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 6:0

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[1] for the days preceding notification.[2]
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).

[1]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.
[2]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 of benefits.