



**The Empire
Plan**

Network Administrative Guide July 2022

This Empire Plan Network Administrative Guide applies to all network participation agreements which reference a “Network Administrative Guide” applicable to The Empire Plan. For network participation agreements that reference a “Manual,” please see the Empire Plan Physician & Provider Manual.

**United
Healthcare®**

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Empire Plan Network physicians, providers, and facilities play a key role as we pursue our commitment to improve the health and well-being of the individuals we serve. This Guide is designed to provide information needed when treating an Empire Plan enrollee. Please share it with others in your office or organization.

The Empire Plan is a unique health insurance program developed by New York State and its employee unions especially for employees of New York State and their families. It is the most selected group health insurance option under The New York State Health Insurance Program (NYSHIP), covering over 1 million employees, retirees and eligible dependents from over 740 participating employers and agencies. UnitedHealthcare administers The Empire Plan's medical portion, and its Empire Plan Network was specifically developed to serve the needs of The Empire Plan. Providers contracted directly for The Empire Plan, primarily in New York State, are separate from UnitedHealthcare's commercial networks which serve the company's standard health plan products, such as HMO, PPO, and POS plans.

However, there are a limited number of other UnitedHealthcare customers with whom you should be familiar because they are granted access to the Empire Plan Network. These customers are noted in your provider agreement. The ID cards for their members contain most of the information you will need, and we encourage you to call the telephone numbers on the ID cards with any questions regarding their plans. Brief reference information concerning these customers is included in certain sections of this manual, but the Guide focuses primarily on the Empire Plan's programs, procedures, and policies.

This Guide is not intended to include every administrative policy or procedure, and only general procedures and descriptions are outlined here. The Guide should not be used for determining coverage in any particular case. Should the information in this Guide conflict with the terms of the enrollee's certificate of coverage, the enrollee's certificate will control.

This Guide is reviewed periodically and may be changed by UnitedHealthcare in its sole discretion. Updated versions of this Guide and other policies and protocols are made available at uhcprovider.com.

Should you have any questions or need additional information, please see "[Section 1: How to Reach Us](#)."

Providing Official Written Notice

As outlined in your participation agreement, you must notify Empire Plan Network Management of certain events in writing. Changes which must be reported include, but are not limited to, tax identification number changes/additions, name changes, practice ownership changes, billing or service address changes, additions or departures of health care providers from your practice, and new locations.

Practice or Facility Demographic Information

You can make demographic updates to your practice information by submitting the change directly through the [My Practice Profile](#) tools available at [UHCprovider.com](#). You can also submit your change by completing and submitting the appropriate [Demographic Information Update Form](#) also available at [uhcprovider.com](#).

All Other Changes

Notify Empire Plan Network Management of all other changes in writing via the fax number or address found later in this section. Be sure to include the appropriate IRS Form W-9 (available at www.irs.gov) for Tax Identification Number changes; changes in name, ownership, or control; or adding a physician or health care provider to your practice.

Communication Avenues

- Online / Electronic

Empire Plan network physicians and providers are expected to conduct business with UnitedHealthcare on an electronic basis wherever possible, including but not limited to determining whether the patient is currently covered, verifying the covered person's benefit, and submitting the claim.

uhcprovider.com

- [UnitedHealthcare Provider Portal](#)

To check eligibility, submit claims, view claim status, request claim adjustments, update demographic information, view reimbursement policies. For more details, see the UnitedHealthcare Provider Portal [overview](#) and [quick reference guide](#).

EmpirePlanProviders.com

- [Empire Plan Participating Provider Directory](#)

Search for physicians and providers that participate in UnitedHealthcare's or MPN's Empire Plan Network.

- Fax

844-897-5439

- Empire Plan Network Management

To notify Empire Plan Network Management of demographic and practice changes.

- Telephone

1-877-7-NYSHIP (1-877-769-7447)

- Empire Plan Medical/Surgical Program (UnitedHealthcare)

Customer Care

To inquire about a patient's eligibility, plan benefits, claim status, claim forms or network provider directories.

Managed Physical Medicine Program

(Managed Physical Network, Inc.- MPN)

To inquire about coverage, referral assistance, concurrent review, or notify MPN of physical medicine services (chiropractic, physical therapy) services.

Benefit Management Program

To inquire about or notify us of outpatient radiology services, outpatient medical case management, home health services including nursing & infusion therapy, durable medical equipment & integral supplies, mastectomy prosthetics over \$1,000, infertility services, and diabetic shoes.

The Empire Plan's dedicated Care Coordination unit is available Monday through Friday from 8:00am to 4:30pm EST. An automated Voice Response System allows callers to reach the appropriate level of staff member to handle their specific requests.

Network Management

To ask questions about your participation/contract, discuss vendor alert notifications, request participation for other members of your practice, or notify us of demographic and practice changes. Select the option to leave a message for your network account manager and enter his/her voice mailbox number.

Cancer Resources Program

To speak with a nurse consultant regarding cancer resources available to Empire Plan enrollees.

- Empire Plan Hospital Program (Empire Blue Cross and Blue Shield)
- Empire Plan Mental Health & Substance Use Program
- Empire Plan Prescription Drug Program
- Empire Plan NurseLine

To inquire about coverage/claims or notify Blue Cross of hospital, skilled nursing facility, or transplant services.

To inquire about coverage/claims, referral assistance, or notify the Behavioral Health Program of mental health & substance use services.

To inquire about prescription drug coverage, notify Prescription Drug Program of certain medications, speak to a pharmacist, or take advantage of mail service pharmacy.

To inquire about health information and support resources available to Empire Plan enrollees.

1-866-UHC-FAST (1-866-842-3278)

To inquire about, register for, or request assistance with uhcprovider.com, UnitedHealthcare Provider Portal tools, Electronic Payments & Statements, or electronic claim submission.

- Mail

Empire Plan Network Management

UnitedHealthcare
PO Box 2300
Kingston, NY 12402-2300

Empire Plan Claims, Claim Forms & Claim Issues

UnitedHealthcare
PO Box 1600
Kingston, NY 12402-1600

Section 2: Empire Plan Product Overview

This table provides information regarding some common features of The Empire Plan.

<i>Attributes</i>	<i>The Empire Plan</i>
How do enrollees access physicians and health care professionals?	<p>Enrollees are not required to designate a primary physician*, although they are encouraged to develop and maintain a relationship with one.</p> <p>To receive the highest level of benefits, the enrollee must obtain medical care from a network physician or provider.</p>
Does the primary physician* have to make a referral to a specialist?	<p>No formal referral is required.</p> <p>Enrollees can choose any physician or health care professional.**</p> <p>The benefit level for services from non-network physicians and health care professionals may be less than that for services from network physicians and health care professionals.</p>
Is the treating physician responsible for required notifications of certain services?	<p>No. Enrollees are responsible for the notifications outlined in Section 7, "Empire Plan Care Coordination." However, network physicians/providers are encouraged to be aware of when their services require notification and notice from the physician/provider is accepted.</p>
Does the physician or provider collect a copayment from enrollees?	<p>Yes, at the time of visit, when required.</p> <p>Please refer to the Empire Plan Copayment Guide for more information regarding required copays.</p>

* Primary physician is defined as a physician or health care professional who has been designated as his/her primary care physician by the enrollee.

** Physicians and health care professionals must be licensed for the health services provided and covered under the enrollee's benefit plan.

Section 3: ID Cards and Eligibility Verification

ID Cards

Empire Plan

Empire Plan participants are furnished with New York State Health Insurance Program (NYSHIP) identification cards by the State of New York Department of Civil Service, the Empire Plan policyholder. Current versions of NYSHIP identification cards are displayed below. Prior versions also remain in circulation. Some list The Empire Plan name and/or carriers involved in coverage; others do not. All are valid Empire Plan identification cards.

**NYSHIP**
New York State
Health Insurance Program

The Empire
Plan

123456789

JEANNIE EMPIRE PLAN ENROLLEE
JOHN EMPIRE PLAN DEPENDENT PARTNER
JANE EMPIRE PLAN DEPENDENT
MICHAEL EMPIRE PLAN DEPENDENT
JAMES EMPIRE PLAN DEPENDENT
MARY EMPIRE PLAN DEPENDENT

In-network OOP Limits: Drug: \$XXXX, Non-Drug: \$XXXX (Ind); Drug: \$XXXX, Non-Drug: \$XXXX (Family)
Non-network Combined Deductible: \$XXXX (Enrollee; Spouse/Partner; all Children combined)
Non-network Combined Coinsurance Max: \$XXXX (Enrollee; Spouse/Partner; all Children combined)
Physical Medicine Program Deductible: \$250 (Enrollee; Spouse/Partner; all Children combined)




For enrollee services,
precertification &
provider relations,
please call:





1-877-7-NYSHIP
(1-877-769-7447)

For details on your
health benefits, visit
[www.cs.ny.gov/
employee-benefits](http://www.cs.ny.gov/employee-benefits)


Providers: This card represents but does not guarantee enrollment in the New York State Health Insurance Program (NYSHIP) for Government Employees.

Submit hospital, skilled nursing facility and hospice claims to your local Blue Plan. Hospital and related services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association.

    Blue Cross Prefix: YLS

 Group# 030500    Bin# 004336

Submit medical provider claims in accordance with your participating provider agreement. Submit behavioral health provider claims to Beacon Health Options. All other non-hospital providers call 1-877-769-7447 for information about eligibility, benefits and claims submission.
In-network Drug OOP Limit does not apply to Empire Plan Medicare Rx enrollees.
Administered by the New York State Department of Civil Service

**NYSHIP**
New York State
Health Insurance Program

Student Employee
Health Plan

Administered by the New York State Department of Civil Service

Smith, John
123456789

Effective until 08/31/22 or when coverage ends, whichever is sooner

Hospital benefits

- \$25 ER/\$200 per admission
- \$15 outpatient visit and hospital-based urgent care
- \$10 P/T

Medical/Surgical benefits

- \$10 office visit, office surgery, labs, radiology, chiropractic treatment, P/T, urgent care

Mental Health/Substance Use benefits

- \$25 ER/\$200 per admission or detox stay
- \$10 outpatient visit

Rx benefits

- Retail Pharmacy 30 days/Mail Service or Specialty Pharmacy 31-90 days*
- \$5/\$5* Level 1 or generic
- \$25/\$50* Level 2 or preferred brand name
- \$45/\$90* Level 3 or non-preferred brand name

In-network Out-of-Pocket Limits:

- Drug: \$3,050, Non-Drug: \$5,650 (Ind); Drug: \$6,300, Non-Drug: \$11,300 (Family)

Non-network Combined Deductible: \$100 per person


Physical Medicine Program Deductible: \$100 per person

 **You must call**

Toll Free
1-877-7-NYSHIP
(1-877-769-7447)


Submit hospital and hospice claims to your local Blue Plan. Hospital and related claims services provided by Empire HealthChoice Assurance, Inc., a licensee of the BlueCross and BlueShield Association.

Submit medical provider claims in accordance with your participating provider agreement. Submit behavioral health provider claims to Beacon Health Options. All other non-hospital providers call 1-877-769-7447 for information about eligibility, benefits and claims submission.

    Blue Cross Prefix: YLS

 Group# 030500   Bin# 004336

This card represents but does not guarantee enrollment in the New York State Health Insurance Program. It is insurance fraud for an enrollee or dependent to use the card to obtain services after eligibility for coverage ends.

**NYSHIP**
New York State
Health Insurance Program

The Excelsior
Plan

Administered by the New York State Department of Civil Service

123456789

JOHN ENROLLEE
JEANNIE DEPENDENT
JANE DEPENDENT
MICHAEL DEPENDENT
JAMES DEPENDENT

\$35 Office Visit \$130 Emergency Department

In-network Out-of-Pocket Limits: Drug: \$3,050, Non-Drug: \$5,650 (Ind); Drug: \$6,300, Non-Drug: \$11,300 (Family)

Non-network Combined Deductible: \$1,500 (Enrollee; Spouse/Partner; all Children combined)

Non-network Combined Coinsurance Max: \$4,750 (Enrollee; Spouse/Partner; all Children combined)





For enrollee services,
precertification &
provider relations,
please call:





1-877-7-NYSHIP
(1-877-769-7447)

For details on your
health benefits, visit
[www.cs.ny.gov/
employee-benefits](http://www.cs.ny.gov/employee-benefits)

Providers: This card represents but does not guarantee enrollment in the New York State Health Insurance Program (NYSHIP) for Government Employees.

Submit hospital, skilled nursing facility and hospice claims to your local Blue Plan. Hospital and related services provided by Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association.

    Blue Cross Prefix: YLS

 Group# 030500    Bin# 004336

Submit medical provider claims in accordance with your participating provider agreement. Submit behavioral health provider claims to Beacon Health Options. All other non-hospital providers call 1-877-769-7447 for information about eligibility, benefits and claims submission.

Additional Covered Groups

Other employer groups that access the Empire Plan Network, as noted in your agreement, receive UnitedHealthcare ID cards. Members may not have access to physical ID cards if they are not required by law. We are moving towards eliminating physical ID cards. You may find UnitedHealthcare-specific member information that will help you identify the member's health benefit plan in the UnitedHealthcare Provider Portal. You may download and keep a copy of both sides of the health plan ID card for your records. Possession of a physical ID card is not proof of eligibility.

UnitedHealthcare **1** **OPTUMRX**

Member: **MEMBER SMITH**

Member ID: **999999999** Group Number: **999999**

PCP: **FIRSTNAME LASTNAME** **4** Customer Name Line 1
PCP Phone: **(999) 999-9999** Customer Name Line 2

Payer ID **87726** **3**

Copays:

Office: \$99	ER: \$99	5
UrgCare: \$99	Spec: \$99	

Coins 99% Ded IND/FAM COPM IND/FAM

Tier 1: \$99999/\$99999	\$99999/\$99999	\$99999/\$99999
INN: \$99999/\$99999	\$99999/\$99999	\$99999/\$99999
OON: \$99999/\$99999	\$99999/\$99999	\$99999/\$99999

Rx Birt: **610279**
Rx PCN: **9999**
Rx Grp: **UHEALTH**

Referrals Required **6**

DOI-0508 Underwritten by UnitedHealthcare Insurance Company

Printed: 10/17/21

8 Members: We're here to help. Check benefits, view claims, find a doctor, ask a question and more.
Web: **myuhc.com**
Phone: **555-555-5555**

Providers: **877-842-3210 or UHCprovider.com**
Medical Claims: **PO Box 740825, Atlanta GA 30374-0825**

9 **MultiPlan** **Preferred Lab**

Pharmacists: **888-290-5416**
Pharmacy Claims: **OptumRx PO Box 650540 Dallas, TX 75265-0540**

- 1. UnitedHealthcare brand:** This includes UnitedHealthcare, All Savers, UnitedHealthcare Level Funded, UnitedHealthcare Oxford Level Funded, Golden Rule, UnitedHealthcare Oxford, UnitedHealthOne, UMR and UnitedHealthcare Shared Services (UHSS), UnitedHealthcare Freedom Plans.
- 2. Member Plan Identifier:** This is a customized field to describe the member's benefit plan (i.e., Individual Exchange, Tiered Benefits, ACO).
- 3. Payer ID:** Indicates claim can be submitted electronically using the number shown on card. Contact your vendor or clearinghouse to set up payer in your system, if necessary.
- 4. PCP name and phone number:** Included for benefit plans that have PCP selection requirements. For Individual Exchange Members "PCP required" is listed in place of the PCP name and number. This section may also include Laboratory (LAB), Preferred Lab Network (PLN) and Radiology (RAD) participant codes.
- 5. Copay information:** If this area is blank, the member is not required to make a copay at the time of service.
- 6. Benefit plan name:** identifies the applicable benefit plan name.
- 7. Referral requirements identifier:** Identifies plans with referral requirements. Requires PCP to send electronic referrals.
- 8. For members section:** Lists benefit plan contact information and, if applicable, referrals and notifications information.
- 9. For providers section:** Includes the prescription plan name.

Determining Eligibility of Plan Participants

Be sure to check the customer's ID card at each visit - especially the first visit of a new year, when information may change - and to copy both sides of the card for your files. At each visit verify that the plan participant continues to participate in the same health plan. You can do this by checking at uhcprovider.com. If you do not have internet access, call 1-877-7-NYSHIP for the Empire Plan or the telephone number listed on the ID card for other groups.

Occasionally, new plan participants do not receive their cards prior to an office visit. Eligibility verification can be obtained via uhcprovider.com or by calling the numbers noted above.

While participants are advised to present their identification cards before services are rendered, this is not required for your participating provider agreement to be binding. And, there is no penalty imposed upon the patient for failure to do so if that patient is otherwise eligible for coverage. In those instances where a patient's initial failure to identify leads a participating practitioner to collect a fee greater than the appropriate copayment, it is the obligation of the provider to refund the excess amount no later than twenty (20) days from the date you first learn of the overpayment.

Eligibility Information Cannot Be Guaranteed

UnitedHealthcare will verify a plan participant's eligibility based on the data available at the time the request is made. Subsequent changes to eligibility may not be available at the time of the request and may alter the plan participant's eligibility on that particular date. Accordingly, verification of eligibility is not a guarantee of coverage.

Eligibility under a benefit contract may change retroactively if:

- We receive information that an individual is no longer a plan enrollee;
- The individual's policy/benefit contract has been terminated;
- The enrollee decides not to purchase continuation coverage; or
- The eligibility information we receive is later determined to be false.

If you have submitted a claim(s) that is impacted by a retroactive eligibility change, a claim adjustment may be necessary. The reason for the claim adjustment will be reflected on the EOB.

Fees Paid by Plan Participants

You should bill plan participants for the following:

- Copayments for Covered Services
- Non-Covered Services

Patient Not Initially Identified as Plan Participant

A patient may be billed directly if it cannot be proved that a patient is a plan participant at the time of service. If it is later determined that the patient is a plan participant and has paid for rendered services which are covered under his or her benefit plan, you must refund the plan participant any amounts collected in excess of applicable copayments no later than twenty (20) days from the date you first learn of the overpayment.

Determining Copayment Amounts

A copayment is a specific dollar amount paid by a plan participant for covered services under the benefit plan (e.g., physician office services).

For Empire Plan members, services that require a copayment are classified into four basic categories:

- Therapeutic/Diagnostic/Preventive Office Treatment,
- Office Surgery,
- Diagnostic Tests – Laboratory Services, and
- Diagnostic Tests – Radiology Services.

In general, one copayment is due for any one service or multiple services within each category during a single visit. This would result in a maximum of four (4) copayments per visit. However, for most plan enrollees, one copayment will be due for office treatment and office surgery on the same date, and only one copayment will be due when laboratory and radiology services are performed on the same date. This results in a maximum of two (2) copayments per visit.

Copayment requirements are subject to change, and an Empire Plan Copayment Guide is periodically distributed to network physicians and providers. Be sure to refer to the most current Empire Plan Copayment Guide. For questions or confirmation, you can also check UHCprovider.com, or call 1-877-7NYSHIP.

Billable Copayments

At the time of service, plan participants can be charged the indicated copayment for billable services performed. A copayment should be collected only for services which are reimbursable under the plan participant's benefit plan.

- If the copayment is more than your contracted fee for the service, collect the contracted fee rather than the copayment amount.
- If the plan participant is covered by more than one benefit plan, see *COB, Fee Schedule* under Coordination of Benefits later in this section concerning collection of copayments.
- Certain services are excluded from copayment requirements under the Empire Plan. These are listed on the Empire Plan Copayment Guide.
- No copayment should be collected for services that are not normally identified/billed separately. Some examples of these services for which no copayment should be collected include:
 - Prenatal visits and six week checkup after delivery
 - Surgical visits included within the global benefits
 - Minor services that would not be normally billed
 - Dispensing of prescription drugs
 - Telephonic care

Additional Fees for Covered Services (ie, Administrative Fees, etc.)

You may not charge plan participants for Covered Services beyond copayments, coinsurance, or deductible as described in their benefit plans. You may not charge Covered Persons retainer, membership, or administrative fees, voluntary or otherwise. This includes, but is not limited to, concierge/boutique practice fees as well as fees to cover increases in malpractice insurance and office overhead. This does not prevent you from charging plan participants nominal fees for missed appointments or completion of camp/school forms.

Non-Covered Services

After the benefit determination has been made, you may seek and collect payment from the plan participant for services not covered under the applicable benefit plan, provided you have first obtained the plan participant's written consent. Such consent must be signed and dated by the plan participant prior to rendering the specific service(s) in question. Retain a copy of this consent in the plan participant's medical record. In those instances in which you know or have reason to know that the service may not be covered (as described below), the written consent also must: (a) include an estimate of the charges for that service; (b) include a statement of reason for your belief that the service may not be covered; and (c) in the case of a determination by us that planned services are not covered services, include a statement that UnitedHealthcare has determined that the service is not covered and that the plan participant, with knowledge of UnitedHealthcare's determination, agrees to be responsible for those charges.

You should know or have reason to know that a service may not be covered if:

- We have provided general notice through an article in a newsletter or bulletin, or information provided on our website (UHCprovider.com), including clinical protocols, medical and drug policies, either that we will not cover a particular service or that a particular service will be covered only under certain circumstances not present with the plan participant;
- We have made a determination that planned services are not Covered Services and have communicated that determination to you on a previous occasion; or
- We have provided a benefit predetermination for the planned services in question, thereby providing all parties with a clear understanding of the coverage, or lack of coverage, available before provision of the service. Benefit predeterminations are particularly helpful when a service/item is not specifically mentioned as a plan exclusion and provide clarity for services that may be considered cosmetic or where the case appears to involve both cosmetic and functional aspects.

You must not bill plan participant for non-covered services if you do not comply with this protocol. And, you must still submit a claim to UnitedHealthcare for benefit consideration.

If you do not obtain written consent as specified above, the rendering provider must accept full financial liability for the cost of care. General agreements to pay, such as those signed by the plan participant at any time of admission or upon the initial office visit, are not considered written consent under this Protocol.

Incomplete/Missing Claim Information

A plan participant may not be billed for services for which a claim submission has been returned to the physician or provider for lack of information or where a claim has never been submitted. For required information on claim submission, please refer to [Section 5, "Claims Overview."](#)

Non-Notification

Although you are encouraged to assist your patients with program compliance, enrollees are responsible for fulfilling notification requirements where necessary. Varying levels of benefit reductions are applied when required notifications are not made. You may bill the patient for the amount of the reduction if/when one applies to your services. Additional information concerning notification requirements can be found in [Section 7, "Empire Plan Care Coordination."](#)

Covered Services Not Medically Appropriate

Benefits are provided for only those covered services which are determined to be medically appropriate by UnitedHealthcare. When the medical appropriateness cannot be established for an otherwise covered service rendered by a participating provider, no benefits are issued. And, the provider cannot bill the plan participant, unless the patient agreed in writing to make payment prior to receiving the service having specific knowledge that plan reimbursement would not be forthcoming. This is often accomplished by having the patient give written consent after receiving a predetermination of benefits decision from UnitedHealthcare.

Covering Physicians

If you are unable to provide care and want to arrange for a substitute, we ask that you try to arrange for care from other physicians and health care professionals who participate with the UnitedHealthcare Empire Plan Network. For the most current listing of network physicians and health care professionals, review our physician and provider directory at www.EmpirePlanProviders.com.

Should a non-network physician/provider be used, benefits will be paid out-of-network.

Coordination of Benefits

Coordination of benefits (COB) is the procedure used to pay health care expenses when a person is covered by more than one insurer or plan which provides health care benefits. Coordination of benefits is administered according to the customer's benefit contract and in accordance with applicable statutes and regulations.

Identification of the Primary Payer and Claim Submission

Prior to submitting a claim, it is important to determine if any other payer, including Medicare, has primary responsibility for payment of a claim. The identification of the primary payer prior to claim submission will improve the efficiency and accuracy of the claim payment process. "Primary plan" means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration.

For the Empire Plan, when more than one plan covers the person making the claim, the order of benefit payment is determined using the first of the following rules which applies:

- The benefits of the plan which covers the person as an enrollee are determined before those of other plans which cover that person as a dependent;
- When the Empire Plan and another plan cover the same child as a dependent of different persons called "parents" and the parents are not divorced or separated:
 - The benefits of the plan of the parent whose birthday falls earlier in the year are determined before those of the plan of the parent whose birthday falls later in the year; but
 - If both parents have the same birthday, the benefits of the plan which has covered one parent for a longer period of time are determined before those of the plan which has covered the other parent for the shorter period of time;
 - If the other plan does not have the rule described in preceding two bullets, but instead has a rule based on gender of the parent and, if as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits:
 - The word "birthday" refers only to month and day in a calendar year, not the year in which the person was born.
- If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
 - First, the plan of the parent with custody of the child;

- Then, the plan of the spouse of the parent with custody of the child; and
- Finally, the plan of the parent not having custody of the child; and
- If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of the terms, the benefits of that plan are determined first. This paragraph does not apply to any benefits paid or provided before the entity had such knowledge.
- The benefits of a plan which covers a person as an employee or as the dependent of an employee who is neither laid-off nor retired are determined before those of a plan which covers that person as a laid-off or retired employee or as the dependent of such an employee. If the other plan does not have this rule, and if as a result, the plans do not agree on the order of benefits, this rule is ignored.
- If none of these rules determined the order of benefits, the plan which has covered the person for the longest period of time determines its benefits first.

If it is determined that another payer is primary, that payer or Medicare should be billed prior to billing UnitedHealthcare. When a balance is due after receipt of payment, submit a claim for that balance including the following information:

- The amount received from the primary plan
- A copy of the other plan's Explanation of Benefits statement.

Note: If the patient is enrolled in Medicare Crossover, it is not necessary to submit a claim to UnitedHealthcare for secondary payment. Medicare does this for you electronically.

If a condition is related to the patient's employment or is the result of an automobile accident, workers' compensation or no fault may apply. For workers' compensation claims, the patient's employer should be contacted. For automobile accident claims, the no fault carrier should be billed as the primary payer.

If UnitedHealthcare is primary, submit the claim as usual.

Impact of Medicare

Retired Employees and/or their Dependents

If a retired employee or dependent is eligible for primary coverage under Medicare - even if s/he fails to enroll - covered medical expenses will be reduced by the amount that would have been paid by Medicare, and UnitedHealthcare will consider the balance for payment, subject to applicable copayments. When Medicare pays primary, covered expenses will be based on Medicare's limiting charge, as established under federal or, in some cases, state regulations rather than the network fee schedule.

Active Employees and/or their Dependents

The Empire Plan will automatically be the primary payor for active enrolled employees, regardless of age, and for the employee's enrolled dependents (except for domestic partner eligible for Medicare due to age) unless end stage renal disease provisions apply. Medicare will be secondary payor. (Note for domestic partners: Under Social Security law, Medicare is primary for an active employee's domestic partner who becomes Medicare eligible at age 65. If the domestic partner becomes eligible due to disability, the Empire Plan is primary.)

Disability

Medicare provides coverage for persons under age 65 who are disabled according to the provisions of the Social Security Act. The Empire Plan is primary for disabled active employees and disabled dependents of active employees. Retired employees, vested employees and their enrolled dependents who are eligible for primary Medicare coverage because of disability must enroll in Parts A and B of Medicare and apply for available Medicare benefits. Empire Plan benefits are reduced to the extent that Medicare benefits could be available.

End Stage Renal Disease

For those eligible for Medicare due to end stage renal disease, whose coordination period began on or after March 1, 1996, the Empire Plan will be primary for the first 30 or 33 months of treatment, depending on the situation. Then, Medicare becomes primary. Benefits are reduced to the extent that Medicare benefits could be available.

Medicare+Choice HMOs

If an Empire Plan enrollee enrolls in a Health Maintenance Organization under a Medicare+Choice Contract, the Empire Plan will not provide benefits for any services available through the HMO or services that would have been covered by the HMO if the patient had complied with the HMO's requirements for coverage. Covered medical expenses under the Empire Plan are limited to expenses not covered under the Medicare+Choice Contract with the HMO. If the HMO Medicare+Choice Contract has a Point-of-Service option that provides partial coverage for services received outside the HMO, covered medical expenses under the Empire Plan are limited to the difference between the HMO's payment and the amount of covered expenses under the Empire Plan.

COB, Fee Schedule

When Medicare or another primary carrier pays benefits first, the total of the primary payer's payment, UnitedHealthcare's payment, and the plan participant's copayment represents payment in full to participating providers. This remains true even if the total paid is less than the amount initially billed and/or the primary payer applies all or a portion of its approved amount to a deductible and pays \$0 or a nominal amount.

When the patient is covered by more than one plan, you should not collect charges that may be covered through coordination of benefits. This would include not collecting copayments. By following this procedure, you will save the time and expense of reconciling payments and remitting reimbursement checks to plan participants who have dual coverage. However, if you do collect payments from the plan participants in error, you are required to reimburse the plan participant.

After Payment Has Been Received

After payment is made, if it is determined that another payer or Medicare is primarily responsible for all or a portion of the claim, UnitedHealthcare requests your cooperation in collecting from the other payer, including providing any documents reasonably required or appropriate for this purpose.

Subrogation

We reserve the legal right to recover benefits paid for a customer's health care services when a third party causes the customer's injury or illness. Subrogation does not change the procedure for processing claims. We process the claim and pay for covered services at established fees. Subrogation activities take place after claims have been processed for payment.

Many subrogation cases result from automobile accidents. You can help us identify subrogation cases by using the accident codes found in the latest edition of the ICD manual or its successor version; you should also provide additional information regarding the nature of the injury or illness in the space provided on the claim form.

Post-Payment Audits

Post-payment audits may be conducted by UnitedHealthcare, UnitedHealthcare's customer (eg, New York State), or a UnitedHealthcare representative. In such cases, an independent audit firm may be employed by to conduct the audit. You must make the necessary information available (e.g., patient's medical and billing records) to ensure a successful audit.

Administrative Fees

UnitedHealthcare will not pay administrative fees for or connected with audit purposes.

Overpayments

If you or UnitedHealthcare identifies a claim where you were overpaid, we ask that you refund the overpayment within 30 calendar days from the date you identify the overpayment or from the date of our written refund request. If your payment is not received by that time, we may apply the overpayment against future claim payments.

Examples of situations that may require a refund are:

- If UnitedHealthcare pays benefits for covered medical expenses and it is subsequently found that we paid more benefits than we should have paid because all or some of the expenses would not have been the participant's liability or were paid by another source.
- If benefits are paid by UnitedHealthcare for non-covered expenses.
- Overpayments identified through claim audits or administrative reviews.

Depending on the type of overpayment, we may make the claim adjustment(s) without requesting additional information from the network physician. You will see the adjustment on the Explanation of Benefits (EOB). When additional or correct information is needed, we will ask you to provide it.

If you disagree with a claim adjustment, you can appeal the determination (see claim appeals). Offsets will continue during the claim appeal process.

You are required to submit complete and accurate claims for all services rendered for Empire Plan enrollees and enrollees of the additional covered groups. In addition to facilitating claim payment, this information may be used for physician and provider profiling and to identify candidates for disease management and preventive care programs.

Claims Process

1. **Register for uhcprovider.com**, our free Web site for network physicians and health care professionals. At UHCprovider.com, you can check eligibility and claims status – and submit claims electronically, for faster claims payment. To register, go to the site and select “New User” or call 1-866-UHC-FAST (1-866-842-3278).
2. **Once you’ve registered, review the patient’s eligibility on the Web site at uhcprovider.com**. To check patient eligibility by phone, call Customer Care using the number found in [Section 1](#) or on the patient’s ID card.
3. **Notify us of planned procedures and services on the notification list.** See [Section 7](#) for list.
4. **Prepare a complete and accurate claim form.** See “Complete Claims” later in this section.
5. **Submit the claim no later than 120 days after the end of the calendar year in which covered services are rendered.**
 - **Electronic Claims.** Claims must be submitted electronically whenever possible using UHCprovider.com or any of a number of other electronic options available. Our electronic payer ID is 87726. For more information or assistance regarding electronic claim submission, call our EDI unit at 1-800-842-1109.
 - **Paper Claims.** For claims that cannot be submitted electronically, submit paper claims for the additional covered groups to the claims address on the patients ID card and claims for The Empire Plan to:

Empire Plan Claims
UnitedHealthcare
PO Box 1600
Kingston, NY 12402-1600
 - **Claims Submitted Late.** When payment is denied because the claim was submitted late, the participating provider cannot bill the patient for the services in question beyond the copayment typically collected at the time of service.
 - **Reconsideration for Untimely Denials.** Provider may request reconsideration of claims that were denied solely because they were deemed untimely submissions. United will pay an untimely claim if the Provider can demonstrate:
 - i. The untimely submission was the result of an unusual occurrence; and
 - ii. Provider has a pattern of timely claims submissions.If these two items are met, United may reduce the reimbursement by an amount not to exceed 25%. This does not apply to claims submitted one (1) year after the date of service which may be denied in full as untimely.
 - If you are requesting review of a claim that was denied because filing was not timely, for:
 - Electronic claims - include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.
 - Paper claims - include a copy of a screen print from your accounting software to show the date you submitted the claim.
 - Delay by primary carrier - include the Medicare or other carrier benefit statement showing the date the primary carrier processed the claim.
 - Litigation, court action, or other unique circumstances - include documented evidence that the delay was beyond your control.
6. **Receive electronic payments and statements.** Optum Pay offers electronic funds transfer (ACH)/direct deposit and electronic remittance advice (ERA) services. Optum Pay is the preferred method of receiving ACH/direct deposit payment from us. Printable and downloadable provider remittance advice (PRA) documents related to those ACH/direct deposit payments are also accessible in the Optum Pay portal. For more

information, visit [Electronic Payment Solutions](#) at [uhcprovider.com](#). Other options for paperless PRAs in the [UnitedHealthcare Provider Portal Document Library](#) and [Electronic Data Interchange \(EDI\)](#).

Complete Claims

Whether you use an electronic or a paper form, complete an Empire Plan form, a CMS form, or any other industry standard accepted form, a complete claim includes the following information. For particular types of services or based on particular circumstances or state requirements, additional information may also be required.

General Requirements:

- Patient's name, sex, date of birth and relationship to subscriber
- Subscriber's name, address and ID number
- Subscriber's employer group name and group number
- Name, signature, 'remit to' address and phone number of physician or provider performing the service, as in your contract document
- Physician's or provider's federal tax ID number
- Physician's or provider's NPI number
- Referring physician's name (if applicable)
- Referring physician's NPI number (if applicable)
- Date of service(s), place of service(s) and number of services (units) rendered
- Current CPT and HCPCS procedure codes with modifiers where appropriate
- Current ICD diagnostic codes by specific service code to the highest level of specificity
- Charges per service and total charges
- Information about other insurance coverage, including job-related, auto or accident information, if available
- Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers
- Attach a detailed description of the procedure or service provided for claims submitted with unlisted medical or surgical CPT or "other" revenue codes as well as experimental or reconstructive services
- Attach the current NDC number for claims submitted with unlisted drug codes
- Include nursing shift hours and attach nursing notes and treatment plan for claims submitted for home health care, nursing or skilled nursing services
- If you need to correct and resubmit a claim, use [UHCprovider.com](#) or submit a Paper Claim Reconsideration Request Form.

Laboratory Claim Requirements:

- All laboratory claims must include the NPI of the referring physician.

Anesthesia Claim Requirements:

- One of the CMS required modifiers (AA, AD, QK, QX, QY, QZ) must be used for anesthesia services reporting
- For electronic claims, report the actual number of anesthesia minutes in loop 2400 SV104 with qualifier MJ in loop 2400 SV103. For CMS-1500 (12-90) paper claims, report the actual number of minutes in Box 24G with qualifier MJ in Box 24H. For CMS-1500 (08-05) paper claims, report the duration in minutes with start and end times in shaded areas of fields 24 A-K, the total minutes in field 24G for each applicable service line, and qualifier 7.
- When medically directing residents for anesthesia services, the modifier GC must be reported in conjunction with the modifier AA or QK
- When reporting obstetrical anesthesia services, use add-on codes 01968 or 01969, as applicable, on the same claim as the primary procedure 01967
- When reporting qualifying circumstance qualifier codes 99100, 99116, 99135 and/or 99140, report the qualifier on the same claim as the anesthesia service
- Additional anesthesia claim and payment information is available in this Guide under Provider Payment Methodologies, via [UHCprovider.com](#) under Policies & Protocols, and upon request from Customer Care or your network account manager.

Additional information needed for a complete UB-04 form:

- Date and hour of admission and discharge as well as patient status-at-discharge code
- Type of bill code
- Type of admission (e.g. emergency, urgent, elective, newborn)
- Current revenue code and description
- Current principal diagnosis code (highest level of specificity)
- Current other diagnosis codes, if applicable (highest level of specificity)
- Attending physician ID
- Referring physician's name (if applicable)

- Bill all outpatient surgeries with the appropriate revenue and CPT code if reimbursed according to ambulatory surgery groupings
- Provide specific CPT and/or HCPCS code(s) and appropriate revenue code (e.g. laboratory, radiology, diagnostic or therapeutic) for services reimbursed based on a contractual fee maximum
- Attach an itemized list of services or complete box 45 for physical, occupational or speech therapy services (revenue code 420-449) submitted on a UB-04
- Submit claims according to any special billing instructions that may be indicated in your agreement (or letter of agreement)

Claims missing any of the required information cannot be processed. Physicians and providers submitting claims without the required information will be notified the claim cannot be processed and advised what additional information is needed to enable adjudication. An enrollee cannot be billed for services where the claim submission has been returned to the physician or provider for lack of information.

Correspondence

Any correspondence concerning claims should include the claim number noted on the Explanation of Benefits (or a copy of the Explanation of Benefits). Also include the plan enrollee's name, alternate identification number, and the group contract holder name and number, all of which also appear on the EOB.

Coverage Payment Policies

Coding Criteria

UnitedHealthcare's standard is to accept current CPT, ICD and HCPCS codes and modifiers. This is the accepted methodology for coding all claim submissions. However, acceptance of a code or modifier does not imply payment or additional payment for the service or situation identified by that code or modifier.

Level III local HCPCS codes should not be used. Level III local HCPCS codes are those codes within the range from W0000 to Z0000.

Provider Payment Methodologies

Unique billing situations and provider payment methodologies may exist or develop. UnitedHealthcare calculates covered expenses following evaluation and validation of all provider billings in accordance with the methodologies in the most recent edition of CPT or as reported by generally recognized professionals or publications. Expenses denied due to our provider payment methodologies cannot be billed to the plan enrollee. [Reimbursement Policies, Medical and Drug Policies, and Coverage Determination Guidelines](#) are available via uhcprovider.com and upon request from Customer Care or your network account manager.

Topics include but are not limited to:

- *After-Hours and Weekend Care*
- *Anesthesia*
- *Assistant Surgeons*
- *Care Plan Oversight*
- *Increased Procedural Services*
- *Laboratory Services, Handling, & Venipuncture*
- *Obstetrical Services*
- *Preventive Medicine and Screening*
- *Professional and Technical Components*
- *Private Duty Nursing*
- *Rebundled Charges*
- *Standby Services*
- *Telemedicine*

Please also note:

- *Charges for Medical Records* Medical record charges are fees for duplicating a patient's medical record. Medical record charges will be denied for network physicians, ancillary providers and facilities. Please refer to sections 5.8 and 5.9 of the Base Agreement for additional information and [Section 8](#) of this Guide.

- *Copayment / Coinsurance Waiver* It is considered an unacceptable billing practice for a physician or provider to waive a copayment or coinsurance obligation. A copayment is an expense that the plan participant is legally obligated to pay. Physicians and providers should collect copayments and coinsurance as defined by the plan participant's benefit plan.
- *Facility Fees for Professional Office Visit Services* UnitedHealthcare does not cover clinic facility fees, often billed under revenue codes 510-529. Payment for facility fees associated with office services is included in the physician professional fee and is not paid separately.
- *Immunizations* Coverage standards vary by customer and health plan. For the Empire Plan, routine well-child immunizations are covered for children up to age 19 including the cost of oral and injectable substances, according to prevailing pediatric clinical guidelines. In addition, for certain Empire Plan members, coverage is also available for flu vaccinations and certain adult immunizations, according to prevailing Centers for Disease Control and Prevention (CDC) guidelines.
- *Multiple Procedures* If you are performing multiple procedures, bill your full normal charge for each procedure; we will adjust payment appropriately per our guidelines for multiple procedures. For the Empire Plan, coverage for multiple procedures is 100% of the allowable amount for the primary procedure and 50% of the allowable amounts for the secondary procedure and non-incident subsequent procedures. For the other covered groups that access the Empire Plan network, the payment guidelines may vary by customer benefit plan design.
- *Non-Medically Appropriate Services* UnitedHealthcare does not cover charges for services that are not medically appropriate. This includes facility, physician and ancillary charges.
- *Taxes* Applicable sales tax is incorporated into the fee schedule allowance and will not be reimbursed as a separate item.
- *TB Tine Test* UnitedHealthcare does not cover TB Tine Tests formerly identified by CPT code 86585. The TB Tine Test is considered to be clinically ineffective in testing for tuberculosis; the Mantoux is now the test of choice (CPT code 86580) for patients at risk. This is supported by the Centers for Disease Control and Prevention and the American Academy of Pediatrics, as well as other respected professional organizations.
- *Urgent Care Centers* Urgent Care services are covered as professional services and charges for the use of a facility to render office services are included within the payment for the professional charge. Therefore, "facility charges" are NOT covered by UnitedHealthcare and are not billable to the UnitedHealthcare plan participant.

Urgent Care Centers billing on UB-04 forms must include:
 - ICD diagnosis coding
 - CPT procedure coding
 - Code 891 in Box 4 of the form (for identification)
 - Revenue code 456.
 Urgent Care Centers billing on HCFA 1500 must include:
 - ICD diagnosis coding
 - CPT procedure coding.
 In addition, the Urgent Care Center must bill under a unique facility tax identification number, or clearly write URGENT CARE VISIT in Box 19 and the amount of copayment received at the time of the visit.

Claim Reconsideration & Appeals

The process described below allows for a TOTAL of 180 calendar days for timely submission of both a Claim Reconsideration Request and an Appeal, NOT 180 days for Claim Reconsideration plus another 180 days for Appeal.

Claim Reconsideration

A claim reconsideration is a request to reconsider a processed claim regarding which the Provider does not agree with the outcome of the original payment/corrected claim.

Timeframe: You must submit your Claim Reconsideration Request within 180 calendar days from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA) as required by law, together with a completed UnitedHealthcare Claim Reconsideration Request form.

How to Submit Your Reconsideration Request: If you believe we underpaid you, the first step in addressing your concern is to submit a Claim Reconsideration Request.

- Online:

Submit your request via the [UnitedHealthcare Provider Portal](https://uhcprovider.com) available at uhcprovider.com.

- Paper:

A [Single Claim Reconsideration/Corrected Claim Request](#) form can be found at uhcprovider.com.

Complete the form as noted in the instructions and mail to the applicable address noted on the EOB along with all required documentation.

If you are submitting a request for a claim which was denied requesting medical documentation, check "Previously Denied/Closed for Additional Information" as your reason for request.

Provide a description of the documentation being submitted along with all pertinent documentation. It is extremely important to include the customer name and health care ID number as well as the provider name, address, and TIN on the Paper Claim Reconsideration Request Form to prevent processing delays.

- Phone:

You can call the number on the EOB or customer's health care ID card to request an adjustment for a claim that does not require written documentation.

Note: If you have a request involving multiple claims with the same denial reason, use the UnitedHealthcare Provider Portal Claim Research Project tool at uhcprovider.com.

Appeals

If you do not agree with the outcome of the Claim Reconsideration decision, you may follow the Appeal process outlined below. You may also follow the below Appeal process if a pre-service request for benefits (a request for benefits that requires notification, precertification, or benefit confirmation prior to receiving medical care) is denied in whole or in part. In the event that a covered person has authorized you to appeal a clinical or coverage determination on the covered person's behalf, such an appeal will follow the process governing covered person appeals as outlined in covered person's benefit contract or handbook.

Level 1 Appeal

Timeframe: An appeal request must be directed to UnitedHealthcare within 180 calendar days from the date of the original Explanation of Benefits (EOB) or Provider Remittance Advice (PRA).

How to Submit Your Appeal: Submit an appeal by writing to the address indicated on the EOB or letter notifying you of the denial/payment. State the reason(s) why you believe the claim determination or precertification improperly reduced or denied benefits. Also, submit any data, documentation, and/or comments to support the appeal of the original determination as well as any data or information requested by UnitedHealthcare.

Response: A written acknowledgment of your appeal will be sent to you within 15 calendar days after it is received.

For a first level appeal of a post-service claim, a review of the appeal will be done, and UnitedHealthcare will provide you with a written decision within 30 calendar days of your request.

For a first level appeal of a pre-service request for benefits, a review of the appeal will be done, and UnitedHealthcare will provide you with a written decision within 15 calendar days of your request.

If the determination is upheld, UnitedHealthcare's written response will cite:

- The specific Plan provision(s) upon which the denial is based;
- Detailed reason(s) for the determination regarding the appeal;
- If the case involves a clinical matter, the clinical rationale for the determination;
- Notification of your right to a further review.

Level 2 Appeal

Timeframe: If, as a result of the Level 1 review, the original determination of benefits is upheld by UnitedHealthcare, in whole or in part, you can request a Level 2 review no later than 60 calendar days after you receive notice of the Level 1 appeal determination.

How to Submit Your Level 2 Appeal: This request may be directed either in writing or by telephone to UnitedHealthcare. When requesting the Level 2 review, state the reason(s) you believe the benefit reduction or denial was improperly upheld and include any information requested by UnitedHealthcare along with any additional data, questions, documentation, and/or comments deemed appropriate.

Response: For a second level appeal of a post-service claim, a review of the appeal will be done, and UnitedHealthcare will provide you with a written decision within 30 calendar days of your request.

For a second level appeal of a pre-service request for benefits, a review of the appeal will be done, and UnitedHealthcare will provide you with a written decision within 15 calendar days of your request.

If the determination is upheld, UnitedHealthcare's written response will cite:

- The specific Plan provision(s) upon which the denial is based;
- Detailed reason(s) for the determination regarding the appeal;
- If the case involves a clinical matter, the clinical rationale for the determination.

Appeals Involving Urgent Situations

If an appeal involves a situation in which a delay in treatment could significantly increase the risk to health, the ability to regain maximum function, or cause severe pain, the appeal will be resolved and you will be notified of the determination in no more than 72 hours following receipt of the appeal. Notice of the determination will be made directly to the person filing the appeal.

Overview of Empire Plan Features

A number of features are included in The Empire Plan to help guide its members through the sometimes complex health care delivery system. These features also help ensure that the health care which plan participants receive is appropriate. In this Guide, we refer to these features collectively as Care Coordination Activities.

Some of these features are informational in nature, while others offer a higher level of benefits when certain requirements are met. They include UnitedHealthcare's Empire Plan provider network procedures and protocols. They also include educational resources and programs administered by UnitedHealthcare and/or other vendors that focus on particular areas of health care.

In general, for those that focus on particular areas of health care, plan participants are responsible for either notifying the program vendor of certain services or for utilizing program providers who are responsible for such. However, UnitedHealthcare's Empire Plan network providers are expected to assist their Empire Plan patients in complying with these programs whenever possible.

For additional details on the programs that follow, you may wish to ask your patients to share the coverage and/or reference documents they have received. You may also contact each program using the numbers found in ["Section 1: How to Reach Us."](#)

UnitedHealthcare's Empire Plan Provider Network Procedures

Services Network Providers Are Expected to Perform or Provide

Physicians, facilities, and other health care professionals are expected to perform, at a minimum, all of the following functions applicable to their areas of expertise:

- When initiating care, the physician must remain accountable for his or her patient's care in an acute care facility/hospital, nursing home, and at home.
- Properly coordinate referrals to other physicians and health care professionals.
- Provide 24-hour, seven days per week telephone access and on-call / substitute coverage. When arranging substitute coverage, we ask that you try to arrange for care from other physicians and health care professionals who participate with the UnitedHealthcare Empire Plan Network. For the most current listing of network physicians and health care professionals, review our physician and provider directory at the internet web site address found in "Section 1: How to Reach Us." Should a non-network physician/provider be used, benefits will be paid out-of-network.
- Schedule appointments in a manner that provides enrollees with reasonable access to health care physicians, providers, and services. UnitedHealthcare recommends the following access standards for appointment availability:
 - Initial appointment for routine health assessment, available within four weeks
 - Initial appointment for urgent problem available within one day
 - Initial appointment for non-urgent care available within three weeks
 - Routine follow-up available within 10 days. Follow-up for problems involving symptoms available within five days.
- Supervise physician assistants and advanced nurse practitioners in accordance with state licensing and regulatory requirements.
- Follow-up and coordinate care with physicians, ensuring that consultation notes are filed in the patient's chart, proper actions are taken, and follow-up care is provided.
- Work collaboratively with UnitedHealthcare and other Empire Plan vendors.

Referral Procedures

Anesthesia Services

Provider will ensure that all anesthesia services rendered at Provider's practice location with regard to Covered Persons are rendered by participating providers for as long as the Agreement is in effect.

Laboratory Services

Provider will conduct any office laboratory services in a Clinical Laboratory Information Act (CLIA) certified office laboratory and will be reimbursed for only those services that provider is certified through CLIA to perform. Provider cannot bill plan participants for any laboratory services for which provider lacks the applicable CLIA certification. In those instances where Provider collects the specimen in the office but does not perform the laboratory services, all such laboratory work must be directed to a network commercial laboratory.

Other Services

When a UnitedHealthcare Empire Plan network physician or provider determines that an Empire Plan participant requires treatment or care/services from another practitioner, the physician or provider will use reasonable efforts to refer the participant to another network provider or to a provider participating in the programs referenced below, whenever appropriate.

For participating provider directory information, please visit the internet web site address found in [Section 1, "How to Reach Us,"](#) or contact the appropriate program vendor(s) as noted in Section 1.

Network Provider Compliance Requirements

All network physicians, hospitals and other health care providers are required by contract to comply with UnitedHealthcare's programs and protocols. Compliance with the Care Coordination Activities is required in the following areas:

Provide Timely Information as Requested

Physicians, hospitals and other health care providers are expected to work collaboratively with UnitedHealthcare and other plan vendors. This includes, but is not limited to, returning telephone calls and providing information, such as medical records, as requested and in a timely manner.

Provide Timely Care Consistent with the Medical Needs of the Member

As soon as it is determined that a member requires a medical service, test or procedure, the service should be performed as soon as reasonably possible.

Confidentiality of Records

As noted in [Section 8](#) of this Guide, physicians, hospitals and other health care providers must maintain the confidentiality of all member medical records in accordance with any applicable statutes and regulations.

Consolidated Appropriations Act (CAA) Requirements

Advanced EOB Network Considerations

Consistent with the Consolidated Appropriations Act (CAA), we must provide information to our members about costs related to the services you provide them. You agree to help us provide them this information. You will provide information about the rules on balance billing under this act, as well as any other state law that requires you to advise our members about what you may charge them after we pay you. In addition, you agree to provide contact information for appropriate state and federal agencies in case a member believes you have violated balance billing rules.

Continuity of Care

Health insurance issuers, plan sponsors and/or health care providers are required to comply with the Continuity of Care requirements under the CAA unless your participation agreement states otherwise. Continuity of Care is provided in the following circumstances:

1. Your participation agreement with us or between you and a downstream provider is terminated by us, a payer, you or a downstream provider.
2. The terms of your network participation with us or a payer changed, and that change leads to certain members no longer receiving in-network coverage for your care.

3. A fully insured group contract between us and a group health plan terminated and that termination leads to members no longer receiving in-network coverage for your care.

Under the CAA, Continuity of Care must be offered to members in your care or the care of your downstream contracted providers who are:

1. Undergoing treatment for a serious and complex medical condition.
2. Undergoing inpatient or institutional treatment.
3. Scheduled to undergo nonelective surgery, including receipt of postoperative care with respect to such a surgery.
4. Pregnant and receiving treatment related to the pregnancy.
5. Terminally ill per the Social Security Act and receiving treatment for the terminal illness.

In accordance with the CAA, you must accept payment from us or a payer based on your participation agreement and negotiated rates for any services rendered pursuant to the Continuity of Care requirements under the CAA. Any care you render to a member under Continuity of Care is subject to our or any payer's applicable policies, procedures and quality standards.

You also acknowledge additional rights for Continuity of Care may be required under state or local law or as specifically required in your participation agreement with us.

Provider Directory

Consistent with the CAA, we will verify information in our provider directory. You will provide us with accurate information and respond to our questions when you receive them. You will respond within any time period listed in the communication we send to you. We may remove health care providers and facilities from the provider directory if we can't verify information.

CAA Prohibition on Gag Clauses

Your participation agreement may include a confidentiality provision that lists information that neither party may disclose to a member, health care provider or other third party except as required by an agency of the government. You agree the CAA constitutes such a requirement by an agency of the government, and nothing in your participation agreement will be interpreted to supersede or conflict with the CAA. Specifically, your participation agreement will not be interpreted to directly or indirectly restrict us (as a health insurance issuer offering group and individual health insurance coverage) or a group health plan from:

1. Providing provider-specific cost or quality of care information to referring health care providers or current and potential members.
2. Electronically accessing de-identified claims and encounter information for each member in the plan or coverage, upon request and consistent with the privacy regulations related to section 264(c) of the Health Insurance Portability and Accountability Act (HIPAA), the amendments made by the Genetic Information Nondiscrimination Act of 2008, and American with Disabilities Act of 1990. This includes, on a per claim basis the following:
 - a. Financial information
 - b. Provider information
 - c. Service codes
 - d. Any other data included in claim or encounter transactions
3. Sharing information with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with HIPAA6, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990

Other UnitedHealthcare Procedures / Requirements

Retrospective Review

UnitedHealthcare may conduct retrospective review of services provided to an Empire Plan enrollee. Retrospective review of any case may include:

- Review of the appropriateness of care if not reviewed previously
- Review of the coding of diagnoses and procedures
- Review for any quality concerns or opportunities to improve the care or outcome

Outcomes

UnitedHealthcare's Care Coordination Activities are designed to help facilitate and coordinate requested health care services in order to achieve care that is:

- Consistent with national standards of medical care.
- Provided at the appropriate level of care and service.
- Rendered without delays in service.
- Timely in meeting the needs of the enrollee.
- Effective in identifying gaps in care, and opportunities to improve care and reduce re-admissions.
- Covered under the enrollee's benefit plan.

Medically Necessary or Medical Necessity

Specific benefit plans may include additional criteria UnitedHealthcare must verify and use when conducting Care Coordination activities and making review determinations, including retrospective review.

For the Empire Plan, covered health care services and supplies must be medically appropriate, and:

- necessary to meet the basic health needs of the Covered Person;
- rendered in the least intensive and most appropriate setting for the delivery of the service or supply;
- consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by UnitedHealthcare;
- consistent with the diagnosis of the condition;
- required for reasons other than the comfort or convenience of the Covered Person or his/her Physician; and
- demonstrated through prevailing peer-reviewed medical literature to be either:
 - safe and effective for treating or diagnosing the condition or sickness for which their use is proposed, or,
 - safe with promising efficacy for treating a life threatening sickness or condition, in a clinically controlled research setting, and using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of these criteria, the term "life threatening" is used to describe sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or pregnancy does not mean that it is a medically appropriate Covered Medical Expense as defined in the Covered Person's benefit contract. These criteria relate only to coverage and may differ from the way in which a Physician engaged in the practice of medicine may define a medically appropriate service.

Services and supplies that do not meet these criteria are not covered and will not be paid. Please refer to the "Appeals" heading in this Section 5 of this Guide for information regarding appeals of such decisions.

There may be instances when a Medical Director will review the medical treatment plan of a member with you. The Medical Director may discuss the reasoning or indication that led you to the proposed or performed procedure/treatment.

Clinical Review Guidelines

UnitedHealthcare utilizes externally licensed clinical guidelines and internally developed medical policies when conducting Care Coordination Activities and retrospective reviews.

UnitedHealthcare's Empire Plan Care Coordination Activities

UnitedHealthcare's Care Coordination Activities focus on assisting members to facilitate and coordinate access to care by offering timely health education programs, helping identify and prevent delays in service(s) and working to eliminate gaps in care while providing support to members with health care needs. For the Empire Plan, UnitedHealthcare's Care Coordination Activities include:

<i>Home Care Advocacy Program</i>	A program designed to facilitate the implementation of the physician's treatment plan by helping coordinate timely access to home care services, including durable medical equipment/supplies, home nursing, and home infusion.
<i>Specialty Care Coordination</i>	Programs designed to provide information and access to Centers of Excellence for highly specialized medical fields, such as infertility treatment.
<i>Disease Management</i>	Programs that provide self-care education and condition monitoring for members with chronic health conditions.
<i>Health Education</i>	Services that provide an ongoing source of general health information including telephone access to registered nurses and recorded messages as well as online health information resources.
<i>Voluntary Case Management</i>	A voluntary program to help coordinate services for serious conditions.

Physician and Provider Expectations

Physicians, hospitals and other health care providers are required to work collaboratively with UnitedHealthcare and other Empire Plan vendors conducting Care Coordination Activities. This includes, but is not limited to, responding to telephone calls and providing information as requested and in a timely manner. Refer to the *Network Provider Compliance Requirements* heading in this section for more information.

Health Education

Our health education activities provide an ongoing source of health information, help with self-care and objective data to help members make health care decisions. We offer members:

- 24-hour telephonic health information and assistance services through Empire Plan NurseLine
- Online health information available via the www.myuhc.com web site.

Home Care Advocacy Program

UnitedHealthcare's Empire Plan Care Coordination Unit administers the Home Care Advocacy Program (HCAP), UnitedHealthcare's program for Empire Plan home care services, durable medical equipment, and certain supplies. An enhanced level of benefits is available, when Empire Plan participants call HCAP to arrange for certain services/items and use HCAP-approved providers. Services/items covered by HCAP include:

- Durable Medical Equipment & Integral Supplies
- Home Nursing Services
- Home Infusion Therapy
- Certain other home health care services and prescription drugs when the home care arranged through HCAP takes the place of hospitalization or care in a skilled nursing facility.

Specialty Care Coordination

Infertility Benefit Management Program

The Empire Plan Infertility Benefit Management Program is designed to facilitate and coordinate access to infertility specialists. The primary components are UnitedHealthcare's Care Coordination Unit and Centers of Excellence. **If there is a member for whom you are recommending infertility related services, including the initial evaluation, advise the member to contact the Care Coordination Unit prior to services being rendered.** Refer to the *Notification Requirements* heading in this section for more information.

<i>Care Coordination Unit's Role</i>	<p>UnitedHealthcare's Empire Plan Care Coordination Unit helps facilitate and coordinate:</p> <ul style="list-style-type: none"> ▪ Eligibility and benefit review ▪ Network education and guidance ▪ Health care services
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<i>Centers of Excellence</i>	<p>Centers of Excellence provide Empire Plan enrollees with access to a network of respected specialists that have demonstrated clinical excellence in the field of infertility. Current infertility services under contract through Centers of Excellence include patient education/program orientation, diagnostic testing, ovulation induction/hormonal testing, surgery to enhance reproductive capability, and certain specialized procedures that facilitate pregnancy but do not treat the cause of infertility.</p>
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Disease Management

UnitedHealthcare's disease management programs consist of interventions designed to help improve the outcome of members with specific chronic diseases by:

- Providing information and education on the member's disease
- Assisting the member in prevention of exacerbations
- Managing the course of their disease

The programs focus on education, self-care, compliance, and health status. The defined interventions are based on nationally accepted medical evidence. The clinical objective of these programs is to work with the member and their physician or other health care providers to achieve desired clinical outcomes.

For The Empire Plan, UnitedHealthcare provides a comprehensive and integrated disease management program for the most prevalent chronic conditions of diabetes, asthma, congestive heart failure, chronic obstructive pulmonary disease, coronary artery disease, and co-morbid conditions of hyperlipidemia, hypertension, depression and obesity. The program is completely voluntary and available to Empire Plan non-Medicare enrollees and their dependents.

Program design features include:

- At-risk, high-need individuals gain access to a personal nurse with condition expertise who can assess and address gaps in care, transfer skills and knowledge, and drive meaningful improvements in individual health;
- Scheduled outbound calls – nurse available to receive calls directly;
- Targeted evidence-based information, program overviews, tracking tools, health logs, self-care materials provided to those with low-intensity needs; all can access online condition-specific information;
- Variable intensity of outreach depending on risk stratification and individual needs;
- Integration and coordination with other clinical resources including NurseLinesm, case management, behavioral health, and hospital discharge planners.

Activities by Other Empire Plan Vendors

The following programs are administered by other vendors or other vendors in partnership with UnitedHealthcare. For contact information, please see "[Section 1: How to Reach Us.](#)"

Prescription Drug Program

Many Empire Plan members are covered by the New York State Empire Plan Prescription Drug Program. The program includes participating pharmacies, copayments, mandatory generic substitution, supply and coverage limits, prior authorization for certain drugs, and mail service pharmacy services. Empire Plan drug lists are available.

Empire Plan network physicians are expected to:

- Prescribe generic drugs whenever therapeutic equivalent drugs are available and/or let your patient know that an equivalent generic drug may be substituted for brand drugs under the benefit program;
- If phoning a prescription to a pharmacy, attempt to utilize a network pharmacy;
- Accept the call from a network pharmacy to notify you of a problem or ask a question regarding the prescribed drug;
- Participate in the prior authorization process when needed.

Mental Health and Substance Use Program

The Empire Plan's Mental Health and Substance Use Program provides comprehensive coverage for mental health and substance use care, including alcoholism. To receive the maximum benefits available under the program, plan participants must call the program administrator before seeking treatment and must follow the administrator's recommendations. Limited benefits may be available for medically appropriate care when they do not. The program includes a participating provider network, certification of covered services, and concurrent review.

Managed Physical Medicine Program

The Empire Plan's Managed Physical Medicine Program covers medically appropriate services typically performed by a chiropractor or physical therapist. Other providers, such as osteopaths and occupational therapists, may also provide these services. The provider must be licensed to perform such services in the state where the service is received, and physical therapy must be prescribed by a doctor. To receive the maximum benefits available, plan participants must use a provider in the administrator's network who is responsible for certifying medically appropriate care, or they must follow the administrator's recommendations when a network provider is not available. Limited benefits may be available for medically appropriate care when they do not.

Practitioners participating in UnitedHealthcare's Empire Plan network may also render services covered under this program. If so, you are required to comply with reviews conducted by the program administrator.

Summary of Notification Requirements

To ensure claims are considered for payment, notification is required for the procedures and services listed in the chart that follows. These services are likely to identify patients with unmet health care needs who will benefit from UnitedHealthcare's programs, or those of other Empire Plan vendors. In general, depending on the particular program, plan enrollees are responsible for either notifying Empire Plan program vendors of certain services or for utilizing program physicians or providers who are responsible for such.

Call 1-877-7-NYSHIP (1-877-769-7447) and follow the prompts to notify the appropriate program carrier/vendor as outlined below.

This notification list may be modified from time to time. The presence or absence of a procedure or service on this list does not mean that benefit coverage exists for that procedure or service. The enrollee benefit contract will determine whether a procedure or service is covered.

Service	Contact
Advanced Diagnostic Imaging Services - CT/CTA Scans, MRI/MRA, PET Scans, Nuclear Medicine/Cardiology	UnitedHealthcare Benefits Management Program
Alcoholism Treatment	Behavioral Health Program
Chiropractic Services	Managed Physical Network, Inc. (MPN) Managed Physical Medicine Program
Durable Medical Equipment & Integral Supplies - Mastectomy Prosthetics Over \$1,000 - Diabetic Shoes When The Empire Plan Is Primary - DME Items Listed on UHCprovider.com When The Empire Plan Is Primary: Advance Notification and Plan Requirement Resources UHCprovider.com	UnitedHealthcare Home Care Advocacy Program
Home Health Services That Take the Place of Hospitalization	UnitedHealthcare Home Care Advocacy Program
Home Infusion Therapy & Enteral Formula - Except administration of enteral formula via tube for patients whose primary coverage is Medicare	UnitedHealthcare Home Care Advocacy Program
Home Nursing Services	UnitedHealthcare Home Care Advocacy Program

Service	Contact
Hospital Admissions - Elective (Maternity is recommended if hospitalized more than 48 hours for vaginal delivery or 96 hours for cesarean delivery) - Emergency/Urgent (within 48 hours)	Empire Blue Cross Blue Shield Benefits Management Program
Infertility Services	UnitedHealthcare Infertility Benefit Program
Mental Health Services	Behavioral Health Program
Physical Therapy	Managed Physical Network, Inc. (MPN) Managed Physical Medicine Program
Prescription Drugs - As noted in Preferred Drug List or Flexible Formulary List	Prescription Drug Program
Skilled Nursing Facility Admissions	Empire Blue Cross Blue Shield Benefits Management Program
Substance Abuse Services	Behavioral Health Program

Section 7: UnitedHealthcare's Empire Plan Quality Improvement Program

Physician and Provider Participation

Physician and provider participation is an integral component of UnitedHealthcare's Empire Plan Quality Improvement Program. Network physicians are given a structured forum for input through representation on the committees described below. In addition, individual physicians are encouraged to give feedback to UnitedHealthcare via communication with Empire Plan Network Management.

Credentialing and Quality Improvement Committees

Committees meet on a regular basis. These committees review physician and provider applications and retention information and make recommendations for acceptance, rejection or termination. They also advise on and influence programs to measure, monitor, analyze and apply interventions to improve the quality of health care coverage and services.

Components of Program

You are expected to cooperate with our quality assessment and improvement activities and to comply with our clinical guidelines, patient safety (risk reduction) efforts and data confidentiality procedures. The Quality Improvement Program is a comprehensive program which may include the following components:

- Preventive health services monitors
- Current preventive health guidelines
- Quality improvement measures and studies
- Risk management
- Health promotion activities
- Compliance with all external regulatory agencies
- Care Coordination
- Ongoing monitoring of key indicators (e.g., mortality review, cesarean section rates, over and under utilization, continuity of care)
- Service measures and studies

The Quality Improvement Program is under the leadership of the medical director, Quality Improvement Committee and Network Management.

Selection and Retention of Network Physicians and Providers

UnitedHealthcare has established criteria for the selection and retention of physicians and providers for participation in its Empire Plan network. These credentialing criteria are reviewed at least annually. This section describes the criteria which are used for the initial and ongoing credentialing of physicians, hospitals, and ancillary providers, facilities, and companies. Nothing in this description limits UnitedHealthcare's discretion to accept and discipline network physicians and providers or grants rights to plan participants, physicians or providers.

Physician Credentialing

All of the information described in this section is reviewed during the initial application process. Review of information to evaluate the continued participation of physicians in UnitedHealthcare's Empire Plan Network is ongoing and periodic. Every three (3) years, UnitedHealthcare seeks to verify that each network physician continues to meet the established selection and retention credentialing standards. These standards and the method and frequency of validation are listed on the next page and are subject to modification by UnitedHealthcare at its sole discretion.

To streamline the credentialing and recredentialing processes, UnitedHealthcare is pleased to participate in an innovative Web-based credentialing application tool. The Council for Affordable Quality Healthcare's (CAQH) Universal Credentialing DataSource is a Web-based solution that enables certain health care professionals to complete credentialing applications online. With this tool, available at www.CAQH.org, health care professionals can control the data stored in the database, easily update it, and electronically submit it to participating health plans, like UnitedHealthcare. Once we receive the application, Aperture, our credentialing verification organization, verifies the credentials listed and may contact you as needed during the verification process.

Physician Credentialing Criteria

Criteria	Means of Validation	Frequency of Validation
<i>Current license or other authorization to practice</i>	<ul style="list-style-type: none"> Primary verification with state licensing agency 	Every 3 years
<i>Completion of highest level of education or training, including Board Certification</i>	<ul style="list-style-type: none"> Primary verification with certifying entity 	Every 3 years if not initially board certified, or at time of required recertification, if applicable
<i>Current Federal Drug Enforcement Agency (DEA) certificate and State Controlled Dangerous Substance (CDS) certificate, if applicable</i>	<ul style="list-style-type: none"> Primary verification with DEA Registration File 	Every 3 years
<i>Current malpractice coverage as required by UnitedHealthcare</i>	<ul style="list-style-type: none"> Information submitted on Physician Application and Updates, with verification as necessary 	Every 3 years
<i>Acceptable malpractice claims history</i>	<ul style="list-style-type: none"> Physician Application and Updates National Practitioner Data Bank 	Every 3 years
<i>Privileges at hospital(s), if applicable to profession</i>	<ul style="list-style-type: none"> Information submitted on Physician Application and Updates, with verification as necessary 	Every 3 years
<i>Appropriate work history of professional activity</i>	<ul style="list-style-type: none"> Information submitted on Physician Application and verification as necessary 	Initial credentialing
<i>Sanction-free status by federal, state and local authorities</i>	<ul style="list-style-type: none"> Disclosure questions on Physician Application and Updates National Practitioner Data Bank reports 	Every 3 years
<i>Acceptable office practice arrangements</i>	<ul style="list-style-type: none"> Physician Application and Updates Physician Office Site Review 	Every 3 years

Hospital and Ancillary Facility and Company Credentialing Criteria

Criteria which are used for initial and ongoing credentialing of hospitals and ancillary facilities and companies include but are not limited to:

- Acceptable accreditation and/or certification
- Site review for facilities and companies that are not accredited.
- In good standing with state and federal regulatory agencies
- Current, applicable state license
- Appropriate insurance coverage

Plan Participant “Bill of Rights”

Plan participants have the following rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you.

Plan participants have the right to:

- Be treated with respect and dignity by UnitedHealthcare personnel, network physicians and health care professionals.
- Privacy and confidentiality for treatments, tests or procedures received.
- Voice concerns about the service and care they receive and to register complaints and appeals concerning your health plan or the care provided to them.
- Receive timely responses to their concerns.
- Participate in a candid discussion of appropriate treatment options for their conditions, regardless of cost or benefit coverage.
- Be provided with access to physicians and health care professionals.
- Participate with their doctor and other caregivers in decisions about their care.
- Receive information about UnitedHealthcare, our services and network physicians and health care professionals.
- Be informed of, and refuse to participate in, any experimental treatment.
- Have coverage decisions and claims processed according to regulatory standards.
- Choose an advance directive to designate the kind of care they wish to receive should they be unable to express their wishes. The federal Patient Self-determination Act (PSDA) gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Under the federal act, physicians and providers including hospitals, skilled nursing facilities, hospices, home health agencies and others must provide written information to patients on state law about advance treatment directives, about patients’ right to accept or refuse treatment, and about your own policies regarding advance directives.

Plan participants have the responsibility to:

- Know and confirm their benefits before receiving treatment.
- Contact an appropriate health care professional when they have a medical need or concern.
- Show their identification card before receiving health care services.
- Verify that the physician or health care professional they receive services from is in the UnitedHealthcare network.
- Pay any necessary copayment at the time they receive treatment.
- Use emergency room services only for injury or illness that, if not treated immediately, could pose serious threat to their lives or health.
- Keep scheduled appointments.
- Provide information needed for their care.
- Follow the agreed-upon instructions and guidelines of physicians and health care professionals.
- Notify UnitedHealthcare Customer Care of a change in address, family status or other coverage information.

Review Programs

As part of the Quality Improvement Program and in conjunction with credentialing and recredentialing, physician office site reviews and medical record reviews are conducted. Appropriate tools are utilized to conduct the reviews and the results are communicated to the physician.

Physician Office Site Review

A physician office site review may be conducted by UnitedHealthcare staff or a representative acting on UnitedHealthcare’s behalf at the time of credentialing and thereafter as necessary. The site review is designed to evaluate accessibility, waiting areas, services/treatment area, office policies and procedures and safety.

Medical Record Review

Medical records and clinical documentation are evaluated based on the minimum standards for record maintenance which are listed below. UnitedHealthcare or a representative acting on its behalf may visit the physician or provider’s office to assess medical recordkeeping practices.

Standards for Medical Records

In providing care for UnitedHealthcare customers, we expect that you:

- Maintain a single, permanent medical record for each patient.
- Protect patient records against loss, destruction, tampering or unauthorized use.
- Maintain medical records in accordance with state and federal regulations, in a confidential manner and provide periodic training to office staff regarding confidentiality processes.
- Maintain a mechanism for monitoring and handling missed appointments.

General Documentation Guidelines

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

- Date all entries, and identify the author.
- Make entries legible.
- Cite significant illnesses and medical conditions on a problem list. Include dates of onset and resolution.
- Give prominence to notes on medication allergies and adverse reactions. Also note if the patient has no known allergies or adverse reactions.
- Make it easy to identify the medical history, and include serious illnesses, injuries and operations for patients seen three or more times. For children and adolescents (through age 18), history includes prenatal care, birth, operations and childhood illnesses.
- For medication record, include name of medication, dosage, amount dispensed and dispensing instructions. Also list over the counter drugs taken by patient.

Document these important items:

- Tobacco habits, including advice to quit, alcohol use and substance abuse for patients age 11 and older
- Immunization record
- Family and social history
- Preventive screening and services
- Blood pressure, height and weight, body mass index
- Copy of advance directive for patient (or other document allowed by state law) or a notation that your patient does not want one.

Demographic Information

The medical record for each patient should include:

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

Patient Encounters

When you see a patient, document the visit by noting:

- Patient's complaint or reason for visit
- Relevant history and physical assessment (including subjective and objective findings)
- Unresolved problems from previous visit(s)
- Diagnosis and treatment plans consistent with your findings
- Growth charts for pediatric patients
- Developmental assessment for pediatric patients
- Patient education, counseling or coordination of care with other providers
- Date of return visit or other follow-up care
- Lab and other studies you ordered
- Review by the primary physician (initialed) on consultation, lab, imaging and special studies
- Consultation and abnormal studies are initialed and include follow-up plans

Patient Hospitalization

When a patient is hospitalized, your records should include:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information

Clinical Decision and Safety Support Tools in place to ensure evidence-based care is provided.**Examples include:**

- ALT/AST laboratory test done if patient taking Statins
- Immunization tracking sheet
- Flow sheet for chronic diseases (eg, diabetes, asthma)
- Patient reminder system
- Electronic medical records
- E-prescribing
- Epocrates

Preventive Guidelines

UnitedHealthcare has adopted preventive care guidelines for healthy children, adolescents and adults based on the recommendations of the U.S. Preventive Services Task Force. To view our preventive guidelines, visit UHCprovider.com.

Plan Participant Satisfaction / Plan Participant Grievance

UnitedHealthcare may survey plan participants to measure their satisfaction with our Empire Plan network and its network physicians and providers. Plan participants, family members, physicians, other providers, or discharge planners may also contact UnitedHealthcare directly of their own accord.

If a UnitedHealthcare receives a complaint about a network physician or provider, customer care will attempt to resolve the problem. If a problem cannot be successfully resolved, Empire Plan Network Management may be asked to intervene.

This procedure may require UnitedHealthcare to contact the physician or provider, to access medical or billing records, and, as necessary, to call upon physicians and providers other than those who provided treatment to the plan participant. Network physicians and providers are required to cooperate fully in resolving plan participant complaints and grievances.

Confidentiality of Patient Data

UnitedHealthcare Empire Plan customers have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates that need that information to fulfill our obligations and to facilitate improvements to our customers' health care experience. We require our affiliates and business partners to protect privacy and abide by privacy law. If a customer requests specific medical record information, we will refer the customer to you as the holder of the medical records.

Termination and Transfer of Plan Participants

Physicians and providers may not seek or request to have a plan participant's participation in plans administered by UnitedHealthcare terminated, or to have plan participants transferred to another physician or provider of medical care or an alternative health benefit program, due to the plan participant's medical condition or amount, variety or cost of covered services required by the plan participant.

If your network participation terminates for any reason, and your patient chooses to transfer to a different physician/provider, you are required to participate in the transition of your patient toward timely and effective care.

Closing of Physician Panel

Network physicians and providers are expected to adhere to the following protocol when closing their panel (practice) to new plan participants and other patients. A physician or provider is expected to:

- Keep his or her panel open to those plan participants who were patients before the closing of his or her panel.
- Uniformly close his or her panel to all new patients, including all commercial or governmental insureds, as well as private payers.

Clinical Practice Guidelines

Although claim payment policies may vary based on plan design and specific customer coverage and benefit wording, UnitedHealthcare's overall medical policies are consistent across all products and businesses. Our core beliefs about the effectiveness and appropriateness of medical care are based upon scientific evidence.

The Medical Policy Committee is a team of professional staff that includes medical directors and physician consultants. The Committee's primary function is to write clinical practice guidelines and to approve externally licensed guidelines that are used throughout UnitedHealthcare.

