Protocols and Guidelines for the State of New York

UnitedHealthcare would like to remind health care professionals in the state of New York of the following protocols and guidelines:

**Care Provider Responsibilities**
As a participating care provider, you agree to certain access standards, and arrange coverage for medical services, 24 hours a day, 7 days a week, including:

a. **Telephone coverage after hours:** You must have either a constantly operating answering service or a telephone recording that directs members to call a special telephone number to reach a covering medical professional. Your message must tell the caller to go to the emergency room or call 911 in the event of an emergency; the message should be in English and any other relevant languages if your panel consists of patients with special language needs.

b. **Covering physicians and other health care professionals:** You must provide coverage of your practice 24 hours a day, 7 days a week; your covering physician or health care professional must be a participating physician or health care professional unless there isn’t one in your area. UnitedHealthcare must certify any non-participating health care professionals you use to provide coverage for your practice.

**Transitional Care When a Care Provider Leaves Our Network**
We use following rules when notifying members affected by the termination of a doctor or other health care professional:

- UnitedHealthcare members in New York qualify for transitional services on an in-network basis for up to 120 days from the date a care provider ceases to be in the UnitedHealthcare Network.
- All members who are patients of any terminated primary care provider (PCP) such as internal medicine, family practice, pediatrics and OB/GYN, are told about our policy and what steps to follow should they need transitional care; the same notice holds true for patients being seen regularly by a specialist who is terminated.
- Patients of such PCPs are instructed to call the Customer Service department whether they choose to select a new PCP, or to ask for transitional care from their current practitioner; they are also encouraged to visit OxfordHealth.com, to make their new selection.
- Patients of a terminated specialist are also told to call the Customer Service department if they need to request transitional care from their current specialist. Additionally they are told to call their current PCP to ask for a referral to a different network specialist.

**Rights of Our Members**
UnitedHealthcare members are entitled to receive complete current information about a diagnosis, treatment and prognosis in terms they can be expected to understand. When it is not advisable to give that information to the member, the information can be given to an appropriate person acting on the member’s behalf.

Members are also entitled to receive information needed to give permission to proceed (e.g., informed consent) before the start of any procedure or treatment.

For detailed information on member rights and responsibilities, go to OxfordHealth.com > Providers > Tools and Resources > Medical Information > Medical and Administrative Policies > Managed Care Act Disclosure Materials > Sample Member Handbook.
**Balance Billing**
UnitedHealthcare’s billing and claims procedures state that a healthcare care provider may not bill the member for services covered by UnitedHealthcare, except for applicable co-pays, co-insurance or permitted deductibles.

**Emergency Procedures**
The definition of an “emergency medical condition” is as follows:
A medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:
- Placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

**Prior Authorizations**
PCPs and OB/GYNs can request a prior authorization for treatment online at OxfordHealth.com > Providers > Transactions > Submit > Precert Requests, or through our automated telephone system at 800-666-1353, by stating ‘Precertifications when prompted. For a list of services requiring prior authorization, go to OxfordHealth.com > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > Services Requiring Prior Authorization.

You may check the status of an existing referral or authorization 24 hours a day, 7 days a week by calling our automated telephone system at 800-866-1353 and following the prompts. Similarly, registered care providers may use our online services at OxfordHealth.com > Providers > Transactions > Check.

**Access to Specialty Care**
A UnitedHealthcare member may self-refer for some specialist services including those provided by an OB-GYN. An OB-GYN referral includes prenatal care, two routine OB-GYN visits per year and any follow-up care, or acute gynecological condition.

To request a referral to a Specialty Care Center, the member must be diagnosed with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time. The member’s PCP, UnitedHealthcare and the specialist must all agree on a treatment plan for the member.

**Out-of-Network Referrals**
A referral cannot be made to a non-participating care provider without our approval. UnitedHealthcare will consider a referral to an out-of-network health care professional when:
- Our network does not include an available care provider with the appropriate training and experience to meet the needs of the member, and
- Medically necessary services are not available through existing network care providers.

The referral will be made in accordance with a treatment plan that has been jointly approved by us, the PCP and the non-participating physician.
Utilization Review Decisions
Utilization review (UR) decisions will be made by the following methods and in the following time frames:

- **Preauthorization** - UR decisions will be made and notice will be given to you and the member, by phone and in writing, within three business days of the receipt of all necessary information.
- **Concurrent review** - UR decisions will be made and notice will be provided to the member or the member's designee by phone and in writing within one business day of the receipt of all necessary information. Please note that this requirement may be satisfied by giving notice to either you, or the physician, or the other health care professional, by telephone and in writing, within 1 business day of receipt of necessary information.
- **Retrospective** - UR decisions will be made within 30 days of receipt of necessary information. We will notify you of the determination in a Remittance Advice statement or a separate notice.

Initial Adverse Determination Notice
A written notice of an initial adverse determination will include:

1. The reasons for the determination, including the clinical rationale, if any;
2. Instructions on how to initiate standard and expedited internal and external appeals;
3. Notice of the availability, upon request of the member or the member's designee, of the clinical review criteria relied upon to make such determination;
4. The notice will also specify what, if any, additional necessary information must be provided to, or obtained, to render a decision on the appeal.

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

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

In the event that an initial adverse UR decision is rendered without attempting to discuss it with the member's physician or other health care professional who specifically recommended the health care service, procedure or treatment under review, the physicians and other health care professionals shall have the opportunity to request reconsideration. Except in cases of retrospective reviews, such reconsideration shall occur within 1 business day of receipt of the request, and shall be conducted by the member’s physician or other health care professional, as the clinical peer reviewer making the determination.

Appeals of Utilization Reviews
Written acknowledgment of the filing of the appeal will be provided to the appealing party within 15 days of the filing of a standard appeal if a determination is not made within 15 days of the filing of the appeal. If we need more information from the member and their physician or other healthcare professional, we will notify you in writing within 15 days of receipt of the appeal. Once the decision is made, we will notify the member and their designee, if applicable, and you in writing within two business days.
An expedited appeal of an adverse determination may be filed for:

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

The process for handling expedited appeals includes:

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

Clinical peer review will be available within one business day. You may file a Utilization Review Appeal for a retrospective denial. After the Clinical Appeals department issues a retrospective final adverse determination, you will be eligible to file an external appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process.

**Final Adverse Decisions**

Each notice of final adverse determination will be in writing, dated and include the following components:

- A clear statement that the notice constitutes the final adverse determination;
- A clear statement describing the basis and clinical rationale for the denial as applicable to the member;
- A contact person and their phone number;
- The member's coverage type;
- The name and full address of our utilization review agent;
- The utilization review agent's contact person and his/her telephone number;
- A description of the health care service that was denied, including, as applicable and available, the dates of service, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service;
- A statement that the member may be eligible for an external appeal and the timeframes for requesting an appeal;
- A description of the external appeal process; and
- A clear statement written in bolded text that the 45-day timeframe for requesting an external appeal begins upon receipt of the final adverse determination of the first-level appeal, regardless of whether or not a second-level appeal is requested.
External Appeals

An external appeal may be filed:

- When the member has had coverage for a health care service which was denied on appeal as not medically necessary;
  - And UnitedHealthcare has rendered a final adverse determination for that health care service or;
- UnitedHealthcare and the member have jointly agreed to waive any internal appeal, or;
- The member has had coverage for a health care service denied as experimental or investigational,
  - And the denial has been upheld on appeal
  - And the member’s health care provider has certified that the member has a life-threatening or disabling condition or disease that:
    - Standard health services or procedures have been ineffective or would be medically inappropriate; or
    - There does not exist a more beneficial standard health service or procedure covered by the health care plan; or
    - There exists a clinical trial.
  - And the member’s health care provider (who is licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat the member’s life-threatening or disabling condition or disease), must have recommended either:
    - A health service or procedure including a pharmaceutical product within the meaning of PHL 4900(5)(b)(B), that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the member than any covered standard health service or procedure; or
    - A clinical trial for which the member is eligible. A physician certification provided under this section will include a statement of the evidence used by the physician in certifying their recommendation.
  - And the specific health service or procedure recommended by the health care provider would otherwise be covered under the policy except for UnitedHealthcare’s determination that the health service or procedure is experimental or investigational.

We will not make the member exhaust the second level of internal appeal to be eligible for an external appeal. An external appeal must be submitted within 45 days after the receipt of the final adverse determination of the first-level appeal, regardless of whether or not a second-level appeal is requested. If a member chooses to request a second-level internal appeal, the member may miss the deadline to request an external appeal.

UnitedHealthcare’s Credentialing and Re-credentialing Notifications

We complete our credentialing process and give notification of the results within 90 days of receiving a completed application. The notification will tell you whether you are credentialed, if additional time is needed, or that UnitedHealthcare is not in need of additional care providers at this time. If additional information is needed, we will notify the applicant as soon as possible, but no more than 90 days from the receipt of the application.

Healthcare Care Provider Performance Evaluations

UnitedHealthcare is required to provide health care professionals with any information and profiling data used to evaluate your performance. On a periodic basis and upon your request, we will make available the information, profiling data and analysis used to evaluate your performance. You will be given the
opportunity to discuss the unique nature of your patient population, which may have bearing on your profile and we will work with you to improve your performance, as needed.

**Healthcare Professional Terminations**
A care provider cannot be prohibited from, nor may UnitedHealthcare terminate or refuse to renew a contract solely for the following:

- Advocating on behalf of a member
- Filing a complaint against UnitedHealthcare
- Appealing a decision made by UnitedHealthcare
- Providing information or filed a report pursuant to PHL4406- c regarding prohibitions
- Requesting a hearing or review