

# **Caterpillar Healthcare PPO NetWork Administrative Manual**

**Provider Relations  
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## The Caterpillar Healthcare PPO NetWork

Caterpillar welcomes you as a provider participant in the Caterpillar Healthcare NetWork. Caterpillar's Healthcare NetWork is a combination of physicians, hospitals and other healthcare professionals who agree to offer their services at pre-established rates to Caterpillar covered employees, retirees and dependents. These covered employees and their dependents have strong financial incentives to utilize NetWork providers. The NetWork is an integral part of a successful healthcare program for our employees.

This manual contains what you as a physician or other medical provider should know in order to participate in The NetWork. We have attempted to keep administrative requirements to a minimum. If you have any recommendations for improving our procedures, please fax our Provider Relations Department at 309-992-6609. The success of The NetWork depends upon you as the provider of medical services.

As a NetWork participant, you agree to refer to other NetWork providers (physicians, hospitals and other medical providers) whenever possible. If you do not do so, you subject the covered individual to receiving a lower level of reimbursement. You agree, for covered services, to accept as full payment the agreed-to fee schedule or other pre-established reimbursement arrangement, and agree to not balance-bill covered employees (see Claims and Billing). Employees are responsible, in some instances, for deductibles and co-payments as well as for payment for non-covered services.

As a NetWork Provider:

- You will be identified in the Caterpillar NetWork directory.
- You will not be charged any enrollment fees or annual dues for participation in The NetWork.
- Your claims will be processed by UnitedHealthcare. Caterpillar has contracted with UnitedHealthcare for claims processing and medical decision-making. Caterpillar will maintain responsibility for Plan changes and revisions as well as administration of The NetWork (including fee schedules).
- Your claims will be processed within thirty (30) working days of receipt of claims that are complete.
- Your claims that are "pending" (questioned or incomplete), will be processed within thirty (30) working days of resolution.

There are no "gatekeepers" for referrals to other NetWork providers. Due to strong financial incentives in The NetWork plan, both your existing patients and potential new patients have important reasons to choose you as their medical provider.

The procedures and descriptions of our health benefit plan outlined in this manual are intended to cover (in a general way) the majority of situations that may present themselves to you and your office staff. If you have any questions about how a benefit or service is administered, please call UnitedHealthcare's Customer Service for Caterpillar at 1-866-CAT-4215 or utilize UnitedHealthcare's online provider portal at [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com). Additional information for NetWork providers may also be found on Caterpillar's Web site: <http://benefits.cat.com/en/providers.html>.

## Help Us Keep Up With Changes in Your Office:

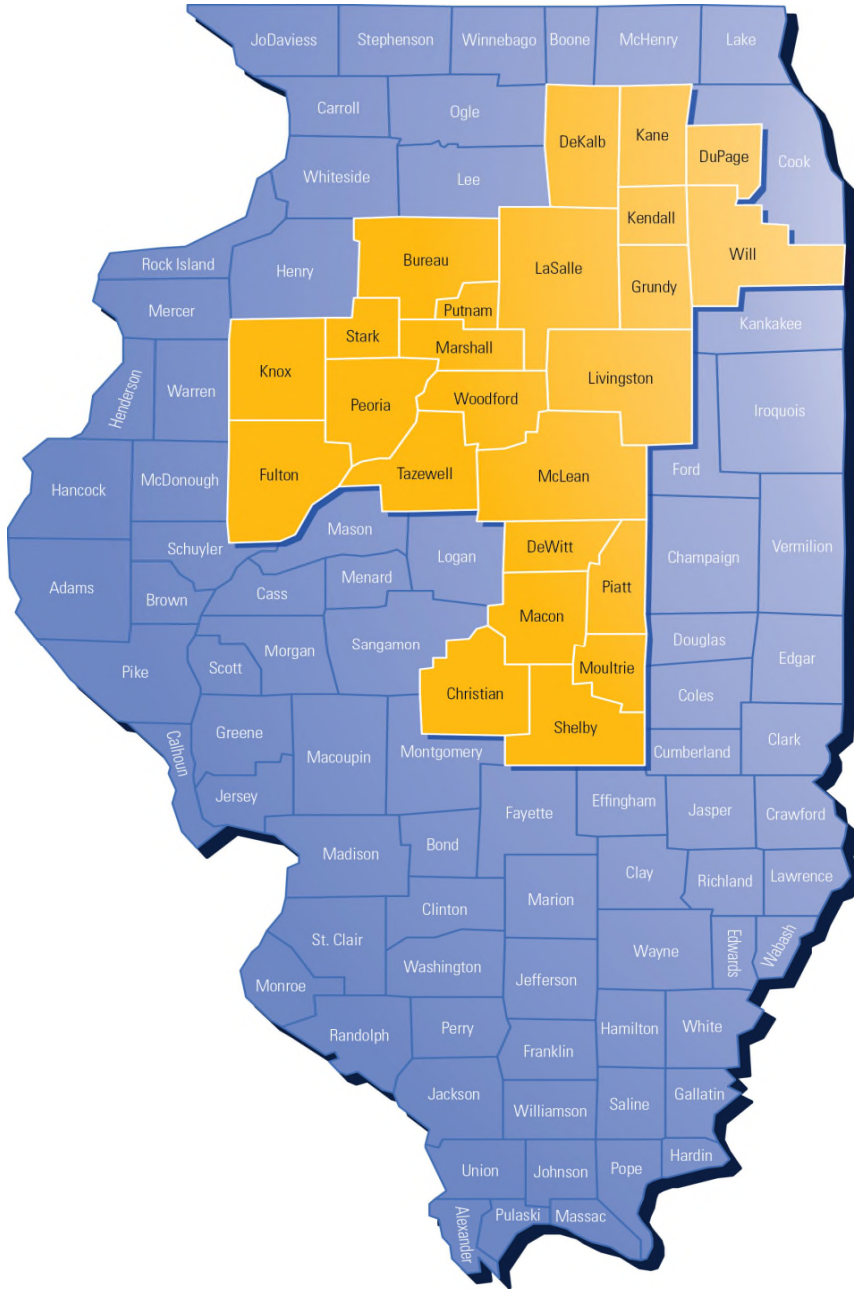
- Please notify Caterpillar immediately (prior to) of any updates in physician personnel, changes in address, telephone number, Fax number, Tax Identification Number and whether you are accepting new patients. This notification must take place at least ten days prior to any changes. Please call (309) 636-1795 for assistance.
- When a new provider joins your group, **he/she is not** considered part of the Caterpillar NetWork until you have received written confirmation from Caterpillar or your physician provider organizations. Please call (309) 636-1795 for assistance.
- Caterpillar must know if there are mid-level providers in your office. A complete credentialing application **must be submitted** before he/she can be approved into the Caterpillar NetWork. Please call (309) 636-1795 if you need any assistance. The following documents will be required for mid-level providers:
  - o Caterpillar Release of Information
  - o Caterpillar Attestation
  - o Caterpillar Healthcare Questionnaire
  - o Initial State of Illinois Uniform Health Care Credentialing and Data Collection form, pages 1-29 and A-F

### All supporting documentation as required:

- o Current copy of provider's State Professional License
- o Current copy of Federal DEA License (if applicable)
- o Current copy of Controlled Substance License (if applicable)
- o Current Professional Liability Insurance with effective and expiration dates and amount displayed per occurrence and in aggregate
- o Current CLIA certificate (if applicable)
- o Current W9 for practice
- o All educational certifications (including current board certification, professional school diplomas as applicable)

Credentialing forms may be found at: <http://benefits.cat.com/en/providers/caterpillar-credentialing.html>.

# Caterpillar Healthcare PPO NetWork Counties



# Non-Compliance of NetWork Provider Policy and Procedure

## POLICY

A NetWork provider is considered non-compliant if the provider is involved in any violation of Caterpillar's administrative policies or procedures. This includes, but is not limited to, non-compliance with the Member benefit plan and/or improper billing practices, abuse of the out-of-NetWork referral process, failure to complete all credentialing/re-credentialing requirements, and refusal to participate in quality initiatives.

## PURPOSE

To ensure the success of the Caterpillar benefit plans.

## PROCEDURE

1. Caterpillar's Corporate Physician, NetWork Provider Relations Team and Credentialing Committee will identify and monitor non-compliant providers.
2. Caterpillar will maintain a protocol for auditing, working with and, if necessary, terminating participating providers.
3. The Caterpillar Corporate Physician and/or Healthcare Benefits Business Manager will notify the physician and/or mid-level and initiate the disciplinary process.
4. If the provider refuses to cooperate with Caterpillar's Corporate Physician or Healthcare Benefits Business Manager, disciplinary action will begin.
5. If the provider refuses or fails to comply with recommended corrective action plan within the time period allowed, steps to terminate the provider from participation in the Caterpillar NetWork will be implemented.

# Corrective Action/ Termination/Reinstatement Policy for Non-Compliant NetWork Providers

## POLICY

Caterpillar's Corporate Physician and/or Caterpillar NetWork Provider Relations Committee may initiate a disciplinary/corrective action plan for a non-compliant provider for both clinical and administrative non-compliance to Caterpillar policies and procedures (e.g. non-compliance with the Member's benefit plan, improper billing practices, abuse of the out-of-NetWork referral process, refusal to participate in quality initiatives, etc.) to make decisions regarding a provider's continued participation in the NetWork.

## PURPOSE

To ensure that participating providers exhibit only high quality, cost-efficient medical care to members, follow Caterpillar Benefit Plans and Agreements and follow established industry standard billing practices.

## PROCEDURE

Causes for corrective action include, but are not limited to:

1. Failure to follow Caterpillar Benefit Plan administration and/or contract requirements.
2. Failure to achieve satisfactory results as follows:
  - i. Member patient satisfaction reviews
  - ii. Medical record reviews
  - iii. Audit reviews
  - iv. Compliance with quality improvement activities
  - v. Failure to demonstrate behavior consistent with good managed care principles

Corrective action will be determined by Caterpillar's Corporate Physician, NetWork Provider Relations Team and Credentialing Committee and includes, but is not limited to:

1. Immediate termination of provider NetWork contract for:
  - i. Loss of License
  - ii. Substance Abuse
  - iii. Felony conviction
  - iv. Loss of Professional Malpractice Liability Insurance
  - v. Sexual Improprieties
  - vi. Occurrence deemed to be detrimental to well-being of Caterpillar Member

### **Process for notification to a NetWork provider for corrective action or impending termination of the provider:**

1. Upon Caterpillar internal approvals, the Corporate Medical Director or Manager of Provider Relations will advise the provider via certified, return receipt requested letter

that Caterpillar is activating a corrective action or terminating its contract with the provider.

2. If a corrective action plan is initiated, a timeframe for corrective results will be advised. The advisement letter will outline specific items requiring correction.
3. If termination is indicated, a termination date will be stated in the letter. The letter may outline specific reasons for the termination.

**Process for reinstatement of a terminated NetWork provider:**

1. A terminated NetWork provider may request reinstatement to The NetWork after three (3) years from the original termination.
2. Reinstatement will be at the sole discretion of Caterpillar's Corporate Physician, Healthcare Benefits Business Manager, NetWork Provider Relations Team, Caterpillar Credentialing Committee and Caterpillar Corporate Legal representative and may be declined, even if the offending behavior has been corrected.



## Caterpillar Healthcare PPO NetWork Provider Directory

To find other providers that participate in the Caterpillar Healthcare PPO NetWork (e.g., Hospitals, Facilities, Professionals, Durable Medical Equipment/Prosthetics, and Home Health Services), the most recent NetWork Provider listings for your NetWork area may be found on <http://benefits.cat.com/en/providers.html>. Select the "Provider directories" link on the left side of the page.

This provider directory is the most current directory available to members and providers. Should your office not have online access, you may call any of the Provider Relations staff listed on page 29 for assistance, and/or a paper copy of the directory.

The information in the directory that is related to providers in your office is based on the information provided in credentialing applications, and through updates received by your office. Please call 309-636-1795 for any corrections or updates to your information.

## National Reciprocity

While the Caterpillar Healthcare PPO NetWork is extensive and comprehensive, we understand that there are times when members need specialized services not available within the NetWork. While there is an established referral process, there is an easier way for members to receive specialized services not available in the Caterpillar NetWork.

The solution is called National Reciprocity and it gives Caterpillar NetWork members access to **most** of UnitedHealthcare's network providers across the country (hospitals, facilities, physicians and other healthcare providers) at their network-contracted rates. **Please note that National Reciprocity is available on a limited basis within the State of Illinois** (please refer to the map on page 5-2).

If you have questions about National Reciprocity, please contact a UnitedHealthcare customer care professional at 866-228-4215, Monday–Friday, 7 a.m.–5 p.m. (Central time). Here are some Frequently Asked Questions related to National Reciprocity:

**1. What providers do members now have access to who previously required an out-of-NetWork referral?**

Members now have access to contracted rates from providers and facilities within UnitedHealthcare's provider network when **specialized services are not available within the Caterpillar NetWork**. For instance, UnitedHealthcare's network currently includes, but is not limited to, such providers as:

Mayo Clinic	University of Iowa
St. Louis University Hospital	Barnes-Jewish Hospital
St. Louis Children's Hospital	The University of Texas MD Anderson
The Cleveland Clinic Foundation	Vanderbilt in Nashville, TN
Scripps in San Diego, CA	The University of Kansas in Kansas City

As with any network, UnitedHealthcare's contracted providers are subject to change at any time.

**2. Are members allowed to use any UnitedHealthcare provider?**

No. Because the Caterpillar NetWork contracts directly with healthcare providers in Illinois, access to National Reciprocity in the State of Illinois has been limited, but it is available in all other states. Please refer to the map on page 5-2 that shows the areas in the State of Illinois for which National Reciprocity is available and not available (**counties in red are not included in National Reciprocity**).

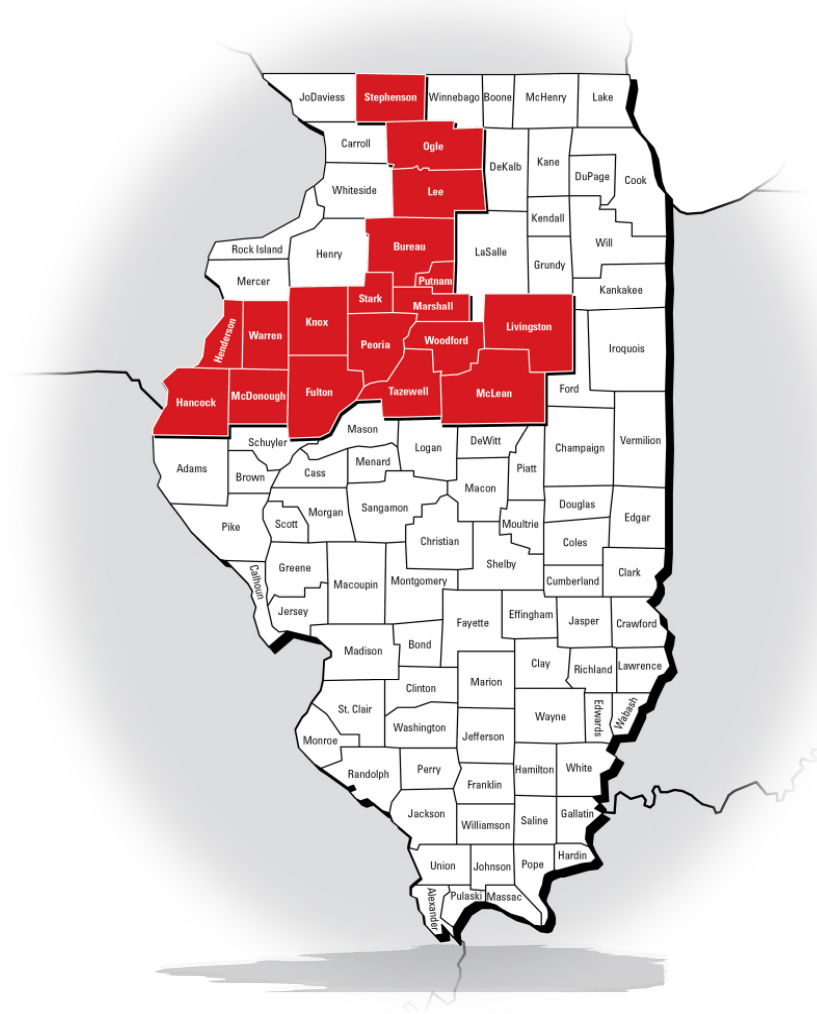
**3. What is an advantage of making referrals to providers covered under National Reciprocity?**

Your office will no longer need to request approval for a referral through UnitedHealthcare.

**4. How do I find a UnitedHealthcare contracted doctor or hospital?**

Visit UnitedHealthcare's provider portal at [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com). Please remember, when checking for doctors or hospitals in Illinois, many counties in Illinois are excluded from National Reciprocity.

**EFFECTIVE JANUARY 1, 2011**  
**ILLINOIS COUNTIES NOT INCLUDED IN NATIONAL RECIPROCITY**  
**NOTED IN RED**



Example:  
 John currently resides in one of the counties shaded red. To receive the Caterpillar *NetWork* discount, John would need to use a Caterpillar *NetWork* contracted doctor or hospital (see the provider directory located on CatHealthBenefits.com). If John seeks service at a **non-Caterpillar *NetWork*** contracted doctor or hospital in any of the counties shaded in red, his claim would be processed as out-of-network and he would be required to pay at least 50% of the charges. **Remember, National Reciprocity does not apply to any of the counties in red.**

## Referrals for Out-of-NetWork Services

**PLEASE NOTE:** Effective January 1, 2013, the referral process has been discontinued for all Caterpillar Healthcare PPO participants. If you contact UnitedHealthcare with a referral request, UnitedHealthcare will not accept the request.

For questions related to finding a provider outside the Caterpillar Healthcare PPO NetWork, please view additional information on the National Reciprocity section of this manual (page 10). You may also contact a UnitedHealthcare customer care professional at 866-228-4515, Monday-Friday, 7:00 a.m. - 5:00 p.m. (Central time).

## Claims and Billing

### Verification of Eligibility

To verify a patient's eligibility please call UnitedHealthcare (1-866-CAT-4215) or use UnitedHealthcare's provider portal: [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com) to inquire about covered services and any pre-authorization requirements that would need to be met. In addition, provider offices will be able to confirm the member's plan and applicable co-insurance level at the time of the call.

### Claim Submission

In addition to the following information, please refer to pages 15-16 for claims submission tips from UnitedHealthcare. Paper claims should be sent to: UnitedHealthcare Medical Claims, PO Box 740800, Atlanta, GA 30374-0800.

If you are interested in electronic submission of your claims, please contact UnitedHealthcare at 1-866-CAT-4215) for more information. UnitedHealthcare's **medical claims** electronic payer ID for Caterpillar is 87726. UnitedHealthcare also allows submission of claims directly through their provider portal. Please visit [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com) for more information.

Please make sure claim forms are complete. Claims missing information necessary to process the claim (including but not limited to Federal Tax ID Number, Social Security Numbers, CPT codes, etc.) will be delayed or returned. Every claim, whether electronic or paper, must indicate that the insured has assigned benefits to the provider in order for the provider to receive direct payment of that claim by UnitedHealthcare. This is indicated in Box 13 on the standard CMS 1500 form. If this box is left blank, and there is no indication made on the claim that indicates a patient payment, the provider will be paid.

Following is a guideline for surgical procedure codes that require an operative report at time of claim submittal:

- All codes listed as a 99 or an "unlisted procedure"
- All codes that end with the modifier 22 or "unusual"

It is not Caterpillar's practice to set specific guidelines or requirements on a NetWork provider's billing and collection practices. Employees are advised to inquire with you directly regarding your policy. Most Caterpillar Plans have deductibles and maximum out of pocket limits. Salaried and Management employees have the choice of three plan options and Hourly Bargained members fall under one of two Plans dependent upon their bargaining unit. The member's I.D. card will not indicate the Plan selected by the member. In order to confirm the member's plan your office may contact UnitedHealthcare's Customer Service Center (1-866-228-4215) or utilize UnitedHealthcare's online physician portal ([www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com)).

Most employees who are on either the salaried or management payroll have an 80% benefit, regardless of their plan selection, for office calls with a diagnosis of injury or illness. Most employees on the hourly payroll (represented by a union) have no coverage for office calls.

Caterpillar provides coverage for some preventive services at a 100% benefit level with no deductible. Most other covered services will be paid up to the amount indicated in your fee schedule or as determined by the pre-established reimbursement agreement schedule.

If you collect the full agreed-to amount from the patient at time of service, please send the CMS 1500 (or applicable updated form) to UnitedHealthcare, or give it to the patient to file, and payment will be made directly to the employee.

If you collect all or part of the amount due (20% co-payment or office call charge only), please submit the completed CMS 1500 (or applicable updated form) to UnitedHealthcare, or give it to the patient to file. Payment will be made to the employee for any eligible expenses paid at the time of service. Payment will be made to you for any covered services not paid by the patient.

If you do not collect from the patient at the time of service, please send the completed CMS 1500 to UnitedHealthcare. Payment will be made to you.

**REMEMBER, FOR COVERED SERVICES YOU MAY NOT COLLECT MORE THAN THE AGREED-TO FEE SCHEDULE AMOUNT (INCLUDING THE COMBINATION OF CATERPILLAR PAYMENT AND EMPLOYEE PAYMENT).**

It is your responsibility to bill the patient for any applicable co-payment or charges for non-covered services. Timely filing limits apply for the submission of claims. Claims must be submitted by the end of the calendar year in which the expense was incurred. Exceptions to the timely filing limit will not be allowed and providers will be required to write-off the expense if not submitted according to the filing limit.

If you disagree with a payment by UnitedHealthcare, please see pages 17-18 for the provider appeal process.

## **Other Coverage**

### **Coordination of Benefits**

When a patient has primary coverage for medical expenses under another plan (including Medicare), a claim should always be submitted to that plan first for payment. Any balance remaining, will be considered under Caterpillar's coordination of benefits provision for non-Medicare coordination of benefits. Caterpillar follows standard non-duplication coordination of benefits processing.

### **Medicare Part B Claims**

UnitedHealthcare is set up to automatically receive Medicare Part B claims through electronic transfer. You can verify that the patient's claim has been forwarded by looking at the Medicare Explanation of Benefits (EOB) form. If that EOB says: "Claim Information Forwarded to: UnitedHealthcare", please do not submit a paper copy unless you have verified through UnitedHealthcare's Customer Service Center that a claim was not received.

## Workers' Compensation

If a condition is related to the patient's employment, Workers' Compensation may apply, and those claims should not be submitted through UnitedHealthcare. Those bills (in paper form), at the agreed-to fee schedule or pre-arranged reimbursement amount, should be sent to the Workers' Compensation Division at the local facility. See below:

For employees at work locations in the State of Illinois, paper Workers' Compensation medical bills should be sent to:

### Peoria area facilities:

Caterpillar Inc.  
ATTN.: Workers' Compensation  
100 NE Adams Street  
Peoria, IL 61629-4400

### Decatur:

Caterpillar Inc.  
ATTN.: Workers' Compensation  
100 NE Adams Street  
Peoria, IL 61629-4400

### Aurora and Joliet:

Caterpillar Inc.  
ATTN.: Workers' Compensation  
PO Box 348  
Aurora, IL 60507

### Pontiac:

Caterpillar Inc.  
ATTN.: Workers' Compensation  
100 NE Adams Street  
Peoria, IL 61629-4400

## **UnitedHealthcare Tips for Provider Claim Submissions**

UnitedHealthcare has provided the following information regarding tips for claims submission. All claims require appropriate identification and claim detail information such as name, ID#, diagnosis, CPT codes, charges etc. Do not use a highlighter on the claim form (this causes problems when a claim is scanned). It is recommended the following additional information be submitted with the original claim submission, if the situation applies:

- Information about other insurance coverage including the EOB (if applicable) or information related to an accident that might be job, auto or accident related if available).
- Medicare EOMB if patient is Medicare eligible.
- Attach operative notes for claims submitted with modifiers 22, 62, 66 or any other team surgery modifiers. Also, attach operative notes for claims submitted with an unlisted or unspecified surgical procedure code or when billing for experimental or reconstructive surgery.
- Attach the operative notes for Interventional Radiology claims.
- Attach an anesthesia report for claims submitted with an -AD modifier.
- Attach nursing notes and treatment plan for claims submitted for home health care, nursing or skilled nursing services.
- If you need to correct and re-submit a claim, submit a new CMS 1500 or UB-04 with the corrected information on the claim. **Please note: Hand corrected claim submissions will not be accepted.** You cannot mark through the original information and handwrite in the new information. **Please indicate "CORRECTED CLAIM" on the new claim submission.**
- Attach a detailed description of the procedure or service provided for claims submitted with unlisted medical CPT code, unlisted HCPCS code, or "other" revenue codes as well as for experimental services. If billing an unlisted code, please include a description of the service in appropriate fields:

- **Paper claims:** Put description in box 24D of the CMS 1500 form.
- **Electronic claims:** Put the description in box 24K of the CMS 1500 form. The EDI loop is as follows:
  - At the service line:
    - 2400 NTE – Comments-Word Descriptions and dosage information
    - 2410 LIN – HIPAA segment for NDC numbers
  - If the clearinghouse connection is not able to pass the above, they may put the information at the claim level:
    - 2300 NTE – Comments.
- Attach the current NDC (National Drug Code) number for claims submitted with unlisted drug codes (e.g.. J3490, J3590, etc.). The NDC number must be entered in field 24D of the CMS1500 paper form or the LIN03 field of the HIPAA 837 electronic form.
- On a UB-04 attach an itemized list of services or complete box 45 for physical, occupational or speech therapy services (revenue code 420-449).



## Provider Appeal Process

The following are steps your office can take with UnitedHealthcare, on behalf of your patient with their consent, to resolve any issues with claims. **During the review/appeal process, please do not submit another claim with the review/appeal. Your office should only submit a copy of the original EOB.**

1. **Always** call UnitedHealthcare first with a question about a claim at 1-866-CAT-4215. If the caller and customer service representative agree that the claim needs to be reviewed, the customer service representative will forward the claim to the appropriate area for review. A response should be received from UnitedHealthcare within approximately **10 business days**.
2. If your office does not agree with the UnitedHealthcare explanation, and wish to appeal, document the concern in writing and send it to the following address along with a copy of the EOB:

**UnitedHealthcare**  
PO Box 30432  
Salt Lake City, UT 84130-0432  
ATTN: Caterpillar Appeals

An Appeal is a request for the review and/or reconsideration of:

- An adverse plan determination of all or part of a pre-service request for provision of health care services or benefits.
- Denial of payment of a claim for a service(s) that has already been provided.

When sending an appeal to UnitedHealthcare, please make sure to include copies of any documentation (EOB, documentation of benefit coverage, clinical information such as operative and clinical reports) with the appeal letter and label the letter "APPEAL" at the top. Your office has 180 days to appeal a payment determination. The following timeframes may be extended if UnitedHealthcare does not have the proper documentation to make a correct decision or resolution. UnitedHealthcare will respond according to the three scenarios as cited under federal legislation.

### **If the service has not yet been provided:**

- **"Urgent Care" Appeal (Clinical):** Urgent care claims are those claims where the timeframe for the standard appeal process would seriously jeopardize the life or health of the consumer, jeopardize the consumer's ability to regain maximum function, or in the opinion of a physician with knowledge of the medical condition could cause severe pain. If the situation in question deals with pre-approval of an urgent care appeal UnitedHealthcare will respond within 72 hours upon receipt of all necessary information to process the appeal. Your office should initiate the urgent care appeal by calling UnitedHealthcare at 1-866-CAT-4215.
- **"Non-urgent" Care Appeal (pre-service Clinical):** If the appeal is for a service or procedure that has not yet been performed and is not considered "urgent",

UnitedHealthcare will respond with a coverage decision within 15 business days upon receipt of all necessary information to process the appeal.

**If the service has already been provided:**

- **Post-Service Appeal (Clinical and Non-Clinical):** UnitedHealthcare will respond with a coverage decision within 30 business days upon receipt of all necessary information to process the appeal.
3. UnitedHealthcare reports their findings back to your office. If your office still does not agree with the review, a second level review may be requested. If the request for second level appeal is for a pre-service urgent care appeal, your office may call UnitedHealthcare to initiate the second level appeal. If the request for a second level appeal is for a non-urgent care appeal, the request must be sent in writing.

If your office disagrees with the outcome of the second level appeal, please contact a member of the Caterpillar NetWork team. The NetWork team cannot address concerns until the above steps have been followed with UnitedHealthcare.

**Please remember: If the issue deals directly with an interpretation of the benefits plans and level of payment for the provider, UnitedHealthcare has the responsibility of administering the Caterpillar Healthcare Plan and in most cases, the provider will have to accept their decision.**

## Advance Notification/Prior Authorization/Medical Necessity Non-Facility Providers

Effective January 1, 2016, Caterpillar will implement an Advance Notification/Prior Authorization/Medical Necessity review process administered by UnitedHealthcare. **To view the most current and complete Advance Notification/Prior Authorization List, including procedure codes and associated services, go to** [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Clinical Resources → Advance and Admission Notification Requirements → UnitedHealthcare Commercial Advance Notification Procedure Codes. This process **will not** apply to any services listed under the “**Specific Medications as Indicated on the Prescription Drug List (PDL)**” or the section called “**Other Advance Notification and Prior Authorization Programs**” on UnitedHealthcare’s provider portal listed above.

### Please Note:

- Applicable Caterpillar Plan Participants will be moved from UnitedHealthcare’s Options PPO product into the Choice Plus product, but this remains a PPO product. The Participant’s ID card will change.
- Physicians, health care professionals and ancillary providers are responsible for providing Advance Notification/Prior Authorization/Medical Necessity review information for services referenced in the Advance Notification List.
- Facilities are responsible, prior to the date of services, for confirming the coverage approval is on file.
- Facilities are responsible for Admission Notification/Medical Necessity information for inpatient services even if the coverage approval is on file.

### Important Facts:

- **Failure to comply with the Advanced Notification/Prior Authorization/Medical Necessity review requirements may result in claims being reduced in whole or in part, and the Participant being held harmless.**
- Services on the list require Prior Authorization which will lead to a clinical coverage review. When submitting an Advance Notification/Prior Authorization, clinical information will be requested and a clinical coverage review (based on medical necessity) will be conducted.
- Certain services may not be covered by a Participant’s benefit plan, regardless of whether Advance Notification/Prior Authorization is required.
- The Advance Notification/Prior Authorization List is available online for your convenience and is subject to change over time. Changes to Advance Notification List will be made via online at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Clinical Resources → Advance and Admission Notification Requirements → UnitedHealthcare Commercial Advance Notification Procedure Codes. It is your responsibility to review the list for updates. If any changes are made, they are generally made on a quarterly basis.

### Advanced Notification/Prior Authorization/Medical Necessity Review Process:

- Advance Notification/Prior Authorization should be submitted as far in advance as possible, but is required to be submitted **at least 5 business days prior** to the planned service date (unless otherwise specified with the Advance Notification/Prior Authorization List) with supporting clinical documentation, to allow enough time for coverage review.
- Advance Notification/Prior Authorization for home health services and durable medical equipment is required **within 48 hours after the start of service**. Submitting Advance Notification/Prior Authorization requests as early as possible is best.
- It may take up to 15 calendar days to render a decision. Prioritization of case review is based on the specifics of the case, the completeness of the information received, or other state or federal requirements. Time may be extended if additional information is needed.
- For services requiring expedited review, please call the telephone number on the Participant’s health care ID card. Expedited review for benefits that require Advance Notification/Prior Authorization or a benefit determination prior to receiving medical care is available where a delay in treatment could seriously jeopardize the Participant’s life or health, or the ability to regain maximum function, or in the opinion of a

Physician with knowledge of the Participant's medical condition, could cause severe pain. You must explain the clinical urgency when requesting an expedited review.

- Services on the Advance Notification/Prior Authorization List require Prior Authorization through a pre-service clinical coverage review that will result in either a coverage approval or adverse coverage determination.
- Once you inform UnitedHealthcare of a planned service on the Advance Notification/Prior Authorization List, UnitedHealthcare will inform you if Prior Authorization through a clinical coverage review is required. UnitedHealthcare will advise you of the required information necessary to complete the review and you will be notified of the coverage decision.
- It is important that you and the Participant are fully aware of coverage decisions before services are rendered.
- **If you provide the service before a coverage decision is rendered, and UnitedHealthcare ultimately determines that the service was not covered, UnitedHealthcare may deny the claim and you must not bill the Participant.** By proceeding prior to the final coverage determination, it is not possible for the Participant to make an informed decision about whether to pay for and receive the non-covered services.
- Receipt of a Prior Authorization approval does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual Participant's benefit plan, the provider being eligible for payment, any claim processing requirements, and the Participating Provider Agreement with Caterpillar.

#### **Clinical Criteria Used to Determine if Services Are Medically Necessary:**

UnitedHealthcare will review services for medical necessity by applying criteria that focuses on whether the services are: (a) scientifically proven to be effective, (b) clinically appropriate for individual members with their respective and specific conditions and diagnoses, and (c) cost-effective when compared to alternative diagnostic or therapeutic options. UnitedHealthcare will use generally accepted standards of medical practice, which are based on credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community. UnitedHealthcare may also use standards that are based on physician specialty society recommendations, professional standards of care, or other evidence-based, industry recognized resources and guidelines, such as the MCG®, to determine medical necessity and appropriate level of care

#### **Updates to an Advance Notification/Prior Authorization Request:**

- You may update or provide additional information related to an Advance Notification/Prior Authorization request until a coverage decision is made regarding the service. Once an approval has been rendered, you may update the Advance Notification/Prior Authorization with a change in date of service only (as long as the original date of service has not passed). You may update the date of service on UnitedHealthcareOnline.com or by phone.
- Advance Notification/Prior Authorization is valid only for the date of service or date range designated on the notification. If the designated date of service or date range has passed and the service(s) has not been rendered, a new Advance Notification/Prior Authorization must be obtained.
- No updates can be made to an existing Advance Notification/Prior Authorization **AFTER** the service has been delivered. If during the service, an additional or different service was performed than was originally approved, you must submit the supporting clinical information for the service at the time of claim submission.

#### **Information to Include with the Advanced Notification/Prior Authorization:**

- Participant name and Alternate ID number.
- Ordering physician, health care professional or ancillary provider name and TIN or National Provider Identification (NPI).
- Rendering physician or health care professional name and TIN or NPI.
- ICD-10-CM diagnosis code for the diagnosis for which the service is requested.
- All applicable procedure codes.
- Anticipated date(s) of service.
- Type of service (primary and secondary) procedure code(s) and volume of service (when applicable).
- Service setting (outpatient, inpatient, physician office, home or other).
- Facility name and TIN or NPI where service will be performed (when applicable)

You must cooperate with all UnitedHealthcare requests for information, documents or discussions for purposes of a clinical coverage review including, but not limited to, all applicable procedure codes, pertinent medical records and imaging studies/reports. Please refer to [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Tools & Resources → Policies, Protocols and Guides → Protocols → Medical Records Requirement for Pre-Service for a list of individual services and specific, additional required information.

You must respond and return calls from UnitedHealthcare’s care management team and/or medical director. You must provide complete clinical information as required within 4 hours if request is received before 1:00 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1:00 p.m. local time (but no later than 12:00 p.m. the next business day).

**How to submit Advance Notification/Admission Notifications/Prior Authorizations Requests:**

Multiple submission options are available to submit Advance Notification/Prior Authorization or Admission Notifications requests to UnitedHealthcare, including electronic methods. To avoid duplication, once an Advance Notification/Prior Authorization or Admission Notifications requests is submitted and confirmation is received, please do not resubmit.

- Notify UnitedHealthcare at [UnitedHealthcareOnline.com](http://UnitedHealthcareOnline.com) → Notifications/Prior Authorizations → Notification/Prior Authorization Submission. UnitedHealthcare will accept daily composite census logs for inpatient admissions with complete and relevant information via fax (see fax numbers below).
- If you do not have electronic access, please call UnitedHealthcare at the number on the Participant’s health care ID card.

	EDI 278 Transactions	UnitedHealthcare Online.com	Live Call	VoiCert	Fax
Method	Electronic	Electronic	Non-Electronic	Non-Electronic	Non-Electronic
	Advance Notification and Prior Authorization (278A) and Admission Notification (278N).	Advance Notification and Prior Authorization and Admission Notification; Notification Status for previously submitted notifications.	Advance Notification and Prior Authorization and Admission Notification Status for previously submitted notifications.	Inpatient Admission Notification.	Advance Notification and Prior Authorization and Admission Notification.
Description	X12 EDI submission directly to UnitedHealthcare or through a clearinghouse.	Portal submission directly to UnitedHealthcare through <a href="http://UnitedHealthcareOnline.com">UnitedHealthcareOnline.com</a>	Phone submission directly to UnitedHealthcare through (866) 228-4215.	Phone submission through assigned 800 number specific to facility.	866-756-9733
	Monday - Friday: 7:00 a.m. to 2:00 a.m. Saturday: 7:00 a.m. to 6:00 p.m. Sunday 7:00 a.m. to 6:00 p.m. Holidays: Same as above.	Generally available 24 hours per day, 7 days a week. Maintenance is scheduled outside of the following hours: Monday - Friday: 6:00 a.m. to 12:00 a.m. Saturday: 6:00 a.m. to 7:00 p.m. Sunday: 7:00 a.m. to 5:00 p.m. Holidays: Same as above.	Monday - Friday: 7:00 a.m. to 8:00 p.m. Saturday: 9:00 a.m. to 6:00 p.m. Sunday 9:00 a.m. to 6:00 p.m. Holidays: 9:00 a.m. to 6:00 p.m.	VoiCert can be used 24/7, but submissions are processed the following business day: Monday - Friday: 7:00 a.m. to 8:00 p.m. Saturday: 9:00 a.m. to 6:00 p.m. Sunday 9:00 a.m. to 6:00 p.m. Holidays: 9:00 a.m. to 6:00 p.m.	Faxes can be sent 24/7 but are processed during the following business hours: Monday - Friday: 7:00 a.m. to 8:00 p.m. Saturday: 9:00 a.m. to 6:00 p.m. Sunday 9:00 a.m. to 6:00 p.m. Holidays: 9:00 a.m. to 6:00 p.m.

## Advance Notification/Prior Authorization/Medical Necessity Facility Providers

Effective January 1, 2016, Caterpillar will implement an Advance Notification/Prior Authorization/Medical Necessity review process administered by UnitedHealthcare. **To view the most current and complete Advance Notification/Prior Authorization List, including procedure codes and associated services, go to UnitedHealthcareOnline.com → Clinical Resources → Advance and Admission Notification Requirements → UnitedHealthcare Commercial Advance Notification Procedure Codes.** This process **will not** apply to any services listed under the “**Specific Medications as Indicated on the Prescription Drug List (PDL)**” or the section called “**Other Advance Notification and Prior Authorization Programs**” on UnitedHealthcare’s provider portal listed above.

### Please Note:

- Applicable Caterpillar Plan Participants will be moved from UnitedHealthcare’s Options PPO product into the Choice Plus product, but this remains a PPO product. The Participant’s ID card will change.
- Physicians, health care professionals and ancillary providers are responsible for providing Advance Notification/Prior Authorization/Medical Necessity review information for services referenced in the Advance Notification List.
- Facilities are responsible, prior to the date of services, for confirming the coverage approval is on file.
- Facilities are responsible for Admission Notification/Medical Necessity information for inpatient services even if the coverage approval is on file.

### Important Facts:

- **Failure to comply with the Advanced Notification/Prior Authorization/Medical Necessity review requirements may result in claims being reduced in whole or in part, and the Participant being held harmless.**
- Services on the list require Prior Authorization which will lead to a clinical coverage review. When submitting an Advance Notification/Prior Authorization, clinical information will be requested and a clinical coverage review (based on medical necessity) will be conducted.
- Certain services may not be covered by a Participant’s benefit plan, regardless of whether Advance Notification/Prior Authorization is required.
- The Advance Notification/Prior Authorization List is available online for your convenience and is subject to change over time. Changes to Advance Notification List will be made via online at UnitedHealthcareOnline.com → Clinical Resources → Advance and Admission Notification Requirements → UnitedHealthcare Commercial Advance Notification Procedure Codes. It is your responsibility to review the list for updates. If any changes are made, they are generally made on a quarterly basis.

### Advanced Notification/Prior Authorization/Medical Necessity Review Process:

- Advance Notification/Prior Authorization should be submitted as far in advance as possible, but is required to be submitted **at least 5 business days prior** to the planned service date (unless otherwise specified with the Advance Notification/Prior Authorization List) with supporting clinical documentation, to allow enough time for coverage review.
- Advance Notification/Prior Authorization for home health services and durable medical equipment is required **within 48 hours after the start of service**. Submitting Advance Notification/Prior Authorization requests as early as possible is best.
- It may take up to 15 calendar days to render a decision. Prioritization of case review is based on the specifics of the case, the completeness of the information received, or other state or federal requirements. Time may be extended if additional information is needed.
- For services requiring expedited review, please call the telephone number on the Participant’s health care ID card. Expedited review for benefits that require Advance Notification/Prior Authorization or a benefit determination prior to receiving medical care is available where a delay in treatment could seriously jeopardize the Participant’s life or health, or the ability to regain maximum function, or in the opinion of a Physician with knowledge of the Participant’s medical condition, could cause severe pain. You must explain the clinical urgency when requesting an expedited review.
- Services on the Advance Notification/Prior Authorization List require Prior Authorization through a pre-service clinical coverage review that will result in either a coverage approval or adverse coverage determination.

- Once you inform UnitedHealthcare of a planned service on the Advance Notification/Prior Authorization List, UnitedHealthcare will inform you if Prior Authorization through a clinical coverage review is required. UnitedHealthcare will advise you of the required information necessary to complete the review and you will be notified of the coverage decision.
- It is important that you and the Participant are fully aware of coverage decisions before services are rendered.
- **If you provide the service before a coverage decision is rendered, and UnitedHealthcare ultimately determines that the service was not covered, UnitedHealthcare may deny the claim and you must not bill the Participant.** By proceeding prior to the final coverage determination, it is not possible for the Participant to make an informed decision about whether to pay for and receive the non-covered services.
- Receipt of a Prior Authorization approval does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual Participant's benefit plan, the provider being eligible for payment, any claim processing requirements, and the Participating Provider Agreement with Caterpillar.

**Clinical Criteria Used to Determine if Services Are Medically Necessary:**

UnitedHealthcare will review services for medical necessity by applying criteria that focuses on whether the services are: (a) scientifically proven to be effective, (b) clinically appropriate for individual members with their respective and specific conditions and diagnoses, and (c) cost-effective when compared to alternative diagnostic or therapeutic options. UnitedHealthcare will use generally accepted standards of medical practice, which are based on credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community. UnitedHealthcare may also use standards that are based on physician specialty society recommendations, professional standards of care, or other evidence-based, industry recognized resources and guidelines, such as the MCG®, to determine medical necessity and appropriate level of care

**Updates to an Advance Notification/Prior Authorization Request:**

- You may update or provide additional information related to an Advance Notification/Prior Authorization request until a coverage decision is made regarding the service. Once an approval has been rendered, you may update the Advance Notification/Prior Authorization with a change in date of service only (as long as the original date of service has not passed). You may update the date of service on UnitedHealthcareOnline.com or by phone.
- Advance Notification/Prior Authorization is valid only for the date of service or date range designated on the notification. If the designated date of service or date range has passed and the service(s) has not been rendered, a new Advance Notification/Prior Authorization must be obtained.
- No updates can be made to an existing Advance Notification/Prior Authorization **AFTER** the service has been delivered. If during the service, an additional or different service was performed than was originally approved, you must submit the supporting clinical information for the service at the time of claim submission.

**Information to Include with the Advanced Notification/Prior Authorization:**

- Participant name and Alternate ID number.
- Ordering physician, health care professional or ancillary provider name and TIN or National Provider Identification (NPI).
- Rendering physician or health care professional name and TIN or NPI.
- ICD-10-CM diagnosis code for the diagnosis for which the service is requested.
- All applicable procedure codes.
- Anticipated date(s) of service.
- Type of service (primary and secondary) procedure code(s) and volume of service (when applicable).
- Service setting (outpatient, inpatient, physician office, home or other).
- Facility name and TIN or NPI where service will be performed (when applicable)

You must cooperate with all UnitedHealthcare requests for information, documents or discussions for purposes of a clinical coverage review including, but not limited to, all applicable procedure codes, pertinent medical records and imaging studies/reports. Please refer to UnitedHealthcareOnline.com → Tools & Resources → Policies, Protocols and Guides → Protocols → Medical Records Requirement for Pre-Service for a list of individual services and specific, additional required information.

You must respond and return calls from UnitedHealthcare's care management team and/or medical director. You must provide complete clinical information as required within 4 hours if request is received before 1:00 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1:00 p.m. local time (but no later than 12:00 p.m. the next business day).

**How to submit Advance Notification/Admission Notifications/Prior Authorizations Requests:**

Multiple submission options are available to submit Advance Notification/Prior Authorization or Admission Notifications requests to UnitedHealthcare, including electronic methods. To avoid duplication, once an Advance Notification/Prior Authorization or Admission Notifications requests is submitted and confirmation is received, please do not resubmit.

- Notify UnitedHealthcare at UnitedHealthcareOnline.com → Notifications/Prior Authorizations → Notification/Prior Authorization Submission. UnitedHealthcare will accept daily composite census logs for inpatient admissions with complete and relevant information via fax (see fax numbers below).
- If you do not have electronic access, please call UnitedHealthcare at the number on the Participant’s health care ID card.
- Options include:

	EDI 278 Transactions	UnitedHealthcare Online.com	Live Call	VoiCert	Fax
Method	Electronic	Electronic	Non-Electronic	Non-Electronic	Non-Electronic
	Advance Notification and Prior Authorization (278A) and Admission Notification (278N).	Advance Notification and Prior Authorization and Admission Notification; Notification Status for previously submitted notifications.	Advance Notification and Prior Authorization and Admission Notification Status for previously submitted notifications.	Inpatient Admission Notification.	Advance Notification and Prior Authorization and Admission Notification.
Description	X12 EDI submission directly to UnitedHealthcare or through a clearinghouse.	Portal submission directly to UnitedHealthcare through UnitedHealthcareOnline.com	Phone submission directly to UnitedHealthcare through (866) 228-4215.	Phone submission through assigned 800 number specific to facility.	866-756-9733
	Monday - Friday: 7:00 a.m. to 2:00 a.m. Saturday: 7:00 a.m. to 6:00 p.m. Sunday 7:00 a.m. to 6:00 p.m. Holidays: Same as above.	Generally available 24 hours per day, 7 days a week. Maintenance is scheduled outside of the following hours: Monday - Friday: 6:00 a.m. to 12:00 a.m. Saturday: 6:00 a.m. to 7:00 p.m. Sunday: 7:00 a.m. to 5:00 p.m. Holidays: Same as above.	Monday - Friday: 7:00 a.m. to 8:00 p.m. Saturday: 9:00 a.m. to 6:00 p.m. Sunday 9:00 a.m. to 6:00 p.m. Holidays: 9:00 a.m. to 6:00 p.m.	VoiCert can be used 24/7, but submissions are processed the following business day: Monday - Friday: 7:00 a.m. to 8:00 p.m. Saturday: 9:00 a.m. to 6:00 p.m. Sunday 9:00 a.m. to 6:00 p.m. Holidays: 9:00 a.m. to 6:00 p.m.	Faxes can be sent 24/7 but are processed during the following business hours: Monday - Friday: 7:00 a.m. to 8:00 p.m. Saturday: 9:00 a.m. to 6:00 p.m. Sunday 9:00 a.m. to 6:00 p.m. Holidays: 9:00 a.m. to 6:00 p.m.

**Standard Notification Requirements for Facilities:**

- For any inpatient or outpatient service on the Advance Notification/Prior Authorization List, the facility must confirm, prior to rendering the service that the coverage approval is on file. The purpose of this requirement is to enable the facility and the Participant to have an informed pre-service conversation; in cases where it is determined that the service will not be covered the Participant can then decide whether to receive and pay for the service.
- If facility fails to confirm that the coverage approval is on file and instead performs the service before a coverage decision is rendered:
  - If the service is ultimately determined not to have been covered under the Participant’s benefit plan, then UnitedHealthcare may deny the facility’s claim for the non-covered service and, the facility must not bill the Participant or accept payment from the Participant, in light of the facility’s non-compliance with the notification requirement.
  - If a coverage review is in process on the date of service as a result of the Advance Notification/Prior Authorization request AND that coverage review ultimately determines the service to have been a covered service under the Participant’s benefit plan, UnitedHealthcare will not deny the facility’s claim despite the facility’s failure to take specific action to confirm the coverage approval.

**Admission Notification**

- Facilities are responsible for Admission Notification for the following types of inpatient admissions:
  - All planned/elective admissions for acute care
  - All unplanned admissions for acute care
  - All Skilled Nursing Facility (SNF) admissions



- All admissions following outpatient surgery
- All admissions following observation
- All newborns admitted to Neonatal Intensive Care Unit (NICU)
- All newborns who remain hospitalized after the mother is discharged (notice required within 24 hours of the mother's discharge)
- Unless otherwise indicated, Admission Notification must be received within 24 hours after actual weekday admission (or by 5:00 p.m. local time on the next business day if 24 hour notification would require notification on a weekend or federal holiday). For weekend and federal holiday admissions, notification must be received by 5:00 p.m. local time on the next business day.
- Admission Notification by the facility is required even if Advance Notification/Prior Authorization was supplied by the physician and a pre-service coverage approval is on file.
- Receipt of an Admission Notification does not guarantee or authorize payment. Payment of covered services is contingent upon coverage within an individual Participant's benefit plan, the facility being eligible for payment, any claim processing requirements, and the facility's Participating Provider Agreement with Caterpillar Inc.
- Admission Notifications must contain the following details regarding the admission:
  - Customer name, Customer health care ID number, and date of birth
  - Facility name and TIN or NPI
  - Admitting/attending physician name and TIN or NPI
  - Description for admitting diagnosis or ICD-10-CM diagnosis code
  - Actual admission date
- For emergency admissions when a Participant is unstable and not capable of providing coverage information, the facility should notify UnitedHealthcare via phone or fax within 24 hours (or the next business day, for weekend or federal holiday admissions) from the time the information is known, and communicate the extenuating circumstances. UnitedHealthcare will not apply any notification-related reimbursement deductions.
- All Skilled Nursing Facility admissions (Participants skilled services must be authorized by an Optum CarePlus Nurse Practitioner or Physician's Assistant. Failure to coordinate authorizations through the Optum clinician may result in full or partial denial of claims.

**Reimbursement Reductions for Failure to Timely Provide Admission Notification:**

If a facility does not provide timely Admission Notification as described above, reimbursement reductions will apply as follows:

Notification Time Frame	Reimbursement Reduction
Admission notification received after it was due, but not more than 72 hours after admission	100% of the average daily contract rate <sup>1</sup> for the days preceding notification. <sup>2</sup>
Admission Notification received after it was, due and more than 72 hours after admission.	100% of the contract rate (entire stay).
No Admission Notification received.	100% of the contract rate (entire stay).

<sup>1</sup>The average daily contract rate is calculated by dividing the contract rate for the entire stay by the number of days for the entire length of stay.

<sup>2</sup>Reimbursement reductions will not be applied to "case rate facilities" if admission notification is received after it was due but not more than 72 hours after admission. As used here, "case rate facilities" means those facilities in which reimbursement is determined entirely by a MS-DRG or other case rate reimbursement methodology for every inpatient service for all benefit plan subject to these Admission Notification requirement.

**Note:** Reimbursement reductions will not be applied for maternity admissions.

**Inpatient Concurrent Review - Clinical Information:**

- Your cooperation is required with all UnitedHealthcare requests for information, documents or discussions for purposes of concurrent review and discharge planning including, but not limited to: primary and secondary diagnosis, clinical information, treatment plan, admission order, patient status, discharge planning needs, barriers to discharge and discharge date. When available, provide clinical information via access to Electronic Medical Records (EMR).
- Your cooperation is required with all UnitedHealthcare requests from the inpatient care management team and/or medical director to support requirements to engage our Participants directly face-to-face or telephonically.
- You must return/respond to inquiries from our inpatient care management team and/or medical director. You must provide complete clinical information and/or documents as required within 4 hours if our request is received before 1:00 p.m. local time, or make best efforts to provide requested information within the same business day if the request is received after 1:00 p.m. local time (but no later than 12:00 p.m. the next business day).

- UnitedHealthcare uses MCGTM Care Guidelines, CMS guidelines, or other guidelines, which are nationally recognized guidelines, to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. You may request a copy of the clinical criteria by calling Care Management at (877) 842-3210.

**Coverage Determinations and Utilization Management Decisions:**

Coverage decisions on health care services are based on the Participant's medical plan benefit terms. The coverage decisions are made based on the appropriateness of care and services and the existence of coverage as defined within the Participant's medical benefit plan.

UnitedHealthcare employees, contractors, or delegates involved in making these coverage decisions are not compensated or otherwise rewarded for issuing non-coverage decisions. UnitedHealthcare and its delegates do not offer incentives to physicians or utilization management decision makers to encourage underutilization of care or services or to encourage barriers to care and service. Hiring, promoting or terminating employees or contractors is not based upon the likelihood or the perceived likelihood that the individual will support or tend to support the denial

## Covered Benefits

Caterpillar is committed to providing comprehensive benefits that are competitive in our market and are truly valuable to Caterpillar participants. While the Caterpillar Group Insurance Plan does cover most costs related to injury or illness, it provides limited benefits for some preventive care. The passing of the Patient Protection and Affordable Care Act has resulted in the expansion of preventive benefits (including immunizations and more screenings) available to many of our members' plans.

There is an office call benefit of 80% for salaried/management employees; there is no office call benefit for most hourly employees (represented by a union). Cosmetic procedures are normally not covered; in those instances where covered, it would be in the provider's (and patient's) best interest to obtain a pre-determination of benefits from UnitedHealthcare prior to the surgery. There may be maximums in the number of visits and/or dollar amounts for certain benefits.

**If you have any questions regarding benefit coverage, please call UnitedHealthcare at 1-866-CAT-4215 or utilize UnitedHealthcare's online provider portal at [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com).** The "Patient Eligibility & Benefits" tab, providers can find detailed information on a member's plan, deductible and out-of-pocket limits and coverage limitations.

## Pre-Determination of Covered Surgical Services

**The final determination of whether any service is covered under Caterpillar's Plan is the responsibility of UnitedHealthcare.** UnitedHealthcare is responsible for making all coverage determinations based on our Plan provisions. Even though a fee may exist on your fee schedule, the service may not always be considered a coverable expense. If you are performing a service and are unsure whether the service will be covered, please contact UnitedHealthcare's Customer Service at 1-866-CAT-4215 (1-866-228-4215) and request a **pre-determination of coverage**.

The pre-determination process may be found on the following page. It is important to request a **pre-determination of coverage** and not use the terminology "pre-approval" when contacting UnitedHealthcare, unless the service is on the listing of services requiring Advance Notification, Pre-Authorization, or Medical Necessity review. As a general rule, pre-determinations of coverage should be requested for any procedure that may be considered cosmetic in nature (e.g., rhinoplasty, blepharoplasty, breast reduction in the absence of cancer, etc.), investigational or unproven. This will allow for up front confirmation of coverage and expedite a claim's payment cycle. Please contact UnitedHealthcare at 1-866-CAT-4215 and request a **pre-determination** of coverage (not pre-approval). UnitedHealthcare has the responsibility for determining when certain services are covered under Caterpillar's Plan based on our Plan provisions.

## Information and Assistance

### Caterpillar Provider Relations Contacts:

**Kelly Coffey - Provider Credentialing & NetWork Provider Maintenance**

Phone: 309-636-1795

Email: [coffey\\_kelly\\_e@cat.com](mailto:coffey_kelly_e@cat.com)

Fax: 309-992-6609

**Angie Karis – Physician and Ancillary Provider Contracting**

Phone: 309-675-4326

Email: [karis\\_angela\\_m@cat.com](mailto:karis_angela_m@cat.com)

Secure Fax: 309-992-6307

**Beth Brosmer – Hospital and Facility Contracting**

Phone: 309-636-1391

Email: [brosmer\\_beth\\_a@cat.com](mailto:brosmer_beth_a@cat.com)

Secure Fax: 309-992-7417

**Team email box:** [PR\\_Credentialing@cat.com](mailto:PR_Credentialing@cat.com)

Advanced Notification/Pre-Authorization/Medical  
Necessity Requests

1-866-CAT-4215

Case Management &  
Home Health Care Authorization

1-866-CAT-4215

Surgical Pre-Determination

1-866-CAT-4215

Transplant Pre-Authorization

1-866-CAT-4215

Utilization Review

1-866-CAT-4215

Verification of Eligibility

1-866-CAT-4215

Caterpillar NetWork Web Site

<http://benefits.cat.com/en/providers.html>

UnitedHealthcare Physician Portal

[www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com)

### About Benefits.Cat.Com:

As part of Caterpillar's commitment to continually communicate with our provider community, we really encourage you to visit our web site. This site has sections dedicated specifically for our various providers. Here are some of the items contained on this site that may interest you:

- View ID cards for various plans
- Access the Caterpillar Preferred Drug lists
- Search for other Caterpillar network specialists in your area
- View and download the most recent Administrative Manual
- Download our Provider Questionnaire forms and view Credentialing information