UNITED HEALTHCARE – COMPASS PLANS

United Healthcare (UHC) Compass is an innovative commercial plan built on the fundamentals of patient-centered health. It is offered as an Individual Healthcare Exchange plan in certain states. Members choose a primary care physician (PCP) to help them navigate to high-quality, cost-effective care.

Compass has a limited network service area in certain states (all counties/parishes are currently included in the Louisiana Compass service area) where coverage is available. No coverage is provided outside the network service area, except for emergency and urgent services.

To review more on the Louisiana Healthcare Exchange, see the websites: www.marketplace.cms.gov, www.healthcare.gov and/or http://lahealthexchange.com/ and review the previously published newsblasts:
- 071813 Health Insurance Exchange How-To for Practices
- 080113 Healthcare Reform - The Marketplace

Provider Participation

If a provider participates in other UHC commercial benefit plans, the provider is considered a network provider for the UHC Compass benefit plan if it is offered in his/her market, unless the plan is specifically excluded in his/her participation agreement. Providers will also be listed in the UHC provider directory for each benefit plan.

Not all providers will be included in every network. UHC is creating more focused networks to meet member requests for additional options at affordable prices.

Because UHC networks are built at the local market level, plans offer tailored networks of care providers that may vary by product.

Identifying Patients

Because of the referral requirements for the UHC Compass plan, MEDTRON strongly encourages providers to use Online eligibility (ONELIG) via MEDPM/MEDEHR and/or the UHC website to identify patients’ plan coverage. Providers should also review the patient’s insurance card for plan specific information, specifically look for the word ‘Compass’ and for a PCP.

Insurance cards will display: ‘United Healthcare Compass’

Sample UnitedHealthcare Compass ID Card
Online eligibility (ONELIG) via MEDPM/MEDEHR through a United Healthcare insurance code will display 'Ins Type: C1 – Commercial United Healthcare Compass' and display patients’ PCP.

**MEDPM:**

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our RequestID</td>
<td>800432815</td>
</tr>
<tr>
<td>Web MD Transaction Reference No</td>
<td>271988190</td>
</tr>
<tr>
<td>Patient No</td>
<td>198819</td>
</tr>
<tr>
<td>Requested Elig Date</td>
<td>12/17/2015</td>
</tr>
<tr>
<td>Patient Name</td>
<td>AARON, JESSICA</td>
</tr>
<tr>
<td>Insured Name</td>
<td>AARON, JESSICA</td>
</tr>
<tr>
<td>Insurance</td>
<td>COMPASS/UNITED HEALTHCARE</td>
</tr>
<tr>
<td>Policy No</td>
<td>974610681</td>
</tr>
<tr>
<td>Prv##/TID/NPI Sent</td>
<td></td>
</tr>
<tr>
<td>PCP</td>
<td>HEINEN, JOHN</td>
</tr>
<tr>
<td>Phone</td>
<td>337/457-8681</td>
</tr>
</tbody>
</table>

**MEDEHR:**

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<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician</td>
<td>HEINEN, JOHN</td>
</tr>
<tr>
<td>Primary Care Physician Phone Number</td>
<td>(865) 552 - 3344</td>
</tr>
</tbody>
</table>
```

Additional information:

- **MEDPM:**
  - Subscriber Info: INSURED/SUBSCRIBER is a PERSON Name: AARON, JESSICA
  - Reference ID Type: SOCIAL SECURITY # Reference ID: 468121102
  - Reference ID Type: GROUP # Reference ID: 902682
  - Address: 621 HIGHWAY 190
  - City: EUNICE
  - State: LA
  - Zip: 705652950
  - Date/Time Type: PLAN BEGIN Date/Time Period: 06/01/2015-12/31/2015
  - Elig/Benefit Info: ACTIVE COVERAGE Service Type: HEALTH BENEFIT PLAN COVERAGE
  - Ins Type: C1-COMMERCIAL UNITEDHEALTHCARE COMPASS
  - Information Retrieved on 12/29/2015 at 15:56 by LESLIE
To house and track the referral requirements unique to the UHC Compass plan, if per ONEIL or UHC website or copy of patients insurance card, patient has UHC Compass plan, MEDTRON suggests:

Use Ins Code: COM

At Patient Insurance Maintenance screen:
Update fields:
'Referral Req' → Y
'Pri Care Phy' → key PCP name and phone #

NOTE: If provider is PCP, 'Referral Req' → N.
NOTE: If multi-specialty practice and PCP is a member of the group, i.e., same TID, ‘Referral Req’ → M.

At Patient Demographics, Add/Change Patient Information screen:
Update fields:
'Master Comment Line (MCL)' → COMPASS PLAN PER ONLINE ELIG: REQUIRES REFERRAL FROM PCP
Referrals

The member’s Primary Care Physician (PCP) coordinates the member’s care and generates online electronic referrals to network specialists. **PCPs cannot request referrals via phone, fax or paper!** Referrals must be submitted by the PCP to UHC prior to the member seeking care with any network physician that is not practicing under the same TIN as the PCP. **If the PCP does not follow referral requirements, the member may face financial penalties.** *(See email from UHC at end of this blast)*

Each referral may include up to six visits. Any unused visits expire after six months from the date the referral was entered. After the six visits are used or expire, the PCP may submit another referral to the network specialist for up to six visits. The referral is effective immediately and will be viewable online within 48 hours.

Per calls to UHC Compass, and email to Amy Spivey with UHC (030816):
Referral numbers will start with the letter ‘R’ followed by 9 digits and are not required on the claim.
If billing for a specialist, the PCP name is not required to be on the claim as long as the PCP the member is assigned to matches the PCP referral on file with UHC.

For members with certain chronic conditions, the online referral screen allows standing referrals to be entered for 99 visits if the member’s diagnosis is included in the Referrals for Chronic Conditions policy on www.UnitedHealthcareOnline.com.

**Per MEDTRON calls to a UHC Compass representative, Compass plan allows a one-time exemption per patient to the online referral requirement in which the provider can still be paid without the referral.**

If claim denied, provider must call to request this one-time exemption.

Referral Submission Requirements:
- Referrals must be submitted by the member’s PCP or a PCP with the same tax ID number.
- Users must have security access to submit referrals and check referral status.
- Referrals can be backdated up to five days prior to the date of entry and have a start date of date of submission or a future date

To learn how to request/submit/view referrals, go to [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com) > Help > Quick Reference > Referral Submission & Status.

Eligible services that do not require a referral include:
- Services from physicians with the same tax ID as the member’s PCP
- Network obstetricians/gynecologists, including perinatologists
- Network urgent care centers or convenience clinics
- Routine refractive eye exams from network providers
- Mental health disorder and substance abuse services from network behavioral health clinicians
- Services from pathologists, radiologists or anesthesiologists
- Services in any emergency room or emergency ambulance
- Physician services for emergency/unscheduled admissions
- Any services from facility-based inpatient/outpatient network consulting physicians, network assisting surgeons, network co-surgeons, or network team surgeons
- Any non-physician services, i.e., not billed by a physician specialist, including:
  - Outpatient labs, x-rays or diagnostics
  - Physical therapy, network rehabilitation services, with the exception of physician services such as manipulative treatment and vision therapy
  - Durable medical equipment, home health, prosthetic devices and hearing aids

Specialists must confirm a referral is on file prior to seeing the member, see above Status. The information also determines member benefits, since some plans either have no benefit or higher member cost share if a referral is not obtained. Facilities should also confirm the referral is on file for the admitting specialist for planned admissions.

If the member does not have a referral to see the specialist for planned admissions, then the facility and specialist claims will be denied for no referral. **However, the member is responsible and can be billed!**

<table>
<thead>
<tr>
<th>Plan Models</th>
<th>Network Provider With Referral</th>
<th>Network Provider Without Referral</th>
<th>Non-network Provider*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compass</td>
<td>Network benefits</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>Compass Balanced</td>
<td>Network benefits</td>
<td>Lower-level benefit</td>
<td>No coverage</td>
</tr>
<tr>
<td>Compass Plus</td>
<td>Network benefits</td>
<td>Lower-level benefit</td>
<td>Non-network benefit</td>
</tr>
</tbody>
</table>

*Except for emergency services and related admissions.*
Prior Authorizations (PA#)

Advance notification and prior authorization is required for certain planned services so UHC can determine if the services are covered under the member's benefits. Prior authorization is granted only for services determined to be medically necessary according to the member's benefit plan and applicable policies and guidelines.

The Notification Requirements section of the UHC Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide ("Administrative Guide") covers protocols about services requiring advance notification and prior authorization and the process for providing advance notification.

Admission notification is required for every inpatient admission. The admission notification requirement applies even if a referral or prior authorization is on file. Admission notification is the hospital's responsibility, as outlined in the current Administrative Guide.

It is the physician's responsibility to follow the advance notification or prior authorization procedures as outlined in the Administrative Guide.

Billing Patients

In accordance with the terms of the participation agreement, providers may bill members for non-covered services under certain circumstances.

For example, while joint replacements are generally covered benefits, a medical necessity review (assume when authorization requested) may determine a particular joint replacement for a member is not covered. If the services you provide are not covered under the member's benefit plan for reason of not being medically necessary, you may bill the member only if they have been informed of the decision of non-coverage prior to the date of the service and have specifically agreed in writing to accept financial responsibility. The written agreement must indicate the member understands UHC has determined the service is non-covered and the member chooses to receive the service and be financially responsible for payment.

MEDTRON emailed Amy Spivey, UHC representative to clarify if providers can bill patients if the referral is not obtained:

From: Spivey, Amy C [mailto:amy_c_spivey@uhc.com]
Sent: Wednesday, October 28, 2015 11:26 AM
Subject: RE: UHC Compass plan / 102715

For a United Healthcare Compass or Navigate member, the Member is responsible for obtaining a referral from the PCP prior to seeking services with the specialist. If the member see's the specialist without a referral the Member is responsible, and you (the provider) may bill the patient. Normally when this happens it only happens 1 time then they fully understand that they have to have a referral in place before seeing a specialist (i.e., the one-time exemption).

Resources

UHC Compass:
https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=c8cd9c8e9633e310VgnVCM2000002a4ab10a____

Contact Software Support for assistance or any questions via:
From MEDPM or MEDEHR Sign On screens, double click on ‘support@medtronsoftware.com’ to compose an email to the Software Support Dept.
-OR-
Phone: (985) 234-0599 (local), (800) 978-0599 (toll free)
-OR-
Fax: (985) 234-0609