 7F and 19A).

Prevnar 13 is approved for use in children six weeks through five years of age. It is indicated for active immunization for the prevention of invasive disease caused by 13 strains of *Streptococcus pneumoniae* (1, 3, 4, 5, 6A, 6B, 7F, 9V, 14, 18C, 19A, 19F, and 23F). Prevnar 13 is also indicated for the prevention of otitis media (ear infection) caused by 7 strains of *Streptococcus pneumoniae* (4, 6B, 9V, 14, 18C, 19F, and 23F). No efficacy data for ear infections are available for strains 1, 3, 5, 6A, 7F, and 19A.

The Advisory Committee on Immunization Practices (ACIP) approved updated pneumococcal conjugate vaccine recommendations on February 24, 2010, which were subsequently published in MMWR on March 12, 2010. ACIP recommends PCV13 for all children aged 2 to 59 months. ACIP also recommends PCV13 for children aged 60 to 71 months with underlying medical conditions that increase their risk for pneumococcal disease or complications. CDC guidance for vaccination providers regarding transition from PCV7 to the PCV13 immunization program was also included in MMWR.

Based on the FDA approval and ACIP recommendation in MMWR, UnitedHealthcare initiated coverage of Prevnar 13 on April 1, 2010. Please note that retro-active coverage of Prevnar-13 is not available.

Coding Clarification:

CPT Code	Description
90669	Pneumococcal conjugate vaccine, 7 valent (Prevnar, PCV 7)
90670	Pneumococcal conjugate vaccine, 13 valent (Prevnar 13, PCV13)

For additional information please refer to:

ACIP Recommendation
http://www.cdc.gov/vaccines/recs/provisional/downloads/pcv13-mar-2010-508.pdf

March 12, 2010 Issue of MMWR
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5909a2.htm

UnitedHealthcare Vaccine Policy or UnitedHealthcareOnline.com > Tools & Resources > Policies and Protocols > Medical & Drug Policies and Coverage Determination Guidelines > Vaccine Policy

UnitedHealthcare High Utilization Opioid Program

The UnitedHealthcare High Utilization Opioid Program identifies your patients who may be over-utilizing opioid analgesics or are potentially seeking these medications inappropriately. The overall goal of the program is designed to make physicians aware of patients receiving opioids from several different physicians/prescribers. Although the majority of use of opioids is appropriate, there may be rare instances when our members/your patients use these medications inappropriately or seek prescriptions from several physicians or prescribers. Based on our review of the program, a decrease in the number of prescriptions per patient, number of different physicians and pharmacies has all been demonstrated.

Our program utilizes the following criteria to identify patients:

- Nine or more opioid prescriptions filled during the quarter, and
- Written by three or more physicians/prescribers, and
- Filled at three or more pharmacies

How does it work?

This is an ongoing program performed on a quarterly basis. Each physician or prescriber who wrote an opioid prescription during the defined time period is provided patient-specific prescription information through a confidential mailing to assist in the review of pharmacy utilization. Often these patients are receiving prescriptions from several different physicians without the knowledge that another physician or prescriber is also writing for opioids. At times, UnitedHealthcare has also identified prescriptions that were fraudulently obtained.

In addition to this valuable resource, if you are a practicing physician in selected states, you may be able to request access to the state reporting systems through the Alliance of States with Prescription Monitoring Programs. These systems allow you to further identify patients who may be paying cash for opioids or controlled substances in an effort to avoid being identified. If you are interested, please visit pmpalliance.org and select your specific state to sign up.

Other entities

This program described does not apply to PacifiCare or government programs such as AmeriChoice®, UnitedHealthcare Medicare Solutions®, SecureHorizons® or Medicare Advantage. Certain self-funded employer groups may not have elected to be included in the program.

UnitedHealthcare Specialty Pharmacy and Home Infusion Network for Medical Benefit Medications: Medical Benefit National Vendor Update

The Specialty Pharmacy and Home Infusion provider networks will change throughout 2010. See below for a reminder of upcoming changes that we first communicated to you in the January edition of the Network Bulletin.

UnitedHealthcare has expanded its relationship with CVS/Caremark and its subsidiaries to provide a targeted group of specialty medications and related services under medical benefit coverage to our members. As of June 1, 2010, CVS/Caremark will no longer be contracted to provide Hemophilia or IVIG, along with any related home infusion services.

- Bioscrip will be the primary provider that will be used for the transition of the members receiving IVIG medications and related Home Infusion services at CVS/Caremark.
- Accredo and Prescription Solutions will be the primary providers that will be used for the

transition of the members receiving Hemophilia factor products from CVS/Caremark. Any members requiring nursing services will be transitioned to Accredo. We will continue to work with physicians and health care professionals to transition impacted members to the current participating provider(s). Impacted physicians and health care professionals and their patients will be sent letters in advance of these changes.

To understand what participating providers are available to best serve your patients, please call our Specialty Network Referral Line at **866-429-8177**.

You also can find a list of specialty pharmacy providers online at UnitedHealthcareOnline.com > Tools & Resources > Pharmacy Resources >Tools & Resources. We will communicate more updates on these changes in future issues of Network Bulletin.

Prescription Solutions for SecureHorizons Plans

For additional information on our Medicare/Medicare Part D formularies and pharmaceutical management procedures, go to Securehorizons.com/ourplans/2009formularies.html or for changes go to Securehorizons.com/ourplans/recentchanges.html. If you do not have internet access and would like to request a copy please contact one of our National Managers of Accreditation and Clinical Quality at 866-934-5717.

Protocol Updates

Commercial

Reminder to use network laboratory providers

Encouraging the use of network laboratory providers will meet your contractual obligations and help support potentially lower out-of-pocket costs for your patients. Moreover, you and your patient may receive additional benefits from using network laboratory providers, such as automatic transmission of data to support care management programs, gaps in care analysis and physician performance assessment programs. To assist you, we offer the following resources and suggested actions:

- **Physicians may Access** the current list of participating laboratories online at UnitedHealthcareOnline.com > Physician Directory > General Physician Directory > Search for Hospital or Other Facility > Search for a Laboratory.
- **Discuss** the importance of using our extensive network for covered laboratory services with your patients; if they have questions, direct them to myuhc.com to access their individual coverage information and directory of participating laboratories.
- **Encourage** the use of network laboratories to optimize your patients' healthcare benefits and possibly reduce the financial costs your patients may incur if their laboratory sample is sent to a non-network laboratory.

UnitedHealthcare provides access to a broad network of more than 1,300 laboratories. In the unusual circumstance that you require a specific laboratory test for which you believe there is no network laboratory provider, we will work with you to ensure those tests are performed. Additional information about UnitedHealthcare's laboratory protocols are located on UnitedHealthcareonline.com under Tools & Resources > Policies and Protocols, or found in the Administrative Guide.

Clinician Resources

Commercial

Depression, Alcohol Abuse & Attention Deficit Hyperactivity Disorder (ADHD) Preventive Health Program UBH Authorizations

Depression, Alcohol Abuse & Attention Deficit Hyperactivity Disorder (ADHD) Preventive Health Program

United Behavioral Health, a UnitedHealth Group company has developed an online Preventive Health Program which offers up-to-date, relevant information and practice tools to support your treatment of major depressive disorder, alcohol abuse/dependence and ADHD. A convenient, reliable and free source of pertinent health information, the Preventive Health Program includes a dedicated section for physicians and other health care professionals with articles addressing aspects of each condition; information about co-morbid conditions; links to nationally recognized practice guidelines from the American Psychiatric Association; a self-appraisal that you can print, use or refer your patients to; and a listing of support resources for you, your patients and their families. Physicians and other health care professionals may access the program online at www.liveandworkwell.com/prevention.

UBH Authorizations

You or your office staff can refer patients directly to a UBH psychiatrist or other UBH behavioral health professional. The UBH clinician can obtain any necessary authorization. You can also direct patients to contact UBH for referrals at which time an initial certification, if needed, will be generated. For a complete listing of behavioral health clinicians, please visit the UBH clinician Web site, www.ubhonline.com. Select "Our Network", then "ubh/usbhpc clinician directory," and specify your search criteria. You and your patients can also contact UBH directly for assistance by calling the number on the back of the patient's medical insurance card.

UnitedHealth Premium® designation program Training Opportunities

This summer UnitedHealthcare will release the 2010 UnitedHealth Premium® physician designation program. We will offer webinar training sessions and a CEU/CME course to help practice administrators and office staff understand the Premium program and to provide physicians with actionable information to assist them in providing care to patients that meets national evidence based standards for quality.

We are committed to providing physician practices with patient-specific information that will help promote delivery of the best possible clinical care. The UnitedHealth Premium physician designation program is an important part of that effort. The program assesses physicians' compliance with evidence-based, specialty society and industry-standard performance criteria. Additional details are provided for your review below. If you have questions, please call us toll-free at 866- 270-5588.

Webinar Training Sessions – June 2010 and July 2010

Attend one of four webinar sessions this summer to learn about the 2010 enhanced UnitedHealth Premium program, featuring:

- New reports that provide more actionable information to address quality and cost efficiency
- New online features to access designation reports, Premium methodology CME/CEU training course (see details below), and information about our new online submission of reconsideration requests
- New e-mail communications to notify physicians of their designation results and how to access their performance reports

For further information about the webinars, go to UnitedHealthcareOnline.com (Go to Clinician Resources > UnitedHealth Premium).

Online CEU/CME Premium Program Training Course – Summer 2010

- ***Earn Free CEU/CME - take the course at your convenience***

- ***Learn more about the Premium program's methodology and new tools to support practice improvement***

UnitedHealthcare offers an online course for the 2010 release of the UnitedHealth Premium® physician designation program. The enhancements for this year's program are based on the feedback from national and local physician advisory committees, specialty society and practicing physician input, as well as the ongoing advances in the performance measurement field. We received positive feedback from many physicians and practice administrators who took the course last year; they found it to be a valuable tool to help them understand the program.

The goals of this course are:

- To help physicians and others understand the methodology used for the 2010 assessment cycle.
- To inform you about online resources such as the assessment reports that will show comparative performance by disease category, condition and procedure, as well as patient-specific assessment of quality and/or cost-efficiency performance (all new for 2010).
- To provide you with information about our new online reconsideration process.

We encourage physicians, practice administrators, nurses and physician assistants to take the course at your convenience this summer and receive CME/CEU credit. Information on how to access the methodology training course will be available this summer on *UnitedHealthcareOnline.com* (Go to Clinician Resources > UnitedHealth Premium > Methodology).

Medicare

The Lawton Instrumental Activities of Daily Living Scale (IADL)

An acute illness or even a worsening of a chronic health condition may hasten functional decline in older people. The IADL scale is an assessment for older people or people who have suffered a stroke that can be used to measure functional decline. The scale may provide an early indicator of functional decline. The IADL measures the ability of a person to perform such tasks as using the telephone, doing the laundry, preparing food, handling finances, and more. There are eight domains and it takes less than 10 minutes to complete. The IADL scale can also be used to help evaluate rehabilitation outcome after a stroke. If you are interested in this tool or other downloadable tools that can help you in your practice, please visit www.unitedhealthcareonline.com > Clinician Resources > Geriatric Conditions.

For more information on IADL please visit: https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Clinician%20Resources/Geriatric%20Resources/Advanced%20Illness%20and%20Planning/Lawton_Activities_Daily_living_Scale.pdf

What is POLST?

The Physician Orders for Life Sustaining Treatment (POLST) or Medical Orders for Life Sustaining Treatment (MOLST) is a program designed to improve the quality of care people receive at the end of life. The POLST Paradigm initiative began in Oregon in 1991. Medical ethics leaders recognized that patient wishes for life-sustaining treatments were not being honored consistently despite the availability of Advance Directives.

Honoring a person's preferences about the type and amount of health care desired if he/she is very ill, is a key element in providing quality end-of-life care. By creating an Advance Directive, the individual has outlined his/her end-of-life wishes which helps provide the individual and the individual's loved ones with peace of mind.

Care Planning is a process which culminates in physicians, nurse practitioner and physician assistants documenting medical orders that reflect the individual's goals of care.

POLST/MOLST was created to provide a single document that would function as an actionable medical order and could transition with a patient through all health care settings. It is intended that the form will be transported with the patient between different health care settings in order that his/her wishes for life-sustaining treatment and CPR will be clearly indicated. It is a brightly colored from so as to be easily recognized.

Currently POLST or MOLST is recognized in seven states; however, state by state recognition and acceptance is growing rapidly.

In general, the content on the order sheet consists of instructions on how to use the form and has specific orders for:

- CPR
- Artificially Administered Nutrition
- Medical Interventions, such as: comfort measures, intubation and oxygen

The form is signed by the physician and the patient or his/her decision-maker. The form should accompany the patient whenever he/she is sent to the emergency room, transferred, or discharged.

Even in states where there are no formal POLST/MOLST programs, the form can be used as a guide for physicians to discuss life-sustaining treatment options with their patients.

This document can go hand in hand with a patient's Advance Directive. Five Wishes, offered through Aging with Dignity, (http://www.agingwithdignity.org/five-wishes.php) is an Advance Directive that is honored in over 40 states. There are also State Specific Advance Directives available through Caring Connections, (http://www.caringinfo.org/stateaddownload)

For more information on POLST, please visit http://www.ohsu.edu/polst/

e-Business Updates

2010 Training Schedules

Whether you are a small office or large organization UnitedHealthcare has an electronic solution for you. Our free, online webcasts show you how to automate and streamline your administrative processes, and introduce eco-friendly alternatives to conducting business manually.

Webcasts are offered twice monthly on Thursdays, starting at 2 p.m. (Eastern). Sessions run between 1 and 1½ hours long and topics alternate every other session. View the 2010 Webcast schedule at UnitedHealthcareOnline.com > Training and Education > Seminars.

Webcast Seminars offered

- **UnitedHealthcareOnline.com** – We take you through a day in the life of your organization and demonstrate how our physician and healthcare professional Web site is there for you (and your patients) every step of the way.
- **Electronic Payments and Statements (EPS)** - The standard for receiving UnitedHealthcare payments and statements, learn how EPS results in faster and easier payment to you.
- **Oxford Training Schedule** – Access the Oxford e-Business webcast schedule, at OxfordHealth.com. Login as a provider or facility then go to Tools & Resources > Administrative Ease (Under Manage Your Practice) and click Physician eSolutions Web Course Schedule. Offerings include: Oxford Web training, Oxford DirectConnect powered by Post-N-Track® and PNC Remittance Advantage, Oxford's ERA/EFT (Electronic Remittance Advice/Electronic Funds Transfer) solution.

835/Electronic Remittance Advice (ERA) updates completed for UnitedHealthcare Government and other lines of business

UnitedHealthcare successfully deployed enhancements to its 835/Electronic Remittance Advice (ERA) on March 20, 2010. The enhancements apply to UnitedHealthcare Government and other lines of business and focused on changes to the reporting of Member Identification Numbers on 835s.

Previously, if a member identification number that was submitted on a claim was different from the member identification number that the claim adjudicated under, the 835 would report only the member ID number that the claim adjudicated under. The 16 digit member ID consisted of the group number, member's ID number, and proprietary patient relationship code, which were combined and reported in one element of the 835 transaction.

With the enhancements, the 835 now returns the original member ID that is submitted on the claim. This is reported in the Patient Name (NM1 with QC Qualifier) and Insured Name, if applicable, segment(s) (NM1 with IL Qualifier). If the submitted member ID is **different** than the adjudicated member ID, the nine digit corrected member identification number is returned in the Corrected Patient /Insured Name (NM1 with 74 Qualifier) segment.

The changes explained in this article apply to UnitedHealthcare government and other lines of business **claims received by UnitedHealthcare on or after March 20, 2010**. Claims received prior to this date report the 16 digit member ID with no corrected member ID (NM1*74). For full release details including 835 examples, please refer to the *Update for Government and Other Business Completed* notice in the News section of UnitedHealthcareOnline.com (post date April 5, 2010).

Enhancements to Improve Provider Remittance Advice

As a result of provider feedback, UnitedHealthcare will implement a system enhancement that will consolidate more commercial claims into one payment and will improve the layout of the Provider Remittance Advice (PRA). This enhancement impacts all claims associated with UnitedHealthcare commercial fully-insured and commercial self-funded business. This affects both 835s and paper versions. Implementation will begin later in 2010. We will notify providers and clearinghouses prior to deployment.

The enhancements will eliminate the existing limit of eight payments and 50 overpayments on a single PRA. PRAs will now be double-sided with better use of white space and shading on alternate rows in the Service Detail and Overpayment Reduction Detail sections. In addition, PRA details will be sorted in alphabetical order using the patient's last name.

The 835 improvements will include the addition of the Product Name along with the current Product Code included in the reference lines, making it easier for providers to match the payment with the associated fee schedule. In addition, we have improved the way we split the 835 transactions into 2 separate files. The enhancement will identify **by claim**, which claims will auto-post and which ones require additional attention. Sorting the **claims** (instead of the **payments**), will allow an increased number of claims to be auto-posted to providers' practice management systems and will allow for earlier and easier identification of payments that may require manual intervention. Finally, providers will see a modification in the TRN02 number, which will change from 10 digits to 11 digits.

Providers who receive 835s will see an expanded use of the Claim Account Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) in the Payment Details section. They will also better understand how the claim payment was determined in the 835 transaction. Where benefits are coordinated with another payer, (called Coordination of Benefits, or COB) the identification of patient responsibility on the outbound 835 transaction reports will be expanded to clarify how UnitedHealthcare determined the patient

responsibility based on the applicable co-pay, deductible, coinsurance, "not covered" and "over reasonable and customary" amounts. Coordinated claims will more clearly report payments at the line level for professional claims and claim level for institutional claims, and as a result eliminate the adjustments frequently seen at the claim level. CARC, RARC and COB improvements will be implemented in the third quarter of 2010.

UnitedHealthcare Online® Tips

Our practice is looking to implement greener processes. Is there anything we can do to make our manual processes more eco-friendly?

Congratulations on taking a step in a greener direction! UnitedHealthcare makes it easy for you to 'go green'. One way to get your office in the green is to enroll in UnitedHealthcare's Electronic Payments & Statements (EPS), a free solution and the standard for receiving UnitedHealthcare payments. EPS can help dramatically reduce the influx of paper to your practice while providing a more efficient, cost-effective solution

- Receive your payments electronically (5 – 7 days faster) and reduce paper **(save trees)**. 83% of EPS users surveyed report improved cash flow and 79% report improved office efficiencies.
- Make fewer trips to the bank **(save gas)**, reduce the probability of lost or stolen checks, and reduce bank and lockbox fees.
- Stop opening envelopes and filing paperwork. Receive e-mail notification one business day in advance; view payment amounts and corresponding ERAs conveniently at UnitedHealthcareOnline.com.

Go to WelcometoEPS.com to enroll or learn more today.

Take Note

Commercial

Cardiology Notification Program: Notification Required for Services Performed On or After September 1, 2010 in Additional States

Acting on behalf of our customers, UnitedHealthcare has worked with external physician advisory groups to develop programs that promote appropriate use of cardiac services. UnitedHealthcare's Cardiology Notification Program was established to help provide consumers with access to cardiac services that are consistent with evidence-based guidelines by ensuring that physicians rendering these procedures are familiar with such guidelines. Adherence to evidence-based guidelines helps reduce unnecessary medical risks to consumers and increases the quality, safety and appropriateness of cardiac services.

As previously communicated, for procedures performed on or after July 1, 2010, physicians in Florida, Missouri, North Carolina, Ohio, and Wisconsin will be **required to notify UnitedHealthcare prior to performing a diagnostic catheterization or electrophysiology implant**. Notification will be required for our members enrolled in UnitedHealthcare Choice, UnitedHealthcare Choice Plus, UnitedHealthcare Select, and UnitedHealthcare Select Plus benefit plans, as well as Medicare Advantage members enrolled in benefit plans issued or administered by SecureHorizons® and Evercare®. This program does not apply to plans jointly offered by UnitedHealthcare and Harvard Pilgrim Health Care for members using the Harvard Pilgrim provider network. The program does not apply to members enrolled in Medicaid government plans such as AmeriChoice®, or benefit plans issued or administered by any legal entities associated with any of the following affiliates: Oxford Health Plans, PacifiCare, MD Individual Practice Association, Inc. (M.D. IPA), Optimum Choice, Inc., MAMSI Life and Health Insurance, Neighborhood Health Partnership, UnitedHealthcare Plans of the River Valley, or Sierra. Members of these plans are subject to the administrative guide, manual or supplement of that Affiliate.

This same notification requirement will be in effect in the following states for procedures performed on or after September 1, 2010: Alabama, Arkansas, Arizona, Colorado, Delaware, Georgia, Hawaii, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maine, Michigan, Mississippi, Nevada, New Hampshire, New Mexico, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Vermont and West Virginia. The existing requirements regarding notification, authorization and/or precertification for the above listed excluded entities remain in place.

CPT codes requiring notification under this program are as follows:

Diagnostic Catheterization

- Coronary Arteriogram: CPT code 93508
- Diagnostic left heart catheterization: CPT codes 93510, 93511
- Combined right and left heart catheterization: CPT codes 93524, 93526

Electrophysiology Implants

- Pacemakers: CPT codes 33206, 33207, 33208, 33212, 33213, 33214, 33225
- Defibrillators: CPT Codes 33240, 33249

To receive payment for services rendered, prior to performing the stated imaging or implant procedure, the rendering physician will be required to notify UnitedHealthcare in one of three ways:

- Online via ***UnitedHealthcareOnline.com*** > *Notifications > Cardiology Notification Submission and Status*
- By calling **866-889-8054** (Direct Line), or using the United Voice Portal line at **877-842-3210** and selecting the Cardiac Option
- By faxing **866-889-8061** (A fax form will be available to download at UnitedHealthcareOnline.com _ Notifications _ Cardiology Notification Submission and Status)

If the procedure is consistent with evidence-based clinical guidelines a notification number will be provided to the physician. While the rendering physician always maintains final decision authority for the performance of the procedure, if the procedure is not consistent with evidence-based clinical guidelines, a cardiologist will conduct a peer-to-peer discussion with the rendering physician. A notification number will be provided following this conversation. Without completion of the entire notification process, a notification number will not be issued and an administrative reimbursement reduction will occur for the physician rendering the service.

Notification under this program will be required for services rendered in all settings (e.g., outpatient, inpatient, and office-based). This notification program will apply to all physicians rendering diagnostic catheterization and electrophysiology implant procedures including those physicians who have received the UnitedHealth Premium® quality and efficiency of care designation.

Physicians should not delay emergency care in order to notify. If a physician determines that a procedure is required on an urgent or emergent basis, the service should be performed, and notification should be requested retrospectively. A Retrospective Notification Process is available so as not to interfere with door-to-balloon times and emergent procedures. Retrospective Notification requests must be made within fourteen (14) calendar days of the service. Documentation must include an explanation as to why the procedure was required on an urgent or emergent basis or why notification could not be obtained during UnitedHealthcare's normal business hours. *Please Note: If a claim is submitted prior to the Retrospective Notification Process being completed, it will receive an automated denial for lack of notification; however, the claim will be reprocessed if Retrospective Notification is received within fourteen (14) calendar days of the date of service.*

Receipt of a notification number does not guarantee or authorize payment, but simply is confirmation that notification was made. Medical coverage/payment authorization is a separate process determined by the member's benefit contract and the physician/provider participation agreement with UnitedHealthcare. However, notification is required for full reimbursement if the coverage/payment process determines payment is appropriate. Balance billing the patient is precluded under the Cardiology Notification Program as outlined in the Cardiology

Notification Protocol and per the physician's participation agreement.

Please be advised that UnitedHealthcare has taken special steps to ensure that the notification criteria we are using is current with best practices and ACC guidelines and was guided by our external cardiac Scientific Advisory Board (which is comprised of leading clinical and academic board-certified cardiologists). The notification criteria will be transparent and subject to ongoing review by these expert cardiologists. Once the ACC publishes appropriate use criteria for diagnostic catheterization imaging and electrophysiology implants we will incorporate them into our notification criteria. In addition, once the ACC appropriate use criteria are incorporated and we have enough experience and clinical data collected from this program, we will analyze which physician groups consistently adhere to the current clinical evidence when ordering these procedures and will consider an expedited notification process for those groups.

For further information about the Cardiology Notification Program, please contact your UnitedHealthcare Network Account Manager. For the most up-to-date program information (including the notification criteria), please visit *www.UnitedHealthcareonline.com > Clinician Resources > Cardiology > Cardiology Notification Program.*

Coordination of Care for Hospitalized Patients at Discharge

Coordination of care for a hospitalized patient can be complex as their care may involve multiple practitioners and facilities. When a patient is discharged from the hospital, communication of a discharge summary or discharge information to the physician who will continue to treat the patient is critical to continuity of care after hospitalization.

In 2009 the UnitedHealthcare Medical Record Review indicated that the UnitedHealthcare national rate of communication of discharge information by a discharging physician or facility is 65%. The rate improved over the 2008 rate of 59% but continues to be below the goal of 85%.

To assist with coordination and continuity of care for your patients, please review your systems to ensure that a process is in place to:

- Identify and list the patient's primary physician on the discharge summary.
- Send a discharge summary to every patient's primary physician for each admission.
- Notify the primary physician regarding an admission or discharge when an integrated electronic medical record system is available

Coordination of care among the members of a patient's healthcare team depends on timely communication in order to ensure that patients receive appropriate, coordinated and comprehensive care.

Corrected Claims, Is There A Cure?

UnitedHealthcare continually seeks ways to reinforce its commitment to improving access to affordable, high-quality care while reducing unnecessary administrative costs. Instrumental to this commitment is the ability to simplify claim submission and processing. The submission of multiple claims for a single episode of care results in administrative burdens for submitting facilities as well as for the health plans that process multiple resulting claims.

As a result of dialogue with our Hospital Advisory Council and a number of other health care providers, we have recently initiated projects focused on specific challenges and inefficiencies related to the submission of corrected claims. Through these projects, industry benchmarks for corrected claims and best practices to reduce the incidence of corrected claims will be identified. We will focus on both the provider and payer operational processes. Over the next few months, we look forward to sharing our findings. For more information please contact your Hospital and Facility Advocate, Provider Relations or Network Management representative.

H1N1

In October of last year, UnitedHealthcare requested that all of its participating physicians and other health professionals respond to the national call to action by U.S. Secretary of Health and Human Services Secretary Kathleen Sebelius to assist in a national

vaccination campaign against the H1N1 virus. Specifically, she requested that all stakeholders in health care remove financial barriers for people to access the H1N1 vaccine. As a part of that effort, UnitedHealthcare and our employer-purchasers covered the administration of the new vaccine with no copays, deductibles or coinsurance fees.

The H1N1 viral outbreak seems to have stabilized in the last few months and the epidemiological threat to have passed. Based on these developments and in consultation with the appropriate federal and state public health officials, we will discontinue the special emergency measures that we enacted in October 2009, including:

- Special contracts with mass vaccinators and retail pharmacies to administer the H1N1 vaccine to UnitedHealthcare members expired on May 1, 2010.
- Special emergency measures to cover the administration for the H1N1 vaccine, including the removal of related deductibles, copays and coinsurance fees, expire on May 31, 2010. For dates of service on or after June 1, 2010, claims for H1N1 vaccine and administration of the H1N1 vaccine will be processed in accordance with our members' benefit plan designs.
- Special emergency reimbursement rates for H1N1 vaccine administration ended on May 31, 2010. H1N1 vaccination services rendered on or after June 1, 2010 will be reimbursed in accordance with contracted fee schedule rates.

UnitedHealthcare's clinical team will continue to work in close collaboration with federal and state public health authorities to monitor the H1N1 flu trends and will update you of any significant changes. For the full announcement and additional information, please visit UnitedHealthcareOnline.com > Tools & Resources > H1N1 Flu Resources.

Improving Quality and Care Coordination for Patients with Diabetes Receiving Dilated Retinal Eye Exams

Quick Reference Guide for Diabetic Dilated Retinal Eye Exams

Annual screening for eye disease is among the most important preventive health services provided to patients with diabetes. In support of your efforts to provide the best possible clinical care to your patients, UnitedHealthcare regularly searches our comprehensive claims data repository to identify potential patient-specific gaps in receiving recommended screenings and exams. Unfortunately, some of the claims may not include the correct ICD-9 diagnosis codes and/or CPT® procedure and HCPCS codes. As a result, some of our members and their care providers may receive unnecessary reminders.

As part of our commitment to streamline and simplify healthcare administration, we are providing information to assist you in improving the accuracy of coding for diabetic dilated retinal eye exams. The tables below include common diabetic retinal-related ICD-9 diagnosis codes and the standard CPT and HCPCS codes reflecting that an eye exam has been performed. When submitting claims, please use the appropriate codes to reflect the care your patient received at the time of service.

Standard CPT and HCPCS codes reflecting the performance of a retinal eye exam

CPT	CPT Category II	HCPCS
67028, 67030, 67031, 67036, 67038-67043, 67101, 67105, 67107, 67108, 67110, 67112, 67113, 67121, 67141, 67145, 67208, 67210, 67218, 67220, 67221, 67227, 67228, 92002, 92004, 92012, 92014, 92018, 92019, 92225, 92226, 92230, 92235, 92240, 92250, 92260, 99203-99205, 99213-99215, 99242-99245	2022F, 2024F, 2026F, 3072F	S0620, S0621, S0625, S3000

Common Diabetic Retinal-related ICD-9 Diagnosis Codes

250.00 Diabetes Mellitus without mention of complication
362.0 Diabetic Retinopathy
362.01 ackground Retinopathy
362.02 Proliferative Diabetic Retinopathy
362.03 Nonproliferative Diabetic Retinopathy

Standard CPT and HCPCS codes reflecting the performance of a retinal eye exam

Please Communicate Exam Results to Your Patient's Primary Physician

In addition to accurately coding diabetic retinal examinations, it is important to communicate the results of diabetic retinal examinations to the patient's primary physician. In fact, this is a performance measure approved by the American Medical Association's Physician Consortium for Performance Improvement and the National Quality Forum. The Diabetic Eye Health Examination Report may be copied and sent to the primary physician or given to the patient to take to their physician at their next office visit. This form is available on UnitedHealthcareOnline > Tools & Resources > Health Resources for Patients.

NCCN Drugs & Biologics Compendium

UnitedHealthcare is pleased to announce that we continue to offer free access to the online National Comprehensive Cancer Network Drugs & Biologics Compendium (NCCN) to providers (and members of their staff) that treat UnitedHealthcare members. We recognize the value of the NCCN Compendium in physician practices and clinics, and we are pleased to continue to offer this service for the next two years.

The National Comprehensive Cancer Network will require an annual re-registration for access to the NCCN Compendium. When your yearly subscription to the NCCN Compendium is set to expire you will be notified of the need to re-register. To continue your free access to the NCCN Compendium you will need to register following these instructions:

1. Access the UnitedHealthcare secure Web portal at UnitedHealthcareOnline.com) and log in
2. Once logged in, select Cancer-Oncology from the Clinician Resources drop-down
3. Select the NCCN Compendium section
4. Under related links, select NCCN Compendium Web site (free for UnitedHealthcare Online registered users)
5. At NCCN.org, log in

It will only be necessary to access the Compendium through UnitedHealthcare Online once a year, at the anniversary of your registration. The process described above allows NCCN.org to recognize that you are entitled to free access as a benefit of your participation in the UnitedHealthcare network.

Payer Summary Disclosure (for California Network Participants)

As a participant in UnitedHealthcare's network, your services may be accessed through our network participation agreement by UnitedHealthcare, its affiliates, and other payers. A list of payers that are licensed in California under the Insurance Codes as of February 1, 2009, can be found at UnitedHealthcareOnline.com > Tools & Resources >Policies & Protocols > Policies. Please also note that this list includes California self-funded payers who are subject to state regulation. This payer list may change from time to time, and you may view a current list online at any time as described above, or you may request a current list in writing.

Quality Improvement Program Update for Commercial Business

In the November Network Bulletin, we provided an overview of some of the results of our Quality Improvement Program based on analysis of HEDIS and CAHPS data received in 2009. Each year we do a comprehensive evaluation of the effectiveness of our Quality Improvement program using those HEDIS and CAHPS measures and additional indicators. One of the key accomplishments in 2009 was significant expansion of our NCQA Accreditation activity.

All of our Commercial HMO/POS health plans maintained at least Commendable accreditation

A total of 21 HMO/POS NCQA surveys, were completed in 2009. Of these, seven or 33% achieved the highest accreditation designation of "Excellent". At the end of 2009, across the Commercial HMO/POS product lines, 19 of 39 (48.7%) plans held an "Excellent" status and 20 (51.3%) held a "Commendable" status.

NCQA Accreditation Activity Expanded to 42 States

In June 2009, UnitedHealthcare submitted a national HPA (PPO) survey. With this survey, UnitedHealthcare achieved NCQA Accreditation across all Commercial product offerings in 43 states and the District of Columbia. For a complete listing of UnitedHealthcare health plans and their NCQA Accreditation status you can go to the NCQA web site at http://reportcard.ncqa.org/plan/external/plansearch.aspx

In 2010, our Quality Improvement Program uses a variety of mechanisms to measure, evaluate and improve the total range of services provided to members. Some of the activities included in the QI Program include:

- Evaluating accessibility and availability of care
- Monitoring compliance with evidence-based guidelines
- Maintaining a comprehensive Credentialing and Recredentialing program
- Evaluating member and physician satisfaction
- Evaluating the effectiveness of important aspects of clinical care using HEDIS and other evidence-based measures
- Identifying and acting on opportunities to improve the continuity and coordination of care across settings
- Oversight of health plan delegated activities
- Supporting initiatives to address racial and ethic disparities in health care

Many key indicators tracked through our QI Program come from HEDIS and CAHPS. Data collection for HEDIS measures and the 2010 CAHPS survey are currently underway. We will provide a status report on these projects later in the year. If you would like a copy of the HEDIS 2009 report card for your health plan, please contact our National Clinical Excellence Team at 954-447-8818.

Red Flag Rule Effective June 1, 2010

As part of the Federal Trade Commission's (FTC) implementation of the Fair and Accurate Credit Transactions (FACT) Act of 2003, most medical providers will need to comply with the Red Flags rule. This rule requires "creditors," which the FTC defines to include most health care providers to establish a program to prevent identity theft in their practices. The program must highlight Red Flags – that is, indicators of a possible risk of identity theft. The program is effective June 1, 2010.

What health care providers need to know:

The Red Flags Rule applies to you if your practice bills patients for services or items after the date of service. As most health care providers bill patients after insurance adjudication, most practices will fall under the FTC mandate. The Rule requires many businesses and organizations to implement a written Identity Theft Prevention Program to detect the warning signs of identity theft in their day-to-day operations. By focusing on red flags now, physicians and other health care professionals will be better able to spot an imposter using someone else's medical or financial identity.

For more information on the Red Flag Rule and its impact to you, view the FAQ in the Appendix of this Network Bulletin. It includes links to the FTC guidelines and additional resources to assist your practice or facility.

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Spine Surgery Influence Model Expanded to Arizona, California, Colorado, Florida, Georgia, Missouri, Ohio, Texas and Wisconsin

In an effort to improve quality of care for our members, UnitedHealthcare has developed an evidence-based medicine review process for spinal surgeries. Physicians in Arizona, Colorado, Missouri, Ohio, Texas and Wisconsin began this process on March 22, 2010. California physicians began this

program on April 19, 2010 and physicians in Florida and Georgia began this process on May 3, 1010. The process is used as an educational program to promote physician discussion around providing spinal care consistent with nationally developed guidelines. The application of this evidence-based review and the anticipated improvement in quality and consistency of care is expected to result in a reduction of unnecessary spine surgeries.

The Spine Surgery Influence Model leverages existing notification requirements and processes to compare the planned procedure to predefined criteria established by North American Spine Society Guidelines (NASS) and *Milliman CareGuidelines*® to determine adherence with guidelines for the planned inpatient spine surgery. Cases found to be inconsistent with guidelines are reviewed by licensed staff using requested medical records. If the secondary review of the case does not demonstrate adherence to the guidelines, a UnitedHealthcare Medical Director engages the surgeon in a peer to peer discussion to better understand the therapeutic decision made for the patient. As long as the notification for the procedure has been received by UnitedHealthcare, the surgery is covered regardless of the outcome of this review process.

Notification may be accomplished online at UnitedHealthcareOnline.com or by calling the United Voice Portal toll-free at 877-842-3210.

This program does not supersede or replace the current notification requirements as described in the 2010 UnitedHealthcare Administrative Guide, and is not a prior authorization or precertification program. Rather, it is an evidence-based medicine review subsequent to the existing notification process. Claims will continue to be subject to the current reimbursement reductions for failure to notify as described in the Administrative Guide.

If you have additional questions or would like to request further information on this program, please contact Dee Wyatt, Program Manager, at 952-992-5128.

Understanding Your Patients' Rehabilitation Services Benefits

Rehabilitation services (PT/OT/ST) can play an important role in your patients' overall health and well-being. Make sure you understand their therapy coverage. Learn more .....

During the course of providing health care, you and your patient may determine that therapy services (physical therapy, occupational therapy or speech therapy) are needed. Therapy may be ordered to assist in treatment of a condition or disease, and also to assist in rehabilitation after a surgery or an injury. Therapy services are generally targeted at muscle strengthening, pain relief, improving joint motion, restoration of mobility, enhancing cognitive and speech related functioning. These services must be performed by a physician or a licensed therapy provider. These services can be provided in an outpatient hospital, free standing therapy clinic, or in a physician's office. When appropriate, in-home exercise programs should be a part of the treatment plan.

Therapy coverage

UnitedHealthcare members who receive benefits for rehabilitation services may have a limit on how many therapy visits and/or the total amount that can be paid for therapy each year. For plans with such a limit, any outpatient therapy services, received from any provider, in any location (such as a physician's office, a free-standing clinic or hospital based therapy clinic), will count toward that limit. To determine any applicable limits to a patient's benefits please visit https://www.unitedhealthcareonline.com.

Optimizing your patient's benefits

It's important that you understand that your patient may have a benefit limit; therefore, when appropriate, in-home exercise should be a regular component of your treatment plan. This may help to preserve your patients' benefits in the event that they require extended therapy, or additional rehabilitation services later in the year for the same or a new condition.

Medicare

2009 UnitedHealthcare Medicare Services Member Satisfaction Survey Results Overview

Annually, UnitedHealthcare Medicare Services conducts an in-depth review of customer satisfaction data in order to identify trends and to establish interventions to improve performance. UnitedHealthcare Medicare Services utilizes the Medicare Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey as a key source of data on members' perceptions of their health care services and experiences. The CAHPS Survey was developed by the Agency for Healthcare Research and Quality (AHRQ) in response to concerns about the lack of good information about the quality of health plans from the enrollees' perspective. AHRQ and the Centers for Medicare and Medicaid Services (CMS) have partnered since 1996 to administer the survey for Medicare beneficiaries.

The CAHPS Survey is critical to UnitedHealthcare Medicare Services, not only for the insight it provides into our members' level of satisfaction, but also as a key component of a number of national initiatives. CMS utilizes CAHPS data as part of their health plan quality star ratings program, which is used by Medicare beneficiaries to compare and choose health plans. The National Committee for Quality Assurance (NCQA) uses CAHPS data to score health plans as part of the accreditation process. Lastly, US News and World Report uses CAHPS data to create their America's Best Health Insurance Plans annual report.

UnitedHealthcare Medicare Services receives case-mix adjusted CAHPS data for 58 Medicare plans within the UnitedHealthcare Medicare Services book of business (based on the size and age of the plan). Some highlights from the 2009 CAHPS Survey include:

	Medicare Services' Averages	National Averages
Composites	**Usually + Always**	**Usually + Always**
Members rate each item Never, Sometimes, Usually, or Always		
Health Plan Customer Service	87.56%	90.84%
• Member Treated with Courtesy and Respect		
• Member Gets Information Needed		
• Forms Easy to Fill Out		
Getting Care Quickly	77.97%	79.15%
• Getting Needed Care Right Away (Urgent Care)		
• Getting Appoints as Soon as Needed (Routine Care)		
• See the Provider within 15 Minutes of Appointment Time		
Getting Needed Care	90.42%	91.51%
• Ease of Getting Appointments with Specialists		
• Ease of Getting Needed Care, Tests, and Treatment		
Doctors Who Communicate Well	93.83%	94.48%
• Doctor Explains Things in Easy To Understand Way		
• Doctor Listens Carefully		
• Doctor Shows Respect for What You Have to Say		
• Doctor Spends Enough Time		
Overall Rating Measures	**7-10**	**7-10**
Members rate each item on a scale of 0-10		
Overall Rating of Health Plan	83.03%	86.74%
Overall Rating of Drug Coverage	82.97%	85.88%
Overall Rating of Care Received	85.38%	87.19%
Overall Rating of Personal Doctors	92.22%	93.12%
Overall Rating of Specialists	90.97%	91.08%

UnitedHealthcare Medicare Services has identified several measures from the CAHPS Survey for ongoing improvement initiatives. The focus is on the interactions that members have with us as their health plan. An interdepartmental work group has targeted functional areas across our operations, including but not limited to customer service, network development, utilization management, and marketing. UnitedHealthcare Medicare Services has set high goals for improvement in our CAHPS results for 2010. The surveys are administered from February to June each year, and UnitedHealthcare Medicare Services is actively engaged in implementing operational improvements that will improve our members' satisfaction with their health care experience. In 2010 and beyond, UnitedHealthcare Medicare Services will continue to monitor and work to improve our CAHPS scores and subsequently our members' satisfaction with us as their health plan.

2010 Conversion Factor General Announcement

As you may be aware, Congress and the White House continue to negotiate on the next steps to address a cut in Medicare reimbursement for physicians. Most physicians who participate in the UnitedHealthcare network serving SecureHorizons and Evercare members, as well as a small number of physicians who serve commercial and AmeriChoice members, will not experience a change for claims processed at this time. Until we are instructed otherwise by the federal government, affected claims will be paid at the pre-reduction 2010 conversion factor and 2010 relative value units and geographic practice cost indices. We will continue to monitor the actions of Congress and await instructions from the federal government.

Important Information for Medicare Physicians

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, 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 uhc.com and select "contact us" then "Network Management".

Medicare Quality Improvement Program 2010 Update

UnitedHealthcare Medicare Services strives to continuously improve the quality of care and service provided by our health care delivery system both from the clinical and non-clinical perspective. The **Quality Improvement Program** establishes the standards that encompass the quality improvement activities across the markets we serve. This Quality Improvement Program is accountable to the **National Quality Oversight Committee (NQOC)**, which is comprised of UnitedHealthcare Medicare Services leaders who make decisions to assure our objectives are met. The structure and processes of this program are outlined in our Quality Improvement Program Description and are available upon request at the number listed below.

UnitedHealthcare Medicare Services is committed to the following enterprise-wide goals in 2010:

- Improving efficiencies to support UnitedHealthcare Medicare Services quality initiatives
- Meeting all state, federal and regulatory requirements for quality improvement
- Obtaining or maintaining NCQA Accreditation at the accreditable entity level for 46 of our Medicare contracts
- Improving performance on specific HEDIS measures
- Improving performance on our CAHPS measures
- Supporting the UnitedHealth Group Patient Safety Program
- Demonstrating Healthcare Quality and Affordability through continuous quality management as a core competency and the reduction of disparities

Throughout 2009, UnitedHealthcare Medicare Services Corporate Quality Improvement Program systematically measured and analyzed performance data, contributed essential information to

management decision-making, and improved the overall quality and services provided to our members. As a whole, UnitedHealthcare Medicare Services established and maintained a continuous quality improvement program that pursued superior quality in all operations and superior outcomes for members. UnitedHealthcare Medicare Services strove to provide exceptional customer service to all members and to use information obtained through the quality improvement process to positively impact the delivery of care and service. Lastly, regional resources, interdepartmental and cross-functional, along with corporate resources, were effectively leveraged to guide the structure and processes implemented to improve outcomes for members by enhancing the value of those services. Evidence of UnitedHealthcare Medicare Services' efforts to meet the quality improvement mission and goals are summarized below:

2009 UnitedHealthcare Medicare Services' Quality Improvement Program Strengths and Accomplishments

- Successful completion of UnitedHealthcare Medicare Services first corporate NCQA survey
- National Quality Committee reporting and oversight
- HEDIS – Of the 735 HMO rates reported both in 2009 and 2008, 204 (28%) of the rates moved up at least one percentile group from 2008 to 2009 based on NCQA HEDIS 2008 Percentiles. Of the 267 PPO rates reported both in 2009 and 2008, 62 (23%) of the rates moved up at least one percentile group from 2008 to 2009 based on NCQA HEDIS 2008 Percentiles.
- Successful scheduling and preparation of NCQA Regional Surveys by establishing a market-level NCQA accreditation schedule based on a Single Site Multiple Entity approach
- Successful participation in the Evercare-RAND Community SNP Project, evaluating the quality of care provided in an Evercare Special Needs Plan
- Accessibility and Availability goals were met
- Enhanced statistical metric reporting and analysis through increased communication with inter-departmental segments and the hiring of additional data quality analysis staff
- Total Quality Management philosophy employed in daily operations
- Successfully supported Regional Health Plan Accreditation goals
- Continued enhancement of the Case Management Programs to improve clinical outcomes and service for high-risk members
- Expanded Clinical Reminders Program to promote preventive screenings and reduce disparities.
- Continued preventive health programs targeting identified high-risk members
- Broadened Medicare Advantage Member Communications, providing valuable information to all enrollees about quality programs and services offered through their health plans.
- Successful promotion of patient safety by assisting in driving compliance to Leapfrog Group goals
- Development of robust CAHPS workgroup to improve member satisfaction and increase access to care
- Development of National Delegation Oversight Committee to align processes and improve outcomes

Opportunities for Improvement in 2010

- Continue NCQA Health Plan Accreditation processes:
  - Obtain level of "Accredited" or higher for all plans going through survey during 2010
  - Receive credit for all standards submitted through the corporate NCQA survey
  - Meet CMS Quality Improvement and Deeming requirements
  - Submission of SNP Structure and Process Measures
- Reduce healthcare disparity in UnitedHealthcare Medicare Services members, identify areas of disparity in UnitedHealthcare Medicare Services membership along with current trends

- Eliminate internal processes that create disparity and proactively intervene to reduce disparity where identified. Current focus on HEDIS outcomes relevant to fee-for-service Medicare, and interventions with positive outcomes in minority population
- Enhance reporting of Appeals and Grievances
- Ensure consistency in quality of services and analytics
- Enhance all Clinical Quality Initiatives
- Continue collaboration with OptumHealth Disease Management programs and reporting to ensure effective delivery of services and monitoring performance for members
- Reduce the recidivism rate and improve clinical outcomes
- Improve data capture to ensure culturally and linguistic appropriate services
- Ensure proactive compliance with NCQA and federal regulatory requirements
- Implement interventions to meet established HEDIS 2010 Goals
- Implement interventions to meet established CAHPS 2010 Goals

Please watch for future articles in the Network Bulletin outlining UnitedHealthcare Medicare Services' ongoing efforts to improve quality of care and service, including specifics related to our HEDIS and CAHPS improvement programs.

If you are interested in additional information or a copy of your health plan results, please contact one of our National Mangers of Accreditation and Clinical Quality at 866-934-5717.

Articles for Additional UnitedHealthcare Affiliates

Oxford

Are You Getting All That You Can Out of Oxfordhealth.Com?

Even if you use another option to obtain benefits, eligibility and claim information, it is still important for you to use Oxfordhealth.com in order to get the fastest access to news items that may affect your organization including: policy updates, clinical and other program information, administrative guides, important messages and more.

Other benefits of using Oxordhealth.com

- Get the fast track on patient eligibility, notifications, and more in real time. Save yourself the hassle and time spent calling in for information. This information and more is immediately available online.
- Take advantage of benefit detail that goes beyond HIPAA-required eligibility information.
- Be in-the-know about policy changes; access the monthly Policy Update Bulletin, which announces changes 30 days in advance of effective dates.
- Learn about our PNC Remittance Advantage tool that streamlines your cash flow via secure, electronic direct deposit (eliminates check processing delays), and offers convenient online remittance information.
- Contact our Provider Services Department via email and receive a response within three business days.
- Determine if a procedure requires precertification using the Precertification Required Inquiry tool.
- View prescription drug lists, radiology and laboratory program information, search for physicians/other healthcare professionals or hospitals/health facilities.

Visit us at Oxfordhealth.com and learn about features you could be using right now. If you're new to the site, have new personnel or need a refresher:

- Attend one of our training Web casts offered monthly. Current schedules can be found at Oxfordhealth.com > Providers or Facilities > Tools & Resources > Manage Your Practice > Administrative Ease > Physician eSolutions Web Course Schedule.
- Get an overview of available transactions. Visit Oxfordhealth.com > Tools & Resources > Manage Your Practice > Administrative Ease > Oxfordhealth.com Overview.
- Check out our new Provider and Facility Quick Reference Cards for step by step instructions.

Need to register?

Simply select the 'Providers' link on the left navigation of the Oxfordhealth.com home page, click on "Need to Register?" and follow the prompts. Facilities can register by calling the Web Help Desk at **800-811-0881**. Registration tips are available at Oxfordhealth.com > Help.

Former Health Net members enrolled with Oxford Health Plans: Prior Authorization requirements for injectable medications obtained through specialty vendors and administered in the office setting

Due to a difference between how Health Net and Oxford require specialty medication vendors to bill, please note the following:

- Certain injectable medications (e.g., Remicade, Botox, factor products) may be administered in a physician office.
- For those products requiring prior authorization by Oxford, a new prior authorization must be obtained after the member enrolls in Oxford. The previous authorization given by Health Net cannot be honored.
- Once the member enrolls with Oxford, Oxford's policies and procedures concerning individual medications apply
- For those physicians who do not purchase or bill for these medications directly, please use UnitedHealth Group/Oxford participating network specialty pharmacies. Please allow sufficient time when ordering medications.

For further information on this program, please call the Specialty Pharmacy Referral Line toll-free at 866-429-8177. For a listing of our clinical policies, including any medication requiring prior authorization please refer to OxfordHealth.com.

Good News: Updated Process for Submission of Facility Corrected Claims for Oxford® Members

As part of our commitment to administrative simplification, going forward you may submit your corrected facility claims via electronic data interchange (EDI), using payor id 06111. The EDI submission must use the appropriate bill type to indicate the claim is a corrected claim. For a list of appropriate bill types, please visit OxfordHealth.com. Documenting the correction in comments will also help us to address your submission as a corrected claim.

Doing all of the suggested things above will allow us to more appropriately identify the claim as a corrected claim to avoid any unnecessary future paper submissions. If you have any questions about this submission change, please contact Provider Services toll-free at 800-666-1353.

Now Available, Free Claim Direct Data Entry

If you currently submit claims on paper, don't have a practice management system or just like the simplicity of keying your claims online, this solution is for you. Submit professional and/or institutional claims for free, courtesy of Oxford DirectConnect powered by Post-N-Track®. Call 860-257-2030 to speak to Provider Outreach at Post-N-Track, for additional information.

TIP For Faster Administration of Oxford Business

In order for physicians and other healthcare professionals to register on Oxfordhealth.com, the correct date of birth (DOB) must be in our systems. If you have trouble registering because of an incorrect DOB, make your updates by emailing us the MPIN, FTIN and DOB to OX_HPDemo@uhc.com, or faxing the information to 866-561-3966.

PacifiCare

PacifiCare Pharmacy and Prescription Solutions Updates

PacifiCare and Prescription Solutions strive to make prescription medications accessible and affordable to our enrollees through our pharmacy benefits program. We accomplish this through the use of a formulary (PacifiCare) and a Prescription Drug List (PDL) for UnitedHealthcare plans with pharmacy benefits administered by Prescription Solutions. A group of physicians and PBM leaders come together as our Business Implementation Committee (BIC) and make tier decisions and changes to the pharmacy formulary/PDL based on a review of clinical, economic and pharmacoeconomic evidence. Our National Pharmacy and Therapeutics Committee provides clinical guidance to assist the BIC in the decision making process. Periodic reviews of the formulary and PDL are performed and medications may move to different tiers resulting in a change to member share of cost. As a reminder, when a medication changes tiers, your patient may be required to pay more or less for that medication. Tier 1 or generic copay represents the lowest copay option.

PacifiCare Formulary and Prescription Solutions PDL Coverage Change for Jan. 1 – July 1, 2010

The following medications will be **added or down-tiered** to the PacifiCare Formulary and Prescription Solutions PDL

Drug	Effective Date	Formulary Status	PDL Status
Astepro (Azelastine)	7/1/10	Preferred Formulary Brand	Tier 2
Saphris (Asenapine)	7/1/10	Preferred Formulary Brand	Tier 2
Valturna (Aliskiren / Valsartan)	7/1/10	Preferred Formulary Brand	Tier 2
Onglyza (Saxagliptin)	2/1/10	Preferred Formulary Brand	Tier 2
Renvela (Sevelamer)	2/1/10	Preferred Formulary Brand	Tier 2
Apriso (Mesalamine)	2/1/10	Preferred Formulary Brand	Tier 2
Fenoprofen Calcium	3/1/10	Preferred Formulary Generic	No Change
Naproxen DR / EC-Naproxen (generic EC-Naprosyn)	3/1/10	Preferred Formulary Generic	No Change
Perindopril (generic Aceon)	3/1/10	Preferred Formulary Generic	No Change
Avodart (Dutasteride)	4/1/10	Preferred Formulary Brand	Tier 2
Cellcept (Mycophenolate Mofetil)	4/1/10	Preferred Formulary Brand	Tier 2
Lovaza (Fish Oil, Omega-3-Fatty Acids)	4/1/10	Preferred Formulary Brand	Tier 2
Welchol suspension (Colesevelam)	4/1/10	Preferred Formulary Brand	Tier 2
Cymbalta (Duloxetine)	5/1/10	Preferred Formulary Brand	Tier 2

The following medications will be **removed** from the PacifiCare formulary or **up-tiered** on the Prescription Solutions PDL.

Drug	Effective Date	Formulary Status	PDL Status	Lower Cost Alternative
Benicar/Benicar HCT (Olmesartan / Olmesartan & HCTZ)	7/1/10	Non-Formulary	Tier 3	Diovan, Micardis, Micardis HCT
Frova (Frovatriptan)	7/1/10	Preferred Formulary Brand	Tier 2	Sumatriptan
Maxalt/Maxalt MLT (Rizatriptan)	7/1/10	Preferred Formulary Brand	Tier 2	Sumatriptan
Zomig/Zomig ZMT (Zolmitriptan)	7/1/10	Preferred Formulary Brand	Tier 2	Sumatriptan
Prevpac (Amoxicillin/ Clarithromycin/ Lansoprazole)	7/1/10	Non-Formulary	Excluded	Omeprazole, Lansoprazole, Pantoprazole, Nexium
Protonix (Pantoprazole)	7/1/10	No Change	Excluded	Omeprazole, Lansoprazole, Pantoprazole, Nexium
Relpax (Eletriptan)	7/1/10	Non-Formulary	Tier 3	Sumatripran, Maxalt
Anzemet (Dolasetron)	7/1/10	Non-Formulary	Tier 3	Ondansetron
Azor (Amlodipine/ Olmesartan)	7/1/10	Non-Formulary	Tier 3	Exforge
Fenofibrate (generic Triglide)	7/1/10	No Change	Tier 3	Antara
Noritate (Metronidazole)	7/1/10	Non-Formulary	Tier 3	Metronidazole, Metrogel
Patanase (Olapatadine)	7/1/10	Non-Formulary	Tier 3	Astelin, Astepro
Quixin (Levofloxacin)	7/1/10	Non-Formulary	Tier 3	Vigamox
Protonix (Pantoprazole)	7/1/10	No Change	Excluded	Omeprazole, Lansoprazole, Pantoprazole, Nexium

Members impacted by a change in formulary or PDL status that results in a higher copayment will be notified by May 1, 2010.

In addition to drug additions and removals, new utilizations edits are being added to the following medications.

Step Therapy Requirements – Please note, members currently taking these drugs are not required to go back through the step requirements.

Drug	Effective Date	Step Requirement
Acanya	2/1/10	Trial of Benzamycin (generic)
Daytrana Desoxyn Focalin / Focalin XR Liquadd Procentra Metadate CD Methylin Ritalin LA	2/1/10	Trial of any two formulary stimulant options
Valturna	2/1/10	Trial of ACE Inhibitor / ACE Inhibitor combo OR ARB / ARB combo
Fibricor	2/1/10	Trial of any two of the following: Antara, Lofibra, Tricor OR Trilipix
Sumavel	3/1/10	Trial of sumatriptan injection
Metozolv	3/1/10	Trial of metoclopramide
Twynsta	3/1/10	Trial of Exforge / Exforge HCT
Fanapt	4/1/10	Trial of preferred atypical antipsychotic
Victoza	4/1/10	Trial of metformin, sulfonylurea, TZD OR insulin AND Byetta

Prior Authorization Required

Drug	Effective Date
Revlimid	5/1/10
Thalomid	5/1/10
Amypyra	4/1/10 PacifiCare only

For the most up-to-date information, UnitedHealthcare enrollees can access the full Prescription Drug List look-up tool through myuhc.com, click on Prescriptions and Pharmacies. For PacifiCare enrollees, the most current formulary information can be found at **PacifiCare.com**.

UnitedHealthcare of the River Valley

2010 River Valley Entities' Provider Manual - Effective August 1, 2010

The 2010 River Valley Entities' Provider Manual (the "Manual") will be effective August 1, 2010 for all River Valley Entities' participating physicians, health care professionals, facilities and ancillary providers.

The 2010 Manual contains some important changes you will want to review. The updated sections include, but are not limited to: a new How to Contact Us list; updates to the *Medical Records and Patient Information, Medical Record Review Standards, Clinical Practice Guidelines, Disease Management;* and information on how the Prescription Drug Benefit works. Please refer to the new Manual for complete information on these and other updates.

The 2010 Manual will be available for viewing and printing at www.uhcrivervalley.com/10provider on August 1, 2010. You also may obtain a hard copy of the updated Manual by contacting your local network management representative. Compliance with the Manual is required under your contract. Non-compliance with the Manual may affect your reimbursement.

Coverage Update

The UnitedHealthcare Services Company of the River Valley, Inc. Coverage Policy Library is available to all contracted physicians and health care professionals. It can be accessed at Uhcrivervalley.com/10provider. This library provides the information used in making coverage determinations.

Coverage Updates only apply to River Valley Commercial membership, except that Coverage Updates do not apply to members enrolled in River Valley's Ohio product. Coverage Updates for the Ohio product are provided in the UnitedHealthcare updates above. The Coverage Updates do not apply to any other River Valley membership.

These coverage decisions become effective on the first day of the month following publication, unless otherwise stated.

Services Requiring Preauthorization

Failure to obtain preauthorization may result in administrative sanctions or any other action available under the terms of the Participation Agreement. Retrospective authorization will not be allowed and charges cannot be billed to the member.

Additional HCPCS codes added to the **Clinical Trials** policy: S9988, S9990, and S9991.
Preauthorization is required through Clinical Coverage Review. Effective: August 1, 2010.

- Services of home health/hospice aide in home health or hospice settings, each 15 minutes. Code: G0156. **Preauthorization is required through Home Health. Effective: August 1, 2010.**
- New HCPCS Code. Injection, ustekinumab, 1 mg. Code: C9261. **Preauthorization is required through Pharmacy Case Management. Effective: April 1, 2010.**
- New HCPCS Code. Fludarabine phosphate, oral, 1 mg. Code: C9262. **Preauthorization is required through Pharmacy Case Management. Effective: April 1, 2010.**

Services Not Covered and Billable to the Member

Member is responsible for payment to provider.

- Injection, sermorelin acetate, 1 mcg. Code: Q0515. **Effective: August 1, 2010.**
- Thermal shrinkage/Capsulorrhaphy of the shoulder. Code: S2300. **Effective: July 1, 2010.**
  - Note: Thermal shrinkage for all other joints remains not covered.
- Home uterine monitor with or without associated nursing services. Code: S9001. **Effective: October, 1, 2010.**
- Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem. Code: S9349. **Effective: October 1, 2010.**

Services Not Allowed and Not Billable to the Member

Provider will not receive reimbursement for these services.

- Additional CPT and HCPCS codes added to the **B Bundle Codes Policy:** 15850. 20930, 20936, 38204, 90887, 91123, 94150, 99002, 99090, 99091, 99288, and Q3031. **Effective: August 1, 2010.**
- United Healthcare Services Company of the River Valley, Inc. will implement the Facility and Professional Reimbursement Policy: Wrong Surgical or Other Invasive Procedures as identified on page 3 of the Volume 36 March 2010 Network Bulletin. **Effective: July 1, 2010.** River Valley will not reimburse for a surgical or other invasive procedure when the physician erroneously performs
  - A wrong procedure;
  - A procedure on the wrong body part; or
  - A procedure on the wrong patient

  reported on a CMS1500 or Professional 837 electronic transaction with the applicable HCPCS modifier(s) PA: Surgery Wrong Body Part; PB: Surgery Wrong Patient: PC: Wrong Surgery on Patient on CMS1500 or on inpatient claims as Type of Bill 110 and one of the following ICD-9-CM diagnosis codes E876.5 - Performance of wrong operation (procedure) on correct patient; E876.5 - Performance of operation (procedure) on patient not scheduled for surgery; E876.7- Performance of correct operation (procedure) on wrong side/body part. River Valley also will not provide reimbursement for facility or professional services related to these wrong surgical or other invasive procedures.

Appendix

FAQ/Talking Points - FTC Red Flags Rule effective June 1, 2010

What is the "Red Flags Rule"?

As part of the Federal Trade Commission's (FTC) implementation of the Fair and Accurate Credit Transactions (FACT) Act of 2003, most medical providers will need to comply with the Red Flags Rule. This Rule requires "creditors," which the FTC defines to include most health care providers, to establish a program to prevent identity theft in their practices. The program must highlight Red Flags – that is, indicators of possible identity theft. The program is effective November 1, 2009.

What Red Flags signal identity theft?

There is not a comprehensive checklist, but here are a few signs that may arouse your suspicions:

- **Suspicious documents.** Has a patient given you identification documents that look altered or forged? Is the physical description on the identification inconsistent with what the patient looks like? Is other information on the identification inconsistent with what the patient has told you? More investigation by your practice may be required.
- **Suspicious personally identifying information.** Personal information that does not match what you have learned from other sources might also be a Red Flag. For example, if the patient information does not match the date of birth shown in UnitedHealthcare records, it is worth investigating whether this is a clerical error or something else. Also, a billing address that appears to be fictitious could signal a problem, as well.
- **Notice.** Your practice may receive notices from victims of identity theft, law enforcement authorities, or others suggesting that an account may have been opened fraudulently. Cooperation is key. Heed warnings from others that identity theft may be occurring.

What health care providers need to know

The Red Flags Rule applies to you if your practice bills patients for services or items after the date of service. Because most health care providers bill patients after insurance adjudication, most practices are subject to the FTC mandate. The Rule requires many businesses and organizations to implement a written Identity Theft Prevention Program to detect the warning signs of identity theft in their day-to-day operations. By focusing on Red Flags now, physicians and other health care professionals will be better able to spot an imposter using someone else's medical or financial identity. For tips on implementing an Identity Theft Prevention Program visit the AMA website (http://www.ama-assn.org/ama/no-index/physician-resources/red-flags-rule.shtml).

Requirements of the Red Flags Rule

The Red Flags Rule requires a creditor that offers or maintains "covered accounts" to develop and implement a written Identity Theft Prevention Program that is designed to detect, prevent and mitigate identity theft in connection with the opening of a covered account or any existing covered account. The Red Flags Rule provides flexibility to medical practices, allowing them to establish programs that are appropriate for their size, patient population and scope of medical services.

The program must include reasonable policies and procedures to:

- Identify relevant Red Flags for the practice - a "Red Flag" is a pattern, practice, or specific activity that indicates the possible existence of identity theft
- Detect Red Flags
- Respond appropriately to any Red Flags that are found
- Provide appropriate training for your staff

Guidelines for developing policies and procedures

It should not be overly burdensome for physicians and other health care professionals who are subject to the Red Flags Rule to develop appropriate policies and procedures. For example, practices should be prepared to react to the following:

- A complaint or question from a patient based on the patient's receipt of a bill for another individual
- A bill for a product or service that the patient denies receiving
- A health care provider bill for which the patient never received services
- A notice of insurance benefits for health services never received
- Records showing medical treatment that is inconsistent with the physical examination or medical history, as reported by the patient
- A disputed bill for a patient who claims to be the victim of any type of identity theft
- A patient who has an insurance number but never produces an insurance card or other physical documentation of insurance

What is medical identity theft?

Medical identity theft occurs when someone uses an individual's name or other parts of the individual's identity (such as insurance information or Social Security Number) without the victim's knowledge or consent, to obtain medical services or goods. Medical identity theft can also occur when someone uses the person's identity to obtain money by falsifying claims for medical services and falsifying medical records to support those claims. The essence of the crime is the use of a medical identity by a criminal and the lack of knowledge by the victim.

What are some ways to secure identification to avoid medical identity theft?

If you do not feel comfortable requesting a copy of a patient's driver's license or other government issued photo identification, request at least two forms of identification before the patient's next appointment so that you have an accurate record for the future. Please note that you are not required to request photo IDs or two forms of identification unless you decide that will be part of your practice's identity theft program.

Remember, UnitedHealthcare makes copies of the patient's health care identification (ID) card available as part of the eligibility and verification process on UnitedHealthcare Online.

Can a patient be refused services for failure to provide identification?

The FTC never envisioned this Rule to deny care for people. However, there is no prohibition for denial of care in their guidance. The Emergency Medical Treatment and Active Labor Act (EMTALA) would prohibit any denial of emergency care for lack of identification. For more information on EMTALA, please visit http://www.cms.hhs.gov/emtala/

Is medical identity theft considered health care fraud?

Yes. Medical identity theft is considered a subset of health care fraud. But it is more than that, because the crime can also have financial and other serious consequences for the victim. Medical identity theft is an information crime involving theft or abuse of identity information, and its victims also include the providers and insurers who may directly bear financial losses.

If a health care worker steals a patient's identity and opens a credit card in the patient's name, is that considered medical identity theft?

Some identity theft cases arise in medical settings, but they are not considered medical identity theft. For example, if a hospital worker steals a patient's credit card information or other financially-related identity information, this is not an example of medical identity theft. This scenario would be considered traditional financial identity theft. In this situation, the crime did not affect the medical identity of the individual, even though it involved the use of personal financial information.

An example of medical identity theft would be a situation in which a sibling of a UnitedHealthcare member used the sibling's card and personal information (home address and employer information) to receive medical care at a local physician's office. Due to the nature of medical identity theft, patients may require access to their medical record to document that services rendered to this third party were not their own.

Where can I find more information?

UnitedHealthcare encourages its participating physicians and facilities to access materials on medical identity theft offered by the American Health Information Management Association and the Medical Group Management Association. Links to resources are posted at UnitedHealthcareOnline.com > Tools & Resources > Health Resources for Patients > Medical Identity Theft.

Sources:

FTC.gov/redflagrule
WorldPrivacyForum.com
http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/regulatory-compliance-topics/red-flag-rules.shtml

CPT codes for Once in a Lifetime Procedures

Code	Description
30160	Rhinectomy; total
31360	Laryngectomy; total, without radical neck dissection
31365	Laryngectomy; total, with radical neck dissection
32440	Removal of lung, total pneumonectomy;
32442	Removal of lung, total pneumonectomy; with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)
32445	Removal of lung, total pneumonectomy; extrapleural
38100	Splenectomy; total (separate procedure)
38102	Splenectomy; total, en bloc for extensive disease, in conjunction with other procedure (List in addition to code for primary procedure)
41140	Glossectomy; complete or total, with or without tracheostomy, without radical neck dissection
41145	Glossectomy; complete or total, with or without tracheostomy, with unilateral radical neck dissection
42140	Uvulectomy, excision of uvula
43620	Gastrectomy, total; with esophagoenterostomy
43621	Gastrectomy, total; with Roux-en-Y reconstruction
43622	Gastrectomy, total; with formation of intestinal pouch, any type
44150	Colectomy, total, abdominal, without proctectomy; with ileostomy or ileoproctostomy
44151	Colectomy, total, abdominal, without proctectomy; with continent ileostomy
44155	Colectomy, total, abdominal, with proctectomy; with ileostomy
44156	Colectomy, total, abdominal, with proctectomy; with continent ileostomy
44157	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, includes loop ileostomy, and rectal mucosectomy, when performed
44158	Colectomy, total, abdominal, with proctectomy; with ileoanal anastomosis, creation of ileal reservoir (S or J), includes loop ileostomy, and rectal mucosectomy, when performed
44950	Appendectomy;
44955	Appendectomy; when done for indicated purpose at time of other major procedure (not as separate procedure) (List separately in addition to code for primary procedure)
44960	Appendectomy; for ruptured appendix with abscess or generalized peritonitis
44970	Laparoscopy, surgical, appendectomy
45110	Proctectomy; complete, combined abdominoperineal, with colostomy
45112	Proctectomy, combined abdominoperineal, pull-through procedure (eg, colo-anal anastomosis)

Code	Description
45119	Proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy when performed
45120	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with pull-through procedure and anastomosis (eg, Swenson, Duhamel, or Soave type operation)
45121	Proctectomy, complete (for congenital megacolon), abdominal and perineal approach; with subtotal or total colectomy, with multiple biopsies
45395	Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy
45397	Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy, when performed
47562	Laparoscopy, surgical; cholecystectomy
47563	Laparoscopy, surgical; cholecystectomy with cholangiography
47564	Laparoscopy, surgical; cholecystectomy with exploration of common duct
47600	Cholecystectomy;
47605	Cholecystectomy; with cholangiography
47610	Cholecystectomy with exploration of common duct;
47612	Cholecystectomy with exploration of common duct; with choledochoenterostomy
47620	Cholecystectomy with exploration of common duct; with transduodenal sphincterotomy or sphincteroplasty, with or without cholangiography
48155	Pancreatectomy, total
51570	Cystectomy, complete; (separate procedure)
51575	Cystectomy, complete; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
51580	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations;
51585	Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
51590	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis;
51595	Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
51596	Cystectomy, complete, with continent diversion, any open technique, using any segment of small and/or large intestine to construct neobladder
51925	Closure of vesicouterine fistula; with hysterectomy
53210	Urethrectomy, total, including cystostomy; female
53215	Urethrectomy, total, including cystostomy; male
54125	Amputation of penis; complete
54130	Amputation of penis, radical; with bilateral inguinofemoral lymphadenectomy

Code	Description
54135	Amputation of penis, radical; in continuity with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
54150	Circumcision, using clamp or other device with regional dorsal penile or ring block
54160	Circumcision, surgical excision other than clamp, device, or dorsal slit; neonate (28 days of age or less)
54161	Circumcision, surgical excision other than clamp, device, or dorsal slit; older than 28 days of age
54861	Epididymectomy; bilateral
55801	Prostatectomy, perineal, subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and /or dilation, and internal urethrotomy)
55810	Prostatectomy, perineal radical;
55812	Prostatectomy, perineal radical; with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55815	Prostatectomy, perineal radical; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric and obturator nodes
55821	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); suprapubic, subtotal, 1 or 2 stages
55831	Prostatectomy (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy); retropubic, subtotal
55840	Prostatectomy, retropubic radical, with or without nerve sparing;
55842	Prostatectomy, retropubic radical, with or without nerve sparing; with lymph node biopsy(s) (limited pelvic lymphadenectomy)
55845	Prostatectomy, retropubic radical, with or without nerve sparing; with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing
56625	Vulvectomy simple; complete
56634	Vulvectomy, radical, complete; with unilateral inguinofemoral lymphadenectomy
56637	Vulvectomy, radical, complete; with bilateral inguinofemoral lymphadenectomy
57110	Vaginectomy, complete removal of vaginal wall;
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57112	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)
57530	Trachelectomy (cervicectomy), amputation of cervix (separate procedure)
57540	Excision of cervical stump, abdominal approach;
57545	Excision of cervical stump, abdominal approach; with pelvic floor repair
57550	Excision of cervical stump, vaginal approach;
57555	Excision of cervical stump, vaginal approach; with anterior and/or posterior repair
57556	Excision of cervical stump, vaginal approach; with repair of enterocele

Code	Description
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s);
58152	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s); with colpo-urethrocystopexy (eg, Marshall-Marchetti-Krantz, Burch)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)
58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)
58240	Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy, with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and ureteral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof
58260	Vaginal hysterectomy, for uterus 250 g or less;
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy;
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
58285	Vaginal hysterectomy, radical (Schauta type operation)
58290	Vaginal hysterectomy, for uterus greater than 250 g;
58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58293	Vaginal hysterectomy, for uterus greater than 250 g; with colpo-urethrocystopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58294	Vaginal hysterectomy, for uterus greater than 250 g; with repair of enterocele
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less;
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g;
58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)

Code	Description
58548	Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less;
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g;
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less;
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g;
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58950	Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy;
58951	Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with total abdominal hysterectomy, pelvic and limited para-aortic lymphadenectomy
58952	Resection (initial) of ovarian, tubal or primary peritoneal malignancy with bilateral salpingo-oophorectomy and omentectomy; with radical dissection for debulking (ie, radical excision or destruction, intra-abdominal or retroperitoneal tumors)
58953	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking;
58954	Bilateral salpingo-oophorectomy with omentectomy, total abdominal hysterectomy and radical dissection for debulking; with pelvic lymphadenectomy and limited para-aortic lymphadenectomy
58956	Bilateral salpingo-oophorectomy with total omentectomy, total abdominal hysterectomy for malignancy
59135	Surgical treatment of ectopic pregnancy; interstitial, uterine pregnancy requiring total hysterectomy
60240	Thyroidectomy, total or complete
60252	Thyroidectomy, total or subtotal for malignancy; with limited neck dissection
60254	Thyroidectomy, total or subtotal for malignancy; with radical neck dissection
60270	Thyroidectomy, including substernal thyroid; sternal split or transthoracic approach
60271	Thyroidectomy, including substernal thyroid; cervical approach
61542	Craniotomy with elevation of bone flap; for total hemispherectomy

NetworkBulletin
An important message to health care professionals and facilities

CPT codes for Moderate Sedation Policy

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