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.

	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