VOLUME 31 MAY 2009

NetworkBulletin

An important message to health care professionals and facilities

Please route as appropriate to UnitedHealthcare contracted physicians and health care professionals in your office.

In This Issue

UnitedHealthcare®
Healing health care. Together.®

UnitedHealthcare respects the expertise of the physicians and health care professionals who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost effective care, and to support practice staff with a simple and predictable administrative experience. The Network Bulletin was developed to share important updates regarding UnitedHealthcare procedure and policy changes*, as well as other useful administrative and clinical information. The complete bulletin is also available on our web site at www.UnitedHealthcareOnline.com, where you will find additional materials and information regarding many of the subjects addressed here.

*To the extent that this bulletin conflicts with applicable state law, UnitedHealthcare will follow such applicable state law.

Reimbursement Policy

Note Regarding Reimbursement Policies

Unless otherwise noted below, these reimbursement policies apply to services reported using the 1500 Health Insurance Claim Form (CMS-1500) or its electronic equivalent or its successor form.

UnitedHealthcare reimbursement policies do not address all issues related to reimbursement for services rendered to UnitedHealthcare enrollees, such as the enrollee's benefit plan documents, UnitedHealthcare medical policies and the UnitedHealthcare Administrative Guide. Meeting the terms of a particular reimbursement policy is not a guarantee of payment.

Anesthesia Reimbursement Policy - Revisions

Reporting Anesthesia Services

Currently, our Anesthesia Payment Policy allows you to report current procedural terminology (CPT®) anesthesia codes (00100 - 01999) or select surgery/medicine codes (CPT Category I codes 10021- 69990, 90281- 99199) and select Category III codes when submitting claims for general anesthesia or monitored anesthesia care services.

On December 1, 2009, the Anesthesia Payment Policy will be revised to require use of CPT anesthesia codes 00100 – 01999 (excluding 01953 and 01996) to report general anesthesia or monitored anesthesia care services rendered. Claims for general anesthesia or monitored anesthesia care that are submitted with any surgery/medicine codes (CPT Category I codes 10021- 69990, 90281-99199) or any Category III codes and submitted with anesthesia modifiers and/or with anesthesia time in minute will not be eligible for payment.

When reporting the provision of the covered medical or surgical procedure, physicians should submit the claim using the appropriate surgery/medicine codes (CPT Category I codes 10021-99499) and Category III. These services should be submitted without anesthesia modifiers and/or without anesthesia time in minutes.

These changes are being made to better align the policy with nationally recognized coding guidelines of the American Medical Association, the Centers for Medicare & Medicaid Services, and the American Society of Anesthesiologists (ASA).

Obstetrical Anesthesia Services

Under the current UnitedHealthcare Anesthesia Reimbursement Policy, when different individual physicians or health care professionals provide the epidural anesthesia for a vaginal delivery and a cesarean section delivery with or without a hysterectomy, the services are reported as follows:

- When one physician provides an epidural for a planned vaginal delivery and another physician performs the cesarean section delivery, then report CPT codes 01967 and 01961 respectively.
- When one physician provides an epidural for a planned vaginal delivery and another physician performs the cesarean section delivery followed by a hysterectomy, then report CPT code 01967 and CPT code 01963 respectively.

Effective in third quarter of 2009 and based on ASA guidelines, the policy will be revised as follows:

- When different individual physicians or health care professionals provide an epidural for a planned vaginal delivery that results in a cesarean section delivery, CPT code 01967 should be reported with the add-on CPT code 01968.
- When different individual physicians or health care professionals provide an epidural for a planned vaginal delivery that results in cesarean section delivery followed by a hysterectomy, then CPT code 01967 should be reported with the add-on CPT code 01969.

Same Day Same Service Policy Revision - *Implementation Update*

As previously announced in the *Network Bulletin*, the Same Day Same Service Policy will be revised to separately reimburse counseling or risk factor reduction intervention services (CPT 99401-99412 & HCPCS G0396-G0397) when reported with an E/M service that is appended with modifier 25. The policy will also be revised to separately reimburse an E/M service

appended with modifier 25 when reported with general ophthalmological services (92002-92014), as well as other E/M Services (99202-99477).

Please be advised that these policy changes are now targeted for the fourth quarter of 2009.

Urgent Care Policy - *Implementation Update*

The *Network Bulletin* article published in January 2009 indicated that effective second quarter of 2009, UnitedHealthcare would implement a new policy that will not separately reimburse the following urgent care S codes in any place of service:

- S9083 Global fee urgent care centers
- S9088 Services provided in an urgent care center (list in addition to code for service)

The system enhancement that is required to not separately reimburse S9088 will become effective third quarter of 2009. Implementation of S9083 has been delayed until further notice.

Medical Policy

Updates

UnitedHealthcare has recently reviewed the clinical evidence supporting the safety and effectiveness of certain medical technologies. The following is a summary of medical policy updates resulting from this review. The appearance of an item or procedure in the list below indicates only that UnitedHealthcare has recently updated or revised a policy; it does not imply that UnitedHealthcare provides coverage for the item or procedure listed. Note that most UnitedHealthcare benefit plan documents exclude from benefit coverage health services identified as investigational or unproven. Physicians and other health care professionals may seek and collect payment from a UnitedHealthcare member for services not covered by the applicable benefit plan, provided they first obtain the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.

Unless otherwise indicated, the policy revisions outlined below will be effective on July 1, 2009. Once implemented, the revised policies may be viewed, in their entirety, on ***UnitedHealthcareOnline.com > Tools & Resources > Policies and Protocols > Medical Policies.***

Policy Title	Summary of Changes	Revised Coverage Rationale
Balloon Sinuplasty	• Revised coverage rationale; removed language indicating the use of balloon sinus catheters to gain access to the sinus without the intent to permanently enlarge the ostium during endoscopic sinus surgery is unproven for the treatment of chronic sinusitis due to inadequate clinical evidence of safety and/or efficacy in published peer-reviewed medical literature • Removed 31256, 31276 and 31287 from list of applicable CPT codes	Balloon sinuplasty during endoscopic sinus surgery is unproven for the treatment of chronic sinusitis.
Bone Growth Stimulators *Note: The revised policy will be implemented in late second quarter or early third quarter of 2009.*	• Policy title changed; previously titled *Electrical and Ultrasound Bone Growth Stimulators* • Revised coverage rationale for; – **Bone growth stimulation using noninvasive or invasive electrical stimulators:** • Removed healing of short bones from list of conditions for which treatment is proven • Specified names of long bones (femur, tibia, fibula, humerus, radius and ulna) for which treatment is proven – **Bone growth stimulation using ultrasound stimulators:** • Removed smoking and age guidelines from criteria for which treatment is proven • Added proven indications for the treatment of for fresh fractures • Added language to indicate treatment is proven for nonunion fractures of the femur, tibia, fibula, humerus, radius and ulna • Added language to indicate bone growth stimulation is unproven to facilitate healing of nonunion fractures in bones other than those listed as proven • Removed coverage rationale for interferential therapy • Added definition for multiple-level fusion • Removed E0761from list of applicable HCPCS codes	Bone growth stimulation using noninvasive or invasive electrical stimulators is proven to facilitate healing of the following: • Nonunion fractures of the femur, tibia, fibula, humerus, radius or ulna • After spinal fusion surgery when: – a. nonunion exists, or – b. patient has previous fusion failure, or – c. patient requires multiple-level fusion Bone growth stimulation using ultrasound stimulators is proven when used as an adjunct to closed reduction and immobilization for the following fresh fractures: • closed or grade I open tibial fractures, or • closed fractures of the distal radius (Colles' fracture) Bone growth stimulation using ultrasound stimulators is proven for nonunion fractures of the femur, tibia, fibula, humerus, radius or ulna. Bone growth stimulation is unproven to facilitate healing of; • Tumor-related fractures. • Nonunion fractures in bones other than those listed above as proven.

Policy Title	Summary of Changes	Revised Coverage Rationale
Cognitive Rehabilitation	• Revised coverage rationale: – Added language to clarify types of brain injury for which treatment is proven. The revised coverage statement now indicates cognitive rehabilitation is proven for the treatment of traumatic brain injury and brain injury due to stroke, aneurysm, anoxia, encephalitis, brain tumors and brain toxins when the patient can interactively participate in the program. – Added language to indicate cognitive rehabilitation is unproven for the treatment of cerebral palsy, Down syndrome, Alzheimer's disease, attention deficit hyperactivity disorder, and developmental disorders such as autism and Parkinson's disease – Coma stimulation remains unproven for the treatment of comatose or minimally responsive patients • Removed 97533 from list of applicable CPT codes	Cognitive rehabilitation is proven for the treatment of traumatic brain injury and brain injury due to stroke, aneurysm, anoxia, encephalitis, brain tumors, and brain toxins when the patient can interactively participate in the program (e.g., is not comatose or at a level of consciousness that would preclude such interaction). The treatment regimen usually includes one of the following modalities: • Specific interventions for functional communication deficits, including pragmatic conversational skills; or • Compensatory memory strategy training Cognitive rehabilitation is unproven for the treatment of cerebral palsy, Down syndrome, Alzheimer's disease, attention deficit hyperactivity disorder, developmental disorders such as autism, and Parkinson's disease. Coma stimulation is unproven for the treatment of comatose or minimally responsive patients who have sustained a brain injury.
Deep Brain Stimulation	• Policy title changed; previously titled *Deep Brain Stimulation for the Treatment of Movement Disorders* • Added chronic pain to list of conditions for which deep brain stimulation is unproven	Deep brain stimulation is proven for treating; • Idiopathic Parkinson's disease when standard recognized medical therapy has either failed to relieve the symptoms, or the side effects of the medications prohibit their continued use. • Essential tremor when standard recognized medical therapy has either failed to relieve the symptoms, or the side effects of the medications prohibit their continued use. • Chronic, intractable primary dystonia (occurs on its own, apart from any illness), including generalized and/or segmental dystonia, hemidystonia and cervical dystonia (torticollis). Deep brain stimulation is unproven for treating; • Secondary dystonia (occurs with illness, after trauma or following exposure to certain medications or toxins). • Treating conditions other than those listed to be proven indications as listed above. Some studies have examined the use of deep brain stimulation for treating major depression, obsessive-compulsive disorder (OCD), epilepsy, Tourette syndrome, cluster headache, impulsive or violent behavior, stroke pain, chronic pain, phantom limb

Policy Title	Summary of Changes	Revised Coverage Rationale
Deep Brain Stimulation ***(continued)***		pain, trigeminal neuralgia and movement disorders of multiple sclerosis (MS). However, because of limited studies, small sample sizes, weak study designs and heterogenous patient characteristics, there is insufficient data to conclude that deep brain stimulation is safe and/or effective.
Dysfunctional Uterine Bleeding and Uterine Fibroids *Note: The revised policy will be implemented in late second or early third quarter 2009.*	• Updated coverage rationale to indicate; – endometrial cryoablation (ECA), thermal balloon endometrial ablation (TBEA), hydrothermal endometrial ablation (HTEA), and levonorgestrel-releasing IUD (LNG-IUD) are proven for the treatment of dysfunctional uterine bleeding in premenopausal women – radiofrequency endometrial ablation (NovaSureTM) is proven for the treatment of menorrhagia in premenopausal women • Removed language indicating; – ECA and levonorgestrel-releasing IUD are unproven for the treatment of uterine fibroids – TBEA and HTEA are unproven for the treatment of dysfunctional uterine bleeding in women with known or suspected endometrial carcinoma, premalignant changes of the endometrium, fibroids, or who wish to retain the ability to become pregnant – uterine artery embolization (UAE) is not recommended for preservation of the uterus and myomectomy is not an alternative for technical reasons • Deleted 37204 from list of applicable CPT codes	Endometrial cryoablation (ECA), thermal balloon endometrial ablation (TBEA), hydrothermal endometrial ablation (HTEA), and the levonorgestrel-releasing intrauterine device (LNG-IUD) are proven for the treatment of dysfunctional uterine bleeding in premenopausal women. Radiofrequency endometrial ablation (NovaSureTM) is proven for the treatment of menorrhagia in premenopausal women. Magnetic resonance imaging (MRI)-gu ided cryoablation and magnetic resonance imaging (MRI)-guided focused ultrasound ablation (FUA) are unproven for the treatment of uterine fibroids. Uterine artery embolization (UAE) is proven for the treatment of confirmed, symptomatic uterine fibroids. Additional clinical recommendations for the use of uterine artery embolization include: • Presence of symptomatic myomata or leiomyomata, including menorrhagia and pain • Failed pharmacotherapy
Electric Stimulation and Electromagnetic Therapy for Wounds	• Topic previously address in the medical policy titled *Treatment of Wounds and Soft Tissue Injuries*; coverage rationale now outlined in a separate policy • No changes to coverage rationale	Electrical stimulation and electromagnetic therapy are unproven for the treatment of wounds including venous stasis ulcers, arterial ulcers, diabetic foot ulcers, chronic pressure sores, and soft tissue injuries.
Epiduroscopy, Epidural Lysis of Adhesions and Functional Anesthetic Discography	• Policy title changed; previously titled *Epiduroscopy and Epidural Lysis of Adhesions* • Revised coverage rationale; added language to indicate: – Spinal myeloscopy is unproven for the diagnosis of back pain – Functional anesthetic discography (FAD) is unproven for the diagnosis of back pain • Added 64999 to list of applicable CPT codes	Epiduroscopy (including spinal myeloscopy) is unproven for the diagnosis of back pain. Functional anesthetic discography (FAD) is unproven for the diagnosis of back pain. Percutaneous and endoscopic epidural lysis of adhesions are unproven for the treatment of back pain.

Policy Title	Summary of Changes	Revised Coverage Rationale
Genetic Testing for Breast Cancer: BRCA1, BRCA2 and BRAC *Note: The revised policy will be implemented on August 16, 2009.*	• Added definitions of *close blood relatives and limited family history* • Added language to indicate; – a breast cancer diagnosis includes either invasive or noninvasive (lobular, ductal carcinoma in situ) types – epithelial cancer includes fallopian tube cancers and primary peritoneal carcinoma – genetic counseling is strongly recommended prior to BRCA testing in order to inform members about the advantages and disadvantages of such testing • Added proven indications for; – testing for female members with; • A personal history of not only breast cancer, but also epithelial ovarian cancer • Breast cancer diagnosed at any age with a personal history of epithelial ovarian cancer, two close blood relatives with breast or epithelial ovarian cancer, two breast primaries in a single individual with a family history of breast, or epithelial ovarian cancer • Known BRCA 1 or 2 mutation • Epithelial ovarian cancer – testing of male and female members without a personal history of breast or epithelial ovarian cancer with strong family history of disease, Ashkenazi Jewish descent, and known BRCA 1 or 2 mutations – women with exceptionally high risk family or personal history, but are determined to be BRCA 1 and/or 2 negative • Removed coverage guidelines for HER2	***Effective August 16, 2009:*** **BRCA Testing** I. BRCA 1 and BRCA 2 testing is proven for female members with a personal history of breast and/or epithelial ovarian cancer in the following situations: 1. Breast cancer diagnosed at age 40 or younger with or without family history; or 2. Breast cancer diagnosed at age 50 or younger with: A. At least one close blood relative with breast cancer at age 50 or younger; or B. At least one close blood relative with epithelial ovarian cancer; or C. Limited family history 3. Breast cancer diagnosed at any age with: A. Personal history of epithelial ovarian cancer; or B. At least two close blood relatives on the same side of the family with breast cancer and/or epithelial ovarian cancer at any age; or C. Two breast primaries in a single individual with at least one close blood relative with breast cancer diagnosed at age 50 years or younger; or D. Two breast primaries in a single individual with at least one close blood relative with epithelial ovarian cancer; or E. Close male blood relative with breast cancer; or F. At least one close blood relative who has a BRCA1 or BRCA2 mutation; or G. Ashkenazi Jewish or ethnic groups associated with higher mutation frequency such as, Icelandic, Swedish, or Hungarian descent. 4. Epithelial ovarian cancer at any age with or without family history II. BRCA 1 and BRCA 2 testing is proven for male and female members without a personal history of breast or epithelial ovarian cancer in the following situations: 1. Members with three or more affected first-degree or second-degree blood relatives on the same side of the family with breast or epithelial ovarian cancer, irrespective of age at diagnosis; or

Policy Title	Summary of Changes	Revised Coverage Rationale
Genetic Testing for Breast Cancer: BRCA1, BRCA2 and BRAC ***(continued)***		2. Members with two first or second-degree relatives with: A. Epithelial ovarian cancer; or B. Breast cancer, one of whom was diagnosed at age 50 or younger; or 3. Members with one or more first-degree or second-degree relatives with epithelial ovarian cancer and one or more first-degree or second-degree blood relatives on the same side of the family with breast cancer at any age; or 4. Members with one or more first-or second-degree relatives with: A. Multiple primary or bilateral breast cancers in a single individual and another first-degree or second-degree relative on the same side of the family with breast cancer diagnosed at age 50 years or younger; or B. Multiple primary or bilateral breast cancers in a single individual and another first-degree or second-degree blood relative on the same side of the family with epithelial ovarian cancer; or C. Close male blood relatives with breast cancer; or D. A known BRCA1 or BRCA2 mutation; or E. Breast cancer or epithelial ovarian cancer at any age in an individual of Ashkenazi Jewish descent III. BRCA1 and BRCA2 testing is proven for male members with a personal history of breast cancer and any of the following: 1. At least one close male blood relative with breast cancer; or 2. At least one close female blood relative with breast or epithelial ovarian cancer; or 3. At least one close blood relative who has a BRCA1 or BRCA2 mutation; or 4. Ashkenazi Jewish descent IV. BRCA1 and/or 2 testing is unproven for all other indications including screening of breast or ovarian cancers or for risk assessment of other cancers

Policy Title	Summary of Changes	Revised Coverage Rationale
Genetic Testing for Breast Cancer: BRCA1, BRCA2 and BRAC ***(continued)***		**BRAC Analysis Rearrangement Test (BART)** BRACAnalysis Rearrangement Test (BART) is unproven for the purpose of screening in the general population. There is inadequate clinical evidence that such screening reduces mortality from breast cancer in a normal risk population. BRACAnalysis Rearrangement Test (BART) is proven for women with exceptionally high risk who have tested negative for sequence mutations and the common large rearrangements already included in Myriad's test and meet the additional selection criteria for BART. One of the following criteria must be met for BART testing: • Invasive breast cancer before age 50 and additional family history of two or more diagnoses of invasive breast cancer before age 50 and/or ovarian cancer at any age • Ovarian cancer at any age and additional family history of two or more diagnoses of invasive breast cancer before age 50 and/or ovarian cancer at any age • Male invasive breast cancer at any age and additional family history of two or more diagnoses of invasive breast cancer before age 50 and/or ovarian cancer at any age • Invasive breast cancer at or after age 50 and ovarian cancer at any age and additional family history of one or more diagnosis of invasive breast cancer before age 50 and/or ovarian cancer at any age • Invasive breast cancer before age 50 and ovarian cancer at any age and no additional relatives required **Genetic Counseling** Genetic counseling is strongly recommended prior to genetic testing for BRCA mutations in order to inform persons being tested about the advantages and limitations of a specific genetic test as applied to a unique person.

Policy Title	Summary of Changes	Revised Coverage Rationale
High Frequency Chest Wall	• Policy title changed; previously titled *High Frequency Chest Wall* Compression and Respiratory Devices • Revised coverage rationale; – Removed coverage guidelines for respiratory devices used for the management of pulmonary secretions in patients with cystic fibrosis – Added respiratory symptoms attributed to amyotrophic lateral sclerosis (ALS), familial dysautonomia, and quadriplegia to list of diagnosis for which high-frequency chest wall compression (HFCWC) is unproven	High-frequency chest wall compression (HFCWC), as a form of chest physical therapy, is proven for treating or preventing pulmonary complications of the following conditions: • cystic fibrosis (CF) OR • bronchiectasis High-frequency chest wall compression (HFCWC), as a form of chest physical therapy, is unproven for diagnoses other than cystic fibrosis and bronchiectasis, including, but not limited to respiratory symptoms attributed to amyotrophic lateral sclerosis (ALS), familial dysautonomia or quadriplegia.
Manipulation Under Anesthesia	• Revised coverage rationale to indicate manipulation under anesthesia is unproven for serial manipulations for any body part or multiple body joints for the management of acute or chronic pain conditions • Removed 718.26, 718.46, 812.40, 813.01, 839.69 and V43.65 from list of applicable diagnosis codes	Manipulation under anesthesia is proven for the treatment of musculoskeletal conditions of the following body parts and joints: • Elbow joint for arthrofibrosis following elbow surgery or fracture • Knee joint for arthrofibrosis following total knee arthroplasty, knee surgery, or fracture • Pelvis for acute traumatic fracture or dislocation • Shoulder joint for adhesive capsulitis (frozen shoulder) Manipulation under anesthesia is unproven for the treatment of musculoskeletal conditions of the following body parts and joints: • Ankle • Finger • Hip joint or adhesive capsulitis of the hip • Knee joint for any condition other than for arthrofibrosis following total knee arthroplasty, knee surgery, or fracture • Pelvis for diastasis or subluxation • Shoulder for any condition other than adhesive capsulitis (frozen shoulder) • Spine • Temporomandibular joint (TMJ) • Wrist Manipulation under anesthesia is unproven for serial manipulations for any body part or multiple body joints for the management of acute or chronic pain conditions.

Policy Title	Summary of Changes	Revised Coverage Rationale
Mechanical Stretching and Continuous Passive Motion Devices *Note: The revised policy will be implemented in late second quarter or early third quarter of 2009.*	• Revised proven indications for low-load prolonged-duration stretch (LLPS) devices and continuous passive motion (CPM) devices: – LLPS devices, previously proven for treating joint contractures of the upper and lower extremities, are now limited to use in the knee, elbow, wrist and finger – CPM devices, previously proven for treating joint contractures of the upper and lower extremities, are now limited to use; • Following manipulation under anesthesia for joint contractures of the knee or elbow • As an adjunct to physical therapy following total knee arthroplasty • Added E1820 and E1821 to list of applicable HCPCS codes	**Mechanical Stretching** Dynamic splinting devices, also known as low-load prolonged-duration stretch (LLPS) devices, are proven, as an adjunct to physical therapy, for treating joint contractures of the knee, elbow, wrist and finger. **Continuous Passive Motion** Continuous passive motion (CPM) devices are proven; • When used following manipulation under anesthesia for joint contractures or arthrofibrosis of the knee or elbow. • As an adjunct to physical therapy, during the postoperative rehabilitation period following total knee arthroplasty. Continuous passive motion devices are unproven for; • Use following the procedures noted below: – Anterior cruciate ligament (ACL) repair – Cartilage transfer [e.g., osteochondral allograft transplantation (OATS) or mosaicplasty] – Autologous chondrocyte implantation (ACI) – Intra-articular fracture repair (e.g., tibial plateau fracture) • Use following surgery of the upper extremities. • Conditions of the lumbar spine.
Orthoptic and Vision Therapy	• Revised coverage rationale to indicate; – Visual perceptual therapy is unproven for the treatment of any type of learning disability or language disorder, including developmental delay – Vision restoration therapy unproven as a treatment for visual field deficits following stroke or neurotrauma • Added 92499 to list of applicable CPT codes • Removed 95.36 from list of applicable ICD-9 Procedure codes	Occlusion therapy is proven for the treatment for amblyopia (lazy eye). Prism adaptation therapy (prior to surgery) is proven for the treatment of acquired esotropia (form of strabismus when the eye deviates inward). Orthoptic therapy is; • Proven for the treatment of convergence insufficiency (ability of eyes to fix on the same point) in the absence of accommodative (focusing) disorder. • Unproven for the treatment of dyslexia and other learning and reading disabilities. Vision therapy is unproven for the treatment of divergence excess exotropia (eye deviates outward) and convergence excess (double vision).

Policy Title	Summary of Changes	Revised Coverage Rationale
Orthoptic and Vision Therapy ***(continued)***		Visual perceptual therapy is unproven for any type of learning disability or language disorder, including developmental delay. Vision restoration therapy is unproven as a treatment for visual field deficits following stroke or neurotrauma.
Platelet Derived Growth Factors for Treatment of Wounds	• Topic previously address in the medical policy titled *Treatment of Wounds and Soft Tissue Injuries*; coverage rationale now outlined in a separate policy • Revised coverage rationale to indicate autologous platelet-derived growth factors (e.g., Procuren®, Autologel® and SafeBlood®) are unproven for the treatment of chronic non-healing wounds	Becaplermin (Regranex® Gel) is proven for the treatment of lower extremity diabetic neuropathic ulcers when used according to U.S. Food and Drug Administration (FDA) approved indications. Becaplermin should be used in combination with standard ulcer wound care. Autologous platelet-derived growth factors (e.g., Procuren®, Autologel® and SafeBlood®) are unproven for the treatment of chronic non-healing wounds. The better designed studies do not demonstrate that autologous platelet-derived growth factors such as Procuren®, Autologel® or SafeBlood® improve healing in chronic wounds.
Topical Oxygen Therapy for Wounds	• Topic previously address in the medical policy titled *Treatment of Wounds and Soft Tissue Injuries*; coverage rationale now outlined in a separate policy • No changes to coverage rationale	Topical oxygen therapy is unproven for the treatment of wounds.
Warming Therapy and Ultrasound Therapy for Wounds	• Topic previously address in the medical policy titled *Treatment of Wounds and Soft Tissue Injuries*; coverage rationale now outlined in a separate policy • Revised coverage rationale to indicate low frequency ultrasound is unproven for the treatment of wounds	Warming therapy, noncontact normothermic wound therapy, and low frequency ultrasound are unproven for the treatment of wounds.

BRCA Genetic Testing Notification and Expanded Access to Genetic Counseling Effective August 16, 2009

Advances in clinical genomics have led to a significant increase in the number of available genetic tests. While these tests may provide valuable information to both doctors and patients, many genetic tests are ordered and performed with incomplete information, unclear indications, and insufficient support services such as test interpretation and genetic counseling. Consequently, patients may experience confusion, anxiety, additional diagnostic testing and in some cases even inappropriate surgery.

In particular, there has been an increase in the use of BRCA testing for breast and ovarian cancer, and this important test is often ordered and performed with insufficient indications for its use. Fortunately, criteria for the use of BRCA testing have been established by organizations such as the United States Preventive Services Task Force, the American College of Genetic Medicine, the American Cancer Society, and the American College of Obstetrics and Gynecology. Therefore, UnitedHealthcare1 is implementing the BRCA Genetic Testing Notification and Counseling program. The program will have two components:

- Prior notification of BRCA genetic testing; and
- Improved access to genetic counseling for UnitedHealthcare members requesting BRCA testing.

BRCA Genetic Testing Notification

Beginning August 16, 2009, UnitedHealthcare and certain Affiliates will require prior notification for all BRCA tests, ordered by all physicians without exception (HCPCS codes S3818 – S3823). The following information will be required as part of the notification process: the patient's ancestry, personal history and three-generation history of breast and/or ovarian cancer.

The coverage determination made regarding BRCA testing for your patient will be based on the UnitedHealthcare medical policy for BRCA testing, which is based on the clinical evidence and is closely aligned with the criteria developed by the organizations listed above. This coverage determination will be conveyed to you promptly by either phone, or letter or both. Of course, adverse determinations are subject to all applicable appeal rights.

Genetic Counseling

As a service to you and your patients, UnitedHealthcare is making available, subject to the patient's benefit plan, improved access to independent and American Board of Genetic Counseling-certified genetic counselors. When we are notified about an intended test, you and your patient will be provided information about accessing this service. The genetic counselor will be prepared to discuss the following information:

- The uses of the BRCA test;
- The evidence used to determine who will benefit from testing; and
- Assistance for your patient to interpret the results and treatment options available.

1 This program applies to commercial members enrolled in benefit plans issued or administered by UnitedHealthcare, Oxford Health Plans and UnitedHealthcare Plan of the River Valley, Inc. The program does not apply to members enrolled in government programs (e.g., SecureHorizons®, Evercare® and AmeriChoice®).

Intensity Modulated Radiation Therapy

UnitedHealthcare and its affiliates have recently reviewed the clinical evidence regarding Intensity Modulated Radiation Therapy (IMRT) and concluded that the use of IMRT is proven in certain circumstances.

Proven Conditions

The use of IMRT is proven for the following conditions:

- Primary Bone and Articular Cartilage cancer of the skull and face, vertebral column, sacrum, and coccyx
- Anal cancer
- Esophageal cancer
- Prostate cancer
- Trachea cancer
- Head and neck cancer

- Malignant (primary and secondary) and benign nervous system neoplasms of the brain (including cranial nerves and cerebral meninges) and spinal cord (including spinal meninges)

Clinical evidence supports that the use of IMRT is proven preferentially for the treatment of breast cancer when homogeneity of dose is essential and the patient has at least one of the following conditions:

- Macromastia as defined by cup size of D or larger

or

- Separation of 25.5 cm or more in the intra-thoracic distance from the midpoint of the posterior light field border of the medial tangential field to the midpoint of the posterior light field of the lateral tangential field.

Additional Coverage Information

Treatment with IMRT for conditions not considered proven, or if the member's condition does not meet the criteria listed below, will be denied as unproven.

IMRT may be indicated for an unproven diagnosis when at least one of the following conditions is present:

- the target volume is in close proximity to critical structures that must be protected

or

- an immediately adjacent area has been previously irradiated and abutting portals must be established with high precision

The UHC IMRT policy is available for your review at ***UnitedHealthcareOnline.com > Tools & Resources > Policies & Protocols > Medical Policies after June 1, 2009***.

Notification Process

Review of all cases for IMRT will be required for members insured by UnitedHealthcare, Oxford, Mid Atlantic Health Plan, Neighborhood Health Partnership and UnitedHealthcare of the River Valley, Inc. Effective dates and process are outlined below. Additional information regarding the process for each entity will be available in the July *Network Bulletin* and on the respective Web sites.

Required information for the IMRT review will need to be forwarded to the appropriate entity. Information necessary for the review includes: member demographics, physician demographics, facility demographics, diagnosis and ICD9 code, clinical information for cases that are not listed as proven conditions. For diagnoses that are not listed above as proven conditions, you may need to provide information mentioned under the "Additional Coverage Information".

Mid Atlantic Health Plan - effective July 1, 2009
Currently, MD Individual Practice Association (MDIPA) and Optimum Choice, Inc (of the Mid-Atlantic Health Plans) require precertification for all radiation therapy. This will not change. Effective July 1, 2009, all requests for IMRT will be reviewed to determine if the request meets the proven criteria for IMRT. Request for IMRT will need to be submitted to Mid-Atlantic Health Plan in writing and need to include the clinical indication for IMRT. These requests can be faxed to **(301) 545-5893**.

Neighborhood Health Partnership - effective July 1, 2009
Currently, Neighborhood Health Partnership (NHP) requires precertification for all radiation therapy. This will not change. Effective July 1, 2009, all requests for IMRT will be reviewed to determine if the request meets the proven criteria for IMRT. The IMRT policy is available for your review at ***UnitedHealthcareOnline.com > Tools & Resources > Policies & Protocols > Medical Policies***. Requests for IMRT will need to be submitted to Alere (Quality Oncology) and need to include the clinical indication for IMRT. To make a request, call **(800) 423-3223** or fax to **(800) 816-6395**.

UnitedHealthcare Plan of the River Valley, Inc. – effective July 1, 2009
UnitedHealthcare Plan of the River Valley, Inc will start requiring prior authorization on July 1, 2009, for all requests for IMRT starting July 1, 2009, or thereafter. Physicians should follow the standard prior authorization process. Requests for preauthorization may be submitted by fax to **(888) 242-9058** (Midwest) or **(888) 242-9078** (Southeast) or by mail to:

River Valley Entities, Clinical Coverage Review Department
1300 River Drive
Moline, IL 61265

Requests for IMRT must include the clinical indication for IMRT. The revised medical policy entitled Intensity

Modulated Radiation Therapy will be posted beginning June 1, 2009, in the Coverage Policy Library.

Oxford Health Plans – effective September 1, 2009
Oxford will continue to require precertification for the use of IMRT for all patients; Providers should continue to follow this process. Requests for precertification may be submitted via OxfordHealth.com or by calling Oxford's Medical Management Department at **(800) 666-1353**. The policy entitled *Intensity Modulated Radiation Therapy (IMRT) for Commercial Plans* will be posted for your reference at ***OxfordHealth.com > Providers > Tools & Resources > Practical Resources > Medical & Administrative Policies > Policy Update Bulletin***.

UnitedHealthcare – effective September 1, 2009
UnitedHealthcare will require advanced notification for all members receiving IMRT starting September 1, 2009. UnitedHealthcare will require physicians to complete a brief document providing clinical rational for IMRT. Providers will be able to fax the required information for review. The Advanced Notification form, fax number and additional details about the process will be announced in the July Network Bulletin and on our Web site.

PacifiCare - effective September 1, 2009
PacifiCare will require prior authorization for all members receiving outpatient IMRT starting September 1, 2009. Physicians treating capitated HMO members will follow their existing authorization protocols to ensure compliance with this policy. Physicians treating all other members will be required to complete and forward to PacifiCare a brief document providing clinical rational for IMRT and will receive a notification of the coverage decision. The prior authorization form, fax numbers and additional details about the process will be announced in the July *Network Bulletin* and on our Web site.

Other entities
At this time, the process for IMRT claims for benefits issued or administered by AmeriChoice, Evercare and SecureHorizons have not been changed. Any changes will be announced in future Network Bulletins and on our Web site(s).

KRAS Testing Required

Effective April 1, 2009, for UnitedHealthcare and Oxford members, the submission of a pathology report documenting KRAS gene type is required in order to determine coverage for Erbitux® (cetuximab, J9055) and Vectibix® (panitumumab, J9303). Subject to the member's benefit plan document, coverage will be available for individuals with colorectal cancer when the normal, (wild-type) KRAS gene is present.

Effective May 1, 2009 Evercare®, SecureHorizons® and UnitedHealthcare Services Company of the River Valley, Inc. is requiring the submission of a pathology report demonstrating the presence of the wild-type KRAS gene in order to determine coverage for cetuximab and panitumumab.

Effective September 1, 2009, PacifiCare, will require the submission of a pathology report documenting KRAS gene type in order to determine coverage for cetuximab and panitumumab. Physicians treating capitated HMO members will follow their existing authorization protocols to ensure compliance with this policy. Physicians treating all other members will be required to forward to PacifiCare the pathology report for review. Additional details about the process will be announced in the July *Network Bulletin* and on the PacifiCare web site.

Claims in which the patient has the KRAS gene mutation are not eligible for reimbursement. The pathology report will only be required once, at the time of the initial claim. Claims for members that have started treatment with cetuximab and panitumumab prior to the effective date will not require the submission of a pathology report for claims processing.

UnitedHealthcare has contracted with two national laboratory companies (Genzyme Genetics and LabCorp) that provide KRAS testing. Many local UnitedHealthcare contracted laboratories also may have the capability to do KRAS testing.

The UnitedHealthcare medical policy entitled KRAS Mutation Analysis in Metastatic Colorectal Cancer is posted for your review on ***UnitedHealthcareOnline.com > Clinician Resources > Cancer – Oncology***. Select KRAS from the list of topics on the left side of the screen and select "KRAS Pathology Requirement" under Tools & Resources. This document provides entity specific implementation details (effective date, pathology report submission, etc).

Claims

Facility Outpatient Procedure Grouper Mapping - July 1, 2009 Update

Each year UnitedHealthcare reviews the outpatient procedure grouper (OPG) mapping used in reimbursing outpatient procedures in hospitals and Ambulatory Surgery Centers contracted under this methodology. Annual updates reflect additions, deletions and changes to the CPT/HCPCS codes assigned to specific grouper levels.

The updated UnitedHealthcare OPG mapping defining the CPT/HCPCS code assignment to grouper level will be effective July 1, 2009. There have been 106 codes added. Of the codes that are the same from the 2008 OPG, 95% are assigned to the same grouper level – 1.6 % have decreased in level assignment and 3.4% have increased in level assignment.

Within the total codes added are 79 codes that the Centers for Medicare and Medicaid Services (CMS) considers reimbursable on an inpatient basis only but are being assigned to a grouper level for outpatient reimbursement by UnitedHealthcare. These codes were identified by a review of national guidelines as appropriate for outpatient procedures when ordered by a physician. Effective July 1, 2009, reimbursement for outpatient procedures will be based on this revised mapping.

Please remember that for reimbursement under the OPG, UnitedHealthcare requires the appropriate line level CPT/HCPCS codes in addition to the revenue codes when billing for outpatient procedures.

Pharmacy Updates

Note: Updates do not apply to PacifiCare and Prescription Solutions. See the Affiliates section for updates specific to PacifiCare and Prescription Solutions.

Medical Benefit Vendor Update

UnitedHealthcare's strategic efforts to create a well managed specialty network under the pharmacy benefit has resulted in better health outcomes and significant cost savings for our customers. We are extending that strategy to the medical benefit, which may affect your existing and new patients who have medical benefits with UnitedHealthcare, SecureHorizons®, Evercare® and AmeriChoice® [1].

As part of an effort to strengthen our specialty pharmacy and home infusion network's performance, we are terminating four contracts and changing one contract agreement benefit over the next several months, leaving several providers who will continue serving our members. This network transition will help contain the escalating costs of specialty medications, while maintaining the quality of the services that our members and network physicians and health care professionals expect.

Despite UnitedHealthcare's best efforts, we were unable to come to an agreement with Coram to continue our relationship. Therefore, effective June 15, 2009, Coram's contract will end with UnitedHealthcare. Coram will no longer be a participating network provider, and if you direct new patients to Coram to receive specialty medications or home infusion services, on or after June 15, 2009, your patients may pay a higher cost.

Coram will continue to provide service in some areas based on local contracts . We are working closely with Coram to ensure the transition process is easy for affected physicians and members with no interruption in care.

In addition to Coram, we are ending our partnership with CuraScript, TheraCom and OptionMed and changing our arrangement with CVS/Caremark.* We will transition affected members to another participating specialty pharmacy or home infusion provider. We will communicate more details on these changes in future issues of the Network Bulletin and will send letters to affected physicians.

Provider	Contract Termination/Change Date
Coram	June 15, 2009
CuraScript	July 31, 2009
TheraCom	July 31, 2009
OptionMed	August 31, 2009
CVS/Caremark	September 31, 2009

UnitedHealthcare is committed to supporting your practice and believes in choice for your provider

relationships. We want to make the transition for your current patients as convenient as possible. We have two strategies to help your practice meet these goals. First, you can initiate the transition process by identifying which of the specialty pharmacy and/or home infusion providers works best for you. Simultaneously, a participating specialty pharmacy and/or home infusion provider will contact you before the effective date to facilitate the transition process. The participating provider you choose will contact your patients to explain their services and answer any questions about the transition process.

You can identify which participating provider is best for your patients by calling our Specialty Network Referral Line at **(866) 429-8177**. You can also find a list of network specialty pharmacy providers online at ***UnitedHealthcareOnline.com > Tools & Resources > Pharmacy Resources > Tools & Resources.***

[1] This transition applies to members of benefit plans administered by UnitedHealthcare Insurance Company and its Affiliates except for benefit plans issued, sponsored or administered by PacifiCare Health System or its subsidiaries or benefit plans issued to the State of New York Empire Plan members or benefit plans issued, sponsored or administered by Oxford Health Plans or Oxford Health Insurance, Inc.

*Terminating only for therapeutic classes IVIG and factor products. Synagis and other select medications will continue to be provided by CVS/Caremark.

Prescription Drug List and Coverage Changes – May 1, 2009

UnitedHealthcare strives to make prescription medications accessible and affordable to our enrollees through our pharmacy benefits program. We accomplish this through the use of a Prescription Drug List (PDL). The UnitedHealthcare PDL Management Committee, a group of senior physicians and business leaders, makes tier decisions and changes to the PDL based on a review of clinical, economic and pharmacoeconomic evidence. The UnitedHealthcare National Pharmacy and Therapeutics (P&T) Committee provides clinical guidance to assist the PDL Management Committee in the decision making process. Periodic reviews of the PDL are performed, and medications may move to different tiers or coverage status may be changed. As a reminder, when a medication changes tiers, your patient may be required to pay more or less for that medication. Tier 1 represents the lowest copay option.

PDL – Tier Changes

Down-Tiering Changes

Down-tiering refers to medications that move to a lower tier, making them more affordable for your patients. Down-tiering changes are allowed at any time throughout the year so your patients can take advantage of the savings as soon as possible. Down-tiering changes were made in several therapeutic categories and are summarized in the table below.

Up-Tiering Changes

Up-tiering refers to medications that move to a higher tier. Effective May 1, 2009, the tier status of Metrogel® (metronidazole) 1% (gel and kit), Nascobal® (cyanocobalamin nasal spray) and Zylet® (loteprednol/tobramycin) will move from Tier 2 to Tier 3. The table below provides a list of the lower tier alternatives.

Summary of PDL Changes for 3-Tier Benefits

Category	Medication	Change in Coverage Status*	Lower Tier/ Cost Alternatives for Medications Moving to Tier 3
Acne rosacea	Metrogel® (metronidazole) 1% gel and kit	Tier 2 _ Tier 3	metronidazole gel 0.75%
Antiinfective agents	Noxafil® (posaconazole)	Tier 3 _ Tier 2	NA
Beta-blockers	Bystolic® (nebivolol)	Tier 3 _ Tier 2	NA
Iron chelators	Exjade® (deferasirox)	Tier 3 _ Tier 2	NA
Ophthalmic agents	Betimol® (timolol)	Tier 3 _ Tier 2	NA
	Zylet® (loteprednol/ tobramycin)	Tier 2 _ Tier 3	tobramycin/ dexamethasone
Overactive bladder agents	Sanctura XR® (trospium)	Tier 3 _ Tier 2	NA
Phenylketonuria	Kuvan® (sapropterin)	Tier 3 _ Tier 2	NA
Vitamin B12 deficiency	CaloMist® (cyanocobalamin)	Tier 3 _ Tier 2	NA
	Nascobal® (cyanocobalamin)	Tier 2 _ Tier 3	CaloMist®

* This document does not provide information on the Tier 4 benefit. Some of your patients may be on a PDL that has a tier placement different than the ones listed above. Patients are encouraged to go to our consumer Web site – **myuhc.com** for the most updated PDL and tier placement information based on their particular pharmacy benefit plan.

Benefit Exclusions

Effective May 1, 2009, several medications will no longer be covered under our pharmacy benefits. Some of our pharmacy benefits allow the exclusion of a medication if it includes the same active ingredient or a modified version of an active ingredient and is therapeutically equivalent to a covered prescription medication. The table below provides a summary of these exclusions and information on the lower tier alternative with the same active ingredient that will continue to be covered. The UnitedHealthcare National P&T Committee has reviewed each of these medications and determined them to be therapeutically equivalent to the covered medication including the same active ingredient.

Medication	Pharmacy Coverage Effective 5/1/09*	Covered Medication(s) with Same Active Ingredient(s)
Soma® 250 (carisoprodol)	Excluded	carisoprodol – Tier 1
Venlafaxine ER® (venlafaxine extended release)	Excluded	venlafaxine – Tier 1 Effexor XR – Tier 2

* Some of your patients may not have benefit designs that allow exclusions.

While we understand there may be sensitivity around the need for our enrollees to change medications, our strategy decreases costs for our customers while maintaining lower tier choices for our enrollees. A comprehensive communication campaign to our enrollees and customers has been developed to address these changes.

Clinical Program Updates – Effective June 1, 2009

Notification Program

Selected medications may require notification and review to be eligible for coverage under the enrollee's pharmacy benefit plan. Sandostatin® (octreotide) will be added to this program and will be covered for the treatment of acromegaly, severe flushing associated with metastatic carcinoid tumors, diarrhea associated with vasoactive intestinal peptide secreting tumors, symptomatic tumors of the gastroenteropancreatic system, chemotherapy-induced diarrhea, and refractory HIV/AIDS related diarrhea.

Supply Limits

Supply limits are based on several factors including FDA-approved dosing as noted in the package label, medical literature, guidelines and other supportive/analytic data. New supply limits will be implemented for several medications effective June 1, 2009.

Cymbalta®

Based on the P&T Committee review of evidence on Cymbalta (duloxetine) dosing, a revised supply limit will be implemented for Cymbalta 30 mg. Cymbalta is available in 20, 30 and 60 mg doses. The new supply limit of 31 tablets per month for the 30mg dose will require that new users who are prescribed the 30 mg dose twice daily switch to a 60 mg dose once daily. While clinical studies show no difference in outcomes between 60 mg once daily therapy as compared to 30 mg twice daily therapy, the cost of therapy is doubled with the 30mg twice daily regimen. Coverage reviews will be available for patients with generalized anxiety disorder and depression that may require this twice daily regimen. In addition, patients currently on the 30 mg twice daily regimen will be allowed to continue with this regimen and therapy will not be disrupted. Affected enrollees and prescribing physicians have been notified of this change in coverage.

Erectile Dysfunction Medications – Cialis® and Levitra®

A supply limit change for two of the oral erectile dysfunction medications, Cialis and Levitra, was communicated to prescribing physicians in April 2009 as effective 6/1/2009. However, the implementation of these changes is being delayed until January 1, 2010. We will communicate additional information about the

supply limit change in the September edition of the *Network Bulletin*.

Supply limits will be implemented for other products effective June 1, 2009. Additional information about these new supply limitations can be obtained on UnitedHealthcare's Web Site at **UnitedHealthcareOnline.com**. The physician PDL can be referenced to determine which medications have supply limits.

Multiple Copays

Certain products are available in package sizes designed to provide more than one month supply of therapy. This change in packaging is indicative of a growing trend by pharmaceutical companies producing larger package sizes, especially for topical products, at times even removing smaller package sizes from the market. For some of our pharmacy benefit designs, for select products we will begin applying an appropriate number of copays that reflect the amount of product and average days supply contained in the package. The table below provides a list of the topical products that will have multiple copays applied. These medications have lower tier options available for a single copay.

Medication	Tier	Number of copays*	Lower Tier Alternatives – Tier 1
Atralin® (tretinoin)	3	2	Tretinoin 0.05% gel and cream
Cutivate® (fluticasone) lotion	3	2	Fluticasone propionate 0.05% cream, desonide 0.05% lotion, hydrocortisone butyrate 0.1% solution
Loprox® (ciclopirox) shampoo	3	2	Ketoconazole shampoo
Metrogel® (metronidazole) 1% gel & kit	3	2	Metronidazole 0.75% gel
Noritate® (metronidazole)	3	2	Metronidazole 0.75% cream

* Some of your patients may not have benefit designs that include multiple copays.

View the **Clinical Programs Changes – June 1, 2009** document at **UnitedHealthcareOnline.com >Tools & Resources >Pharmacy Resources > UnitedHealthcare**.

Note: The changes described may not apply to members in benefit plans insured or administered by PacifiCare or government programs such as AmeriChoice, Evercare, SecureHorizons or Medicare Advantage.

Clinician Resources

Free CME/CE Activities from OptumHealth Education

As a network provider, you now have unlimited access to a variety of free, live, and enduring continuing medical education/continuing education (CME/CE) activities sponsored by OptumHealth Education. Visit **OptumHealthEducation.com** to view a calendar of upcoming live events such as national/regional symposia, dinner meetings, grand rounds, medical education forums, and educational simulcasts. You also may take advantage of an extensive catalog of Webcasts, monographs, DVDs and podcasts.

CME/CE activities include topics in cardiovascular medicine, CNS/neuroscience, internal medicine, oncology/hematology, rheumatology/immunology and women's health. Here are just a few activities that are currently available for CME/CE credit:

- **CNS/Neuroscience**
  - On-demand Webcast

  Diagnostic and Treatment Challenges of Major Depressive Disorder with Comorbid Chronic Pain

  This activity will review the challenges associated with the diagnosis and treatment of co-occurring major depressive disorder and chronic pain. (Expiration Date: March 2010)

- On-demand Webcast

New Directions in the Treatment of Major Depressive Disorder

This activity will review the neurobiology of major depressive disorder and identify evidence-based treatment options including monotherapy and augmentation strategies.
(Expiration Date: February 2010)

- E-monograph

The Role of the Primary Care Physician in the Treatment of Fibromyalgia: A New Paradigm

This activity will review the pathophysiology of fibromyalgia, including the mechanisms involved in its development, such as central sensitization, suppression of descending inhibitory pathways, excessive activity of glial cells, and abnormalities in neurotransmitter release and/or regulatory proteins.
(Expiration Date: April 2010)

Internal Medicine/Cardiology

- On-demand Webcast Series

Issues and Controversies in PCI Management

1: Optimizing Oral Antiplatelet Therapy in Patients with Ischemic Cardiovascular Disease

This activity will examine optimal oral antiplatelet therapy in patients with ischemic cardiovascular disease undergoing percutaneous coronary intervention.
(Expiration Date: February 2010)

2: Current Recommendations, New Data, and Unanswered Questions

This activity will examine the latest clinical trial data and unanswered questions related to oral antiplatelet therapy in patients undergoing percutaneous coronary intervention.
(Expiration Date: February 2010)

Oncology/Hematology

- Live simulcast via satellite, Internet, and teleconference
  Wednesday, June 24, 2009 (12:00–1:00 PM ET)

Best Practices in the Diagnosis and Treatment of Renal Cell Carcinoma

This activity will discuss current best practices in the management of patients with renal cell carcinoma.

- Live simulcast via satellite, Internet, and teleconference
  Wednesday, July 29, 2009 (12:00–1:00 PM ET)

Best Practices in the Adjuvant Treatment of Breast Cancer

This activity will discuss current best practices in the management of patients with breast cancer.

- On-demand Webcast

Chronic Myelogenous Leukemia: Assimilating the Data on Biologic Therapy

This activity will address front-line therapy issues, review new drugs that may replace imatinib, and present information about the next-generation agents for the treatment of chronic myelogenous leukemia.
(Expiration Date: October 2009)

If you would like to be notified when new CME/CE activities are added, visit **OptumHealthEducation.com** and click "Create Account." Once registered, you will automatically begin receiving OptumHealth Education's monthly E-newsletter monthly activity guide *Activities at a Glance*.

You also can follow OptumHealth Education on Twitter at **http://twitter.com/OptumHealthEd**.

Geriatric Resources Survey

In November 2008, Geriatric Resources was launched under the Clinician Resources tab at **UnitedHealthcareOnline.com**. Educational information and resources for physicians were introduced to help improve geriatric competence in recognition of the shortage of geriatricians in the United States.

The areas of content include: assisting caregivers supporting their loved ones, advanced illness planning and palliative care, coordination of care, and conditions or issues relevant to the aging population- hearing impairment, urinary incontinence, risk for falls, medication issues, cognitive impairment and health care financial planning.

Please take a few moments to visit the site and participate in a quick survey to provide us with feedback and recommendations. To take the survey, go to ***UnitedHealthcareOnline.com > In The Spotlight***.

Important Behavioral Health Information Screening for Depression

United Behavioral Health* is responsible for managing the behavioral health care benefits for most UnitedHealthcare enrollees. United Behavioral Health is committed to supporting primary care physicians in identifying and treating mental health disorders. The U.S. Preventive Services Task Force recommends screening patients for depression in primary care. If left untreated, depression can adversely affect patient quality of life and clinical outcomes. Screening for depression is critical to treatment as it can contribute to the patient's readiness to change. You can help by screening all patients, including adolescents, for depression.

To assist, United Behavioral Health has identified a sensitive and specific screen which is accurate and easy to use. The screen is the Whooley Depression Screen (Whooley et al., 1997). To obtain a copy of the screen, e-mail your request to **BHInfo@uhc.com**. For more information on depression, you and your patients may access the **LiveAndWorkWell.com** Web site of United Behavioral Health. To refer a patient to a United Behavioral Health clinician for assessment and/or treatment, call United Behavioral Health at the toll free number on the back of the patient's health care ID card.

Depression, Alcohol Abuse & Attention Deficit Hyperactivity Disorder (ADHD) Preventive Health Program

United Behavioral Health has developed an online Preventive Health Program which offers up-to-date, relevant information and practice tools to support your treatment of major depressive disorder, alcohol abuse/dependence and ADHD. A convenient, reliable and free source of pertinent health information, the Preventive Health Program includes:

- A dedicated section for physicians and other health care professionals with articles addressing aspects of each condition
- Information about co-morbid conditions
- Links to nationally recognized practice guidelines
- A self-appraisal that you can print, use or refer your patients to
- A listing of support resources for you, your patients and their families

Physicians and other health care professionals may access the program via ***UnitedHealthcareOnline.com > Clinician Resources > Patient Safety > Behavioral Health or at LiveAndWorkWell.com/prevention.***

United Behavioral Health Authorizations

You or your office staff can refer patients directly to a United Behavioral Health psychiatrist or other United Behavioral Health behavioral health professional. The United Behavioral Health clinician can obtain any necessary authorization. You can also direct patients to contact United Behavioral Health for referrals at which time an initial certification, if needed, will be generated. For a complete listing of behavioral health clinicians, please visit the United Behavioral Health clinician Web site, **Ubhonline.com**. Select "Our Network", then "ubh/usbhpc clinician directory," and specify your search criteria. You and your patients can also contact United Behavioral Health directly for assistance by calling the number on the back of the patient's medical insurance card.

Psychiatric Consults for Medical Patients

If you would like to arrange a psychiatric consultation for a patient in a medical bed, are unclear whether a consultation is warranted, or need assistance with any needed behavioral health authorization, please contact United Behavioral Health by calling the telephone number on the back of the patient's health care ID card.

** References to United Behavioral Health include its affiliates PacifiCare Behavioral Health and PacifiCare Behavioral Health of California*

Melanoma: June is Skin Cancer Awareness Month

The skin is our largest organ and the number of cancers of the skin seen annually in the U.S. exceeds each of the other individual organ sites. All forms of skin cancer are more common on sun-exposed skin. The closer one lives relative to the equator, the warmer the climate, the more likely we are to minimize our cover with clothing. The more common skin cancers, basal cell and squamous cell carcinomas, rarely spread and can usually be managed successfully with surgery or radiation.

Melanomas, cancers of the pigmented layer of the skin, can be more aggressive and are more likely to spread although they are also highly curable when detected early. The American Cancer Society estimates that there are more than 62,000 new cases of melanoma in the U.S. each year, along with more than 8,000 deaths. The life-time risk of developing melanoma is 2.42% in men (one case for every 41 men) and 1.63% (one case for every 61 women). Melanomas occur more commonly in Caucasian patients than African-American patients. When African-Americans develop melanoma, the disease occurs more commonly on light areas of the skin: palms, soles, under the nails.

Any sore demonstrating delayed healing should be brought to the attention of a physician. This includes irritated areas of the skin as well as mucosal surfaces. Physicians should remember the "ABCDE rule" when evaluating a mole. Consider:

- **ShApe.** Do the two sides of the mole match each other?
- **Borders.** Are the borders of the lesion irregular, ragged, notched, or blurred?
- **Color**. Is there variability in the color of the mole ranging from black to brown to tan to red?
- **Diameter**. Is the lesion greater than approximately 6 mm, about the size of a pencil eraser?
- **Elevation**. Is there evidence that the lesion is elevating above the surface of the skin?

Most melanomas will not demonstrate all five of these findings, of course, so the physician should remain vigilant. Other considerations include whether the patient has multiple moles, whether there is a family history of melanoma or multiple moles, and whether the suspect lesion has appeared recently. A history of sun sensitivity with difficulty tanning in a fair-skinned red head or blonde is notable. Severe sunburns, particularly in childhood, and the use of tanning booths or sun lamps are of concern. The most common locations for melanomas are the lower extremities in women and the back in men.

Preventive strategies include avoidance of sun exposure, particularly at mid-day and vigorous and repeated use of sun screen. In the last two decades, once the relationship to solar exposure was appreciated, massive public education campaigns developed in northern Australia and New Zealand and, later, in the southern states of the U.S. With increased awareness, people began to identify early melanomas on themselves and others and the outcomes improved.

In Australia, a massive Slip / Slop / Slap campaign was instituted. The message was SLIP on a long-sleeved shirt and long-legged pants, SLOP on sun screen, and SLAP on a wide-brimmed hat to protect the face and eyes.

Enhanced public awareness is critical! Emphasis should be on the following:

- Minimize exposure to ultraviolet (UV) radiation during peak hours
- Wear protective clothing, hats, and UV-opaque sunglasses
- Seek shade
- Keep infants and children out of the sun as much as possible. Sunscreen is generally not recommended for infants under six months., however, it can be used sparingly on small areas of the body

- Routine body checks are critical for early identification and treatment of melanoma

For more Geriatric information please visit ***UnitedHealthcareOnline.com > Clinician Resources > Geriatric Conditions.***

NCCN Drugs & Biologics Compendium - Free Access

UnitedHealthcare is pleased to provide physicians and other health care professionals free access to the National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium™. We recognize the value of the NCCN Compendium in physician practices and clinics, and we are pleased to sponsor access.

To use the NCCN Compendium free of charge, physicians and health care professionals will need to log in to UnitedHealthcareOnline.com with their user ID and password. Then, go to ***Clinician Resources > Cancer – Oncology > NCCN Compendium.*** In the Related Links section, click the NCCN Compendium Web site link. Once on the NCCN Offers page, scroll down to the bottom of the screen to find the UnitedHealthcare section and select Enter Here. Users will need to register at the NCCN site (even if you have had a past account with NCCN) and should receive the following message after successful registration: "Free Subscription for United Healthcare Provider".

The 20-Minute Medicare Visit

Is your office practice so busy that you don't have the time you would like to spend with your geriatric patients? If you answered yes, you are not alone.

As a result of the increased burden of disease and disability associated with aging, older adults require more health care than younger adults. Care is expensive, challenging to coordinate, and cost is rising faster than ever.

In spite of high expenditures, studies have shown that the care that older adults receive is frequently inadequate, especially for geriatric conditions such as incontinence, falls, cognitive decline, malnutrition and more. [1]

Later life depression can also complicate the clinical situation of geriatric patients. "Depression is probably the most common example of the nonspecific and atypical presentation of illness in the geriatric population." (Dr Robert Lane, et al, 2004) Implementing changes to improve the care of older adults in existing clinical settings has been difficult.

Barriers exist, many of which apply to the management of geriatric conditions, lack of physician knowledge about management, inadequate patient adherence and lack of follow-up.

The Assessing Care of Vulnerable Elderly Persons (ACOVE) project identified elders at increased risk for death or functional decline and created quality indicators for 22 conditions. They found that compliance for geriatric conditions was far worse than for general medical conditions (31% vrs.52%).1

ACOVE, in its second phase, developed a model to improve the care of older adults in community based physician practices using existing resources.

David B. Reuben, M.D. from UCLA and the research team have developed tools, assessments, and strategies to improve management and provide effective and efficient care to geriatric patients. To learn more go to ***UnitedHealthcareOnline.com > Clinician Resources > Geriatric Resources > Resources for Aging > Patient Resources.***

[1] Reuben, DB, Roth, C, Kamberg, C, and Wenger, NS. Restructuring Primary Care Practices to Manage Geriatric Syndromes: The ACOVE-2 Intervention. JAGS 2003; 51: 1787-1793.

Your Place to Learn About Culturally Diverse Patients

New information about cultural diversity and associated disparities in treatment has been added to the AARP Cultural Education Library (CEL). The CEL and other research from peer-reviewed journals can be found on the Geriatric Resources page of the UnitedHealthcare Online Web site ***(UnitedHealthcareOnline.com > Clinician Resources > Geriatric Resources)***.

Twenty-two new abstracts (all published in 2008 or 2009) have been added to the CEL. These new abstracts describe studies about cultural diversity and disparities in treatment for cancer, heart disease, and women's health issues. Information about race/ethnicity and appropriate use of immunization/vaccination can be found there too.

Please note that you will need your password to get access to the Diversity Abstracts link where abstracts can be found. If you do not yet have a password, you can obtain one on the UnitedHealthcare Online home page.

We will continue to provide updates on an ongoing basis, in an effort to advance the awareness of disparities and cultural competency in the health care setting. Our next update will focus on women with heart disease.

e-Business Updates

Claim Letters on UnitedHealthcareonline.com – New!

We are pleased to offer UnitedHealthcare Online users the ability to ***view claim letters online!*** This new functionality is available to all UnitedHealthcare claim submitters, regardless of their network or non-network status. Users can view claim letters* sent in response to a claim, as well as letters responding to individual claim reconsideration requests (excluding appeals).

With online claim letters, physicians and health care professionals get a full view of a claim including all claim-related activity for the patient. Access to claim letters sent to your patients can facilitate claim administration and follow-up (for example, if a claim is on hold because of information needed from the patient). This functionality promises to improve administrative efficiency.

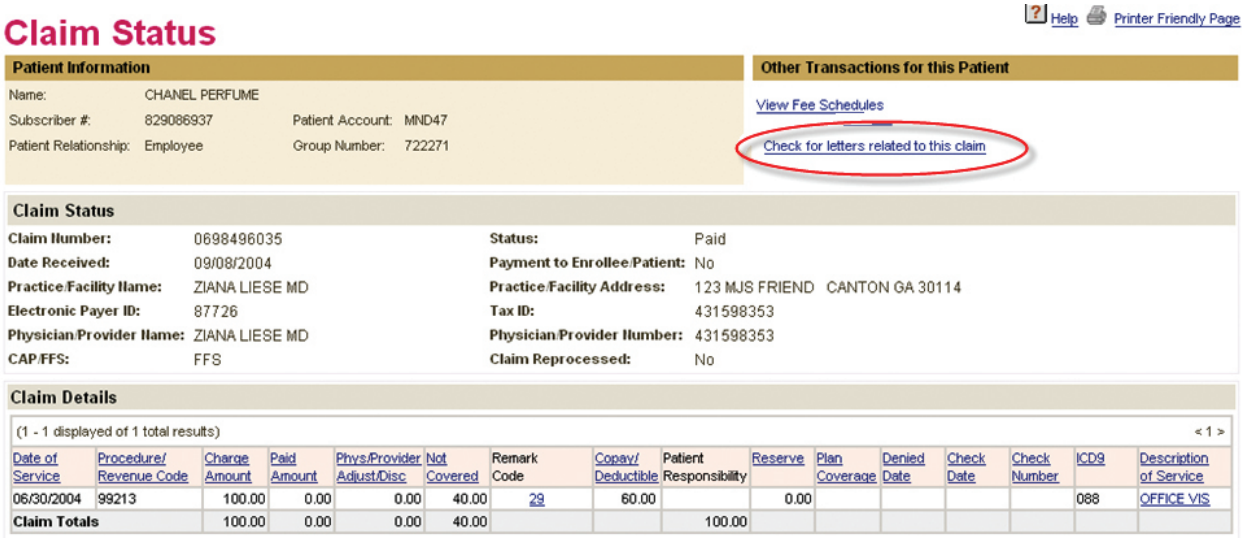
To access claim letters online, go to the Claim Status transaction. Claim letters can be found via a new link titled "Check for Letters related to this Claim," under "Other Transactions for this Patient."

Simply click on the link to view a list of letters related to the specific claim. Upon viewing Claim Status search results, users can:

- Sort by any of the column headings returned in "Search Results" to clearly see which letters are directed to the provider versus the subscriber. You can view letters sent to the subscriber such as coordination of benefits (COB), student status and eligibility update requests. Letters addressed to dependents are not viewable.
- Print or download the letter using the options on the toolbar once the letter displays.

Online training materials have been updated to reflect this new functionality, including: Claim Status Step by Step Help, Quick Reference Cards, and FAQs. Access these materials under Help on the global navigation of any UnitedHealthcareOnline.com page.

*Only commercial claim letters generated since August 28, 2008, are available online at this time. Letters for government products are not included.



Claim Status

Help Printer Friendly Page

Patient Information

Name: CHANEL PERFUME
Subscriber #: 829086937 Patient Account: MND47
Patient Relationship: Employee Group Number: 722271

Other Transactions for this Patient

View Fee Schedules
Check for letters related to this claim

Claim Status

Claim Number:	0698496035	Status:	Paid
Date Received:	09/08/2004	Payment to Enrollee/Patient:	No
Practice/Facility Name:	ZIANA LIESE MD	Practice/Facility Address:	123 MJS FRIEND CANTON GA 30114
Electronic Payer ID:	87726	Tax ID:	431598353
Physician/Provider Name:	ZIANA LIESE MD	Physician/Provider Number:	431598353
CAP/FFS:	FFS	Claim Reprocessed:	No

Claim Details

(1 - 1 displayed of 1 total results) < 1 >

Date of Service	Procedure/ Revenue Code	Charge Amount	Paid Amount	Phys/Provider Adjust/Disc	Not Covered	Remark Code	Copay/ Deductible	Patient Responsibility	Reserve	Plan Coverage	Denied Date	Check Date	Check Number	ICD9	Description of Service
06/30/2004	99213	100.00	0.00	0.00	40.00	29	60.00		0.00					088	OFFICE VIS
Claim Totals		100.00	0.00	0.00	40.00			100.00							

Managing Your UnitedHealthcare Online User ID(s) and Password(s)

Are you having trouble with your UnitedHealthcareOnline.com password? Do you need to reset your password or get new staff set up with access to your Tax ID? While the UnitedHealthcareOnline.com Help Desk is available to answer your questions, you might also find detailed printed instructions handy and useful if you need to give new staff access to the Web site.

One of the most common questions we get has to do with resetting passwords and the criteria needed for creating new passwords. UnitedHealthcareOnline.com passwords are case sensitive and must contain between eight and 12 alphanumeric characters (including at least one number and one letter), with no symbols or spaces. Passwords cannot contain three repeating or sequential characters (i.e. AAA, 111, ABC, 123), cannot contain the user ID, or be the same as the current or four previous passwords.

Another common question we receive is how to provide access to a new user. You can either:

1. Direct the employee to register online by clicking on "New User" and following the prompts, or
2. Have the password owner or an administrator set them up

If you elect to have the new user self-register, he or she can enter their contact information, select their own user ID and password, then select the Password Owner or Administrator, which triggers an e-mail requesting approval of the registration. Upon approving a registration, the password owner or administrator determines the appropriate user functions, Tax IDs & Specialties that the new user will have access to. When the password owner or administrator completes the process, an e-mail is sent back to the user letting him or her know they can logon.

If the password owner or administrator sets up a new user, he or she must enter the user's contact information, create a User ID and a temporary password for the new user, and decide which functions and Tax IDs/Specialties the user will have access to. An e-mail is then sent to the user instructing him or her to log in and set up a permanent password, security question and answer.

Detailed help is available at UnitedHealthcareOnline.com for many other user ID and password management questions. Simply click on Help on the top navigation then click ***Quick Reference > User ID and Password Management.*** There you will find Quick Reference and Step-by-Step guides to help set up Users, create Access Profiles (the Tax IDs and Specialties a user has access to), request or grant Multi-TIN Access (the ability to link Tax IDs together under one login), and set up Role Functions (the functions on the site that a user may access). We also have a quick reference card designed specifically for billing company needs.

Real-Time Claims Submission Options Increasingly Available

UnitedHealthcare is one of only a handful of payers taking the initiative to help physicians and their patients adjust to the demands of consumer-driven health care. Currently UnitedHealthcare offers real-time claims adjudication (RTA) through its physician and health care professional Web site UnitedHealthcareOnline.com, as well as other regional and national clearinghouse vendors including Athena, Availity, Payerpath, Instamed, Medical Transcription Billing Company (MTBC), and Navicure.

We're committed to simplifying the health care experience for consumers and physicians. To help enable this, additional capabilities and functionalities have been and continue to be developed that complement and enhance real-time claims adjudication. These include:

- Bringing real-time claim adjudication to physician desktops by making it available through all channels. This includes working with clearinghouse vendors to incorporate the technology into their products and services.
- Online tools for consumers to estimate the cost of care prior to service.
- Patient health care ID cards with swipe technology allow for more efficient data retrieval of patient eligibility and benefit information and helps streamline the claim submission process by reducing keystrokes and data entry errors.

- UnitedHealthcare and OptumHealth Financial Services continue to collaborate on products and services designed to further streamline and simplify the health care experience, including integrated card technology designed to allow access to both financial services and medical information with a single health care ID card.

Real-time claims adjudication enables physicians and patients to know the actual cost of care at the point of care, while also simplifying the payment process for both physicians and consumers. As consumers take on greater responsibility for their health care choices and costs, physicians are taking on greater responsibility for collecting patient-owed amounts. Real-time claims adjudication gives physicians the ability to immediately learn exactly how much they will be reimbursed and the amount the patient may owe, helping to reduce bad debt and collection costs. If you use a clearinghouse vendor for your claims submissions, ask if they have already incorporated RTA into their services. Or, simply go to UnitedHealthcareOnline.com and try RTA today.

Training Schedules

Whether you are a small office or large organization, UnitedHealthcare has an electronic solution for you. Our free, online webcasts show you how to automate and streamline your administrative processes, and introduce eco-friendly alternatives to conducting business manually.

Webcast Seminar Topics

- UnitedHealthcareOnline.com – We take you through a day in the life of your organization and demonstrate how our free physician and health care professional Web site is there for you (and your patients) every step of the way.
- **Electronic Payments and Statements (EPS) is the standard way of doing business with UnitedHealthcare** – Learn how to reconcile your accounts and receive payments electronically while reducing the flow of paper coming into your office. It's easy with EPS.

Our Webcasts are offered every other Thursday at 2 p.m. (Eastern). Sessions run between 1 and 1.5 hours long and topics alternate every other week. View our Webcast schedule at ***UnitedHealthcareOnline.com > Tools & Resources > Training and Education > Seminars.***

UnitedHealthcare Online" Tips – May 2009

How do I reduce the likelihood of claim denials?

To assist you in understanding how your claims will be paid, UnitedHealthcare's Claim Estimator includes a feature called Professional Claim Bundling Logic which helps you determine allowable bundling logic and other claims processing edits for a variety of CPT and HCPCS procedure codes.

Note: Only bundling logic and other claims processing edits are available under this option. Pricing and payment calculations are not included.

TIP: Use Claim Estimator's estimated bundling logic prior to submitting a claim. You'll achieve increased claim submission accuracy and reduce the likelihood of resubmission or rework due to claim denials.

To use the Estimated Bundling Logic and Policy Rules option simply:

1. Select Claims & Payments and then Claim Estimator.
2. Select the Professional Claim Bundling Logic link and agree to the terms and conditions.
3. Select the Physician Details.
4. Select the Patient Details.
5. Select the Service Details.
6. Review and Submit.
7. The Bundling Logic Results page displays.

Is there a quick way to look up my fee schedule?

UnitedHealthcare Online has a Fee Schedule Lookup feature that was recently enhanced to include a complete list of products from which to choose.

Three Steps to Check Fee Schedule Lookup

1. Login to UnitedHealthcare Online and select Fee Schedule Lookup from the Claims & Payments drop down menu.
2. Complete Required Information.
3. View Search Results.

Take Note

Advance Directives

The federal Patient Self-Determination Act gives individuals the legal right to make choices about their medical care in advance of incapacitating illness or injury through an advance directive. Under this act, physicians and other health care professionals including hospitals, skilled nursing facilities, hospices, home health agencies and others must provide written information to patients on state law about advance treatment directives, about patients' right to accept or refuse treatment, and about your own policies regarding advance directives. Whenever possible, physicians should encourage their patients to execute an advance directive and a limited durable power of attorney. To comply with this requirement, we also inform enrollees of state laws on advance directives through our enrollee handbooks and other communications.

External Review Program for UnitedHealthcare Enrollees

If, following completion of the internal appeal process, your patient is dissatisfied with a coverage decision, he or she may have the right to appeal the decision to an independent review organization. An independent clinical expert will review the plan's decision within the framework of the individual's contracted benefits using documents provided during the internal review process while incorporating published peer-reviewed medical literature.

UnitedHealthcare will use the decision made by the independent review organization as the final coverage determination. This process provides enrollees with a timely, fair and objective decision about their health care coverage concerns. UnitedHealthcare's external review program complies with review programs mandated by individual states. UnitedHealthcare enrollees in states without mandated external review can be referred to their Certificate of Coverage for information on our Voluntary External Review Program.

* This program is standard for our fully-insured enrollees and is available for purchase by our self-funded enrollees.

Financial Incentives

UnitedHealthcare notifies enrollees that treatment decisions are made between physicians and patient, and coverage decisions on health care services are based on the contract the enrollee's employer has with UnitedHealthcare.

- The coverage decisions are made based on the appropriateness of care and services as defined within the contract our enrollee's employer has with UnitedHealthcare.
- The UnitedHealthcare staff and the physicians making these coverage decisions are not specifically rewarded for issuing non-coverage decisions.
- UnitedHealthcare does not offer incentives to physicians to encourage underutilization of care or services or to encourage barriers to care and service.

Articles for Additional UnitedHealthcare Affiliates

Rights and Responsibilities for PacifiCare Enrollees

Note: The following information is available to PacifiCare enrollees and is provided here as a courtesy to physicians and other health care professionals.

As a member/enrollee, you have the right to receive information about, and make recommendations regarding, your rights and responsibilities.

You have the right to:

- Receive information about PacifiCare, contracting practitioners and providers, and the covered services under your plan/policy.
- Submit complaints regarding PacifiCare or contracting providers or request appeals for denied service.
- Be treated with dignity and respect and have your right to privacy recognized in accordance with state and federal laws.
- Discuss and actively participate in decision-making with your contracting provider regarding the full range of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit
- Refuse any treatment or leave a medical facility, even against the advice of a contracting provider. Your refusal in no way limits or otherwise precludes you from receiving other medically necessary covered services for which you consent.
- Complete an Advance Directive, living will or other directive and provide it to your contracting provider to include in your medical record. Treatment decisions are not based on whether or not an individual has executed an advance directive.
- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment for your health care.

Your responsibilities are to:

- Review information regarding your benefits, covered services, any exclusions, limitations, deductibles or copayments, and the rules you need to follow as stated in your Evidence of Coverage.
- Provide PacifiCare and contracting providers, to the degree possible, the information needed to provide care to you.
- Follow treatment plans and care instructions as agreed upon with your contracting provider. Actively participate, to the degree possible, in understanding and improving your own medical and behavioral health condition and in developing mutually agreed upon treatment goals.
- Accept your financial responsibility for health plan premiums, any other charges owed and any copayment or coinsurance associated with services received while under the care of a contracting provider or while a patient in a facility.

PacifiCare Pharmacy and Prescription Solutions Updates

PacifiCare and Prescription Solutions strive to make prescription medications accessible and affordable to our enrollees through our pharmacy benefits program. We accomplish this through the use of a formulary (PacifiCare) and a Prescription Drug List (PDL) for UnitedHealthcare plans with pharmacy benefits administered by Prescription Solutions. A group of physicians and PBM leaders come together as our Business Implementation Committee (BIC) and make tier decisions and changes to the pharmacy formulary/PDL based on a review of clinical, economic and pharmacoeconomic evidence. Our National Pharmacy and Therapeutics Committee provides clinical guidance to assist the BIC in the decision making process. Periodic reviews of the formulary and PDL are performed and medications may move to different tiers resulting in a change to member share of cost. As a reminder, when a medication changes tiers, your patient may be required to pay more or less for that medication. Tier 1 or generic copay represents the lowest copay option.

PacifiCare Formulary and Prescription Solutions PDL Coverage Change April 1, 2009

Proton Pump Inhibitor (PPI) Class changes

Effective April 1, 2009, the tier status of Aciphex and Zegerid products will increase from Tier 2 (PDL) or Brand copay (formulary) to Excluded status for the Prescription Solutions PDL and Non-Formulary for the PacifiCare Formulary. Step therapy will be required for the PacifiCare plans. Nexium products are being down-tiered to Tier 2 (PDL) or Brand copay (formulary) on April 1, 2009. Protonix products are also available at Tier 2 (PDL) and Brand copay (formulary) and omeprazole is available at Tier 1 (PDL) or the generic copay (formulary). The table below outlines the tier status of the PPIs.

Step Therapy Requirements

- Step therapy for plans with a three-tier pharmacy benefit will be required effective April 1, 2009, for Aciphex and Zegerid.
- Members with new prescriptions must fail or be intolerant of two (2) formulary PPIs (Nexium, omeprazole, Protonix) in order to fill a prescription for these medications. For PacifiCare members, Prior Authorization with demonstration of Medical Necessity will be required for coverage of Aciphex and Zegerid if patients do not meet the Step Therapy criteria.
- Members currently taking these medications may continue to do so without meeting the Step Therapy requirements, but will pay the higher Tier 3 copayment.

Tier Placement Effective April 1, 2009

Medication	PacifiCare Formulary	Prescription Solutions PDL
Omeprazole	Generic	Tier 1
Nexium products	Brand	Tier 2
Protonix BRAND products	Brand	Tier 2
Aciphex	Non-formulary/Step	Excluded
Kapidex	Non-formulary/Step	Excluded
Pantoprazole	Non-formulary/Step	Excluded
Prilosec BRAND	Non-formulary/Step	Excluded
Zegerid products	Non-formulary/Step	Excluded

Step Therapy and availability of Prior Authorization for Aciphex and Zegerid will not apply to the PDL.

PacifiCare Formulary and Prescription Solutions PDL Coverage Change May 1, 2009

Overactive Bladder Class changes

Step Therapy Requirements – PacifiCare Formulary & PDL

- Step therapy for plans with a three-tier pharmacy benefit will be required effective May 1, 2009 for any product other than formulary or Tier 1/2 products (covered products are: oxybutinin, Oxytrol, Enablex and VESIcare).
- Enrollees with new prescriptions must fail or be intolerant of oxybutinin AND either Enablex or VESIcare in order to fill a prescription for these medications. Prior Authorization with demonstration of Medical Necessity will be required for coverage of all non-formulary products if patients do not meet the Step Therapy criteria.
- Enrollees currently taking these medications may continue to do so without meeting the Step Therapy requirements, but will pay the higher Tier 3 copayment.

Other changes to be noted include the following:

PDL Downtiers or Formulary Additions
Advair Diskus, Advair HFA, Tier 2 (Brand) copay
Flovent Diskus, Flovent HFA, Tier 2 (Brand) copay
Symbicort, Tier 2 (Brand) copay

PDL Uptiers or Formulary Deletions
Asmanex to Tier 3, (NF) copay
Maxair Autohaler to Tier 3 (NF) copay
Pulmicort Flexhaler to Tier 2 (Brand) copay
QVAR to Tier 2 (Brand) copay
Ridaura to Tier 3 (NF) copay

Prescription Solutions Advantage and Traditional PDL Changes and PacifiCare Formulary Changes May 1, 2009

PDL Downtiers and Formulary Additions

Brand Name	Tier	Generic Name	Effective Date
Advair Diskus	2	Fluticasone / Salmeterol	5/09
Advair HFA	2	Fluticasone / Salmeterol	5/09
Antara	2	Finofibrate	1/09
Flovent Diskus	2	Fluticasone	5/09
Flovent HFA	2	Fluticasone	5/09
Lidoderm	2	Lidocaine patch	1/09
Nexium	2	Esomeprazole	4/09
Patanase	2	Olopatadine	1/09
Seroquel XR	2	Quetiapine SR	1/09
Simcor	2	Niacin / Simvastatin	1/09
Symbicort	2	Budesonide / Formoterol	5/1/09
Tekturna (HCT)	2	Aliskiren (HCT)	1/09
Veramyst	2	Fluticasone	1/09
Welchol	2	Colesevelam	1/09

PDL and Formulary Medications Now Available Generically

Brand Name	Tier	Generic Name	Effective Date
Altace	1	Ramipril capsules	1/09
Imitrex tablets	1	Sumatriptan	2/09
Keppra tablets	1	Levetiracetam	2/09

PDL and Formulary Restrictions (Note: This applies to ALL medications)			
Brand Name (Tier 3 = non-formulary)	**Generic Name**	**Effective Date**	**Formulary Alternatives**
Acanya (Tier 3)	Clindamycin / Benzoyl Peroxide	3/09	Limited to 50g/month at retail and 150g/Rx at mail service.
Aciphex (Tier 3)	Rabeprazole	4/09	**Exclusion for PDL.** For PacifiCare, requires trial of 2 of 3 formulary products - Nexium, omeprazole generic and Protonix Brand. Limited to 1 tablet per day.
Acne Medications	Various	5/09	Age edit is reduced to 29 years old, then requires a prior authorization.
Adderall XR	Amphetamine / Dextroamphetamine	3/09	5mg, 10mg, 15mg limited to two capsules per day. 20mg, 25mg, 30mg limited to one capsule per day.
Aplenzin (Tier 3)	Bupropion HBr	3/09	Limited to one tablet per day.
Astepro (Tier 3)	Astelin	3/09	Limited to two inhalers/month at retail and 6 inhalers/Rx at mail service.
Atacand (Tier 3)	Candesartan	1/09	4mg: limited to 1 tablet per day. 8mg: limited to three tablets per day. 16mg: limited to two tablets per day. 32mg: 1 tablet per day.
Atacand HCT (Tier 3)	Candesartan HCTZ	1/09	16/12.5mg limited to two tablets per day; 32/12.5mg limited to one tablet per day.
Cimzia (Tier 3)	Certolizumab	1/09	Requires prior authorization.
Cinryze (Medical)	C1 Inhibitor	3/09	Requires prior authorization.
Detrol (Tier 3)	Tolterodine	5/09	Requires a trial of oxybutinin AND either VESIcare or Enablex. Limited to two tablets per day.
Detrol LA (Tier 3)	Tolterodine SR	5/09	Requires a trial of oxybutinin AND either VESIcare or Enablex. Limited to one capsule per day.
Ditropan XL (Tier 3)	**Oxybutinin SR**	5/09	Requires a trial of oxybutinin AND either VESIcare or Enablex. 5 mg is limited to one tablet per day; 10 and 15 mg are limited to two tablets per day.
Enablex	Darifenacin	5/09	Limited to one tablet per day.
Estrogens & Estrogen Combinations	Various	3/09	Limited to one tablet per day. Male gender exclusion.
Gelnique (Tier 3)	Oxybutinin	4/09	Requires a trial of oxybutinin AND either VESIcare or Enablex.

PDL and Formulary Restrictions (Note: This applies to ALL medications)			
Brand Name (Tier 3 = non-formulary)	**Generic Name**	**Effective Date**	**Formulary Alternatives**
Kapidex (Tier 3)	Deslansoprazole	3/09	**Exclusion for PDL.** For PacifiCare, requires trial of two of three formulary products - Nexium, omeprazole generic and Protonix Brand. Limited to one capsule per day.
Liquadd (Tier 3)	Dextroamphetamine	1/09	Limited to 60 mL per day.
Nexium	Esomeprazole	4/09	Limited to one capsule per day.
Omeprazole	**Omeprazole**	4/09	Limited to one capsule per day.
Omnaris (Tier 3)	Ciclesonide	1/09	Limited to one inhaler/month at retail and three inhalers/Rx at mail service.
Oxytrol	Oxybutinin	5/09	Limited to 10 patches/month and 30 patches/Rx at mail service.
Patanase (Tier 3)	Olopatadine	1/09	Limited to one inhaler/month at retail and three inhalers/Rx at mail service.
Pantoprazole	**Pantoprazole**	4/09	**Exclusion for PDL.** For PacifiCare, requires trial of two of three formulary products - Nexium, omeprazole generic and Protonix Brand. Limited to one tablet per day.
Prandimet (Tier 3)	Repaglinide - metformin	2/09	Requires step therapy of two of the following: metformin, a sulonfylurea or a TZD. Limited to five tablets per day.
Prevacid Products (Tier 3)	Lansoprazole	4/09	**Exclusion for PDL.** For PacifiCare, requires trial of two of three formulary products - Nexium, omeprazole generic and Protonix Brand. Limited to 1 unit per day.
Protonix Powder Packets	**Omeprazole**	4/09	**Exclusion for PDL.** For PacifiCare, requires trial of two of three formulary products - Nexium, omeprazole generic and Protonix Brand. Limited to 1 packet per day.
Proscar (Tier 3)	**Finasteride**	5/09	**Requires prior authorization for PDL.**
Protonix	Pantoprazole	4/09	Limited to one tablet per day.
Rapaflo (Tier 3)	Silodosin	3/09	Limited to one capsule per day. **Requires prior authorization for PDL.**
Ryzolt (Tier 3)	Tramadol	3/09	Limited to three tablets per day.

PDL and Formulary Restrictions (Note: This applies to ALL medications)			
Brand Name (Tier 3 = non-formulary)	**Generic Name**	**Effective Date**	**Formulary Alternatives**
Sanctura (Tier 3)	Trospium	5/09	Requires a trial of oxybutinin AND either VESIcare or Enablex. Limited to two tablets per day.
Sanctura XR (Tier 3)	Trospium SR	5/09	Requires a trial of oxybutinin AND either VESIcare or Enablex. Limited to one capsule per day.
Sancuso (Tier 3)	Granisetron	2/09	Limited to one patch per prescription.
Seroquel XR	Quetiapine SR	1/09	50 mg is limited to three tablets per day. 150 mg is limited to five tablets per day. 200 mg is limited to four tablets per day. 300 and 400 mg is limited to two tablets per day.
Simcor	Niacin-simvastatin	1/09	Step therapy of Advicor or simvastatin required. Limited to two tablets per day.
Taclonex Ointment & Scalp (Tier 3)	Calcipotriene - betamethasone	1/09	Limited to 60g/month at retail and 180g/RX at mail service.
Tekturna (HCT)	Aliskiren (HCTZ)	1/09	Step therapy of an ACE (HCTZ) inhibitor, ARB (HCTZ), ACEI/CCB combinations or ARB-calcium channel blocker is required. Limited to one tablet per day.
Toviaz (Tier 3)	Fesoterodine	3/09	Requires a trial of oxybutinin AND either VESIcare or Enablex. Limited to one tablet per day.
Uloric (Tier 3)	Febuxostat	3/09	Limited to one tablet per day.
Valtrex	Valcyclovir	2/09	Limited to 31 tablets/Rx at retail and 90 tablets/Rx at mail service.
Veramyst	Fluticasone	1/09	Limited to one inhaler/month at retail and three inhalers/Rx at mail service.
VESIcare	Solifenacin	5/09	Limited to one tablet per day.
Xenazine (Tier 3)	Tetrabenazine	3/09	Requires prior authorization.
Wellbutrin XL	**bupropion SR**	5/09	**Requires prior authorization for PDL.**
Zegerid products (Tier 3)	Omeprazole bicarbonate	4/09	**Exclusion for PDL.** For PacifiCare, requires trial of two of three formulary products - Nexium, omeprazole generic and Protonix Brand. Limited to one unit per day.

PDL and Formulary Deletions and Uptiers			
Brand Name	**Generic Name**	**Effective Date (Texas will be 1/1/2010)**	**Formulary Alternatives**
Accolate	Zafirlukast	5/1/09	Singulair
AccuChek products	Test Strips	5/1/09	Freestyle, OneTouch products, Precision
Aciphex – exclusion for PDL	Rabeprazole	4/1/09	Nexium, omeprazole, Protonix BRAND
Altace tablets	Ramipril tablets	1/1/09	Generics of Accupril, Capoten, Lotensin, Monopril, Univasc, Vasotec, Zestril
Asmanex	Mometasone	5/1/09	Flovent, Pulmicort, QVAR
Avandaryl	Rosiglitazone-Glimepiride	5/1/09	Avandia with generic sulfonylurea
Cenestin	Estrogens, conj synthetic	1/1/09	Generics of Estrace and Ogen, Enjuvia, Premarin
Clindagel	Clindmycin	5/1/09	Benzoyl peroxide/erythromycin; Clindamycin gel, lotion, solution; Erythromycin gel, pads, solution
Famvir	**Famciclovir**	5/1/09	Acyclovir, Valtrex
Lialda	Mesalamine	5/1/09	Asacol, Canasa, Rowasa
Locoid Lipocream	**Hydrocortisone butyrate**	1/1/09	Generics of Aclovate, Cutivate, Diprolene, Diprosone, Lidex, Synalar, Temovate, Topicort, Valisone
Maxair Autohaler	Pirbuterol	5/1/09	Xopenex HFA
Prevacid SoluTab – exclusion for PDL	Lansoprasole	1/1/09	Nexium, omeprazole, Protonix BRAND
Ridaura	Auranofin	5/1/09	Numerous other DMARD's.
Verelan PM	**Verapamil**	5/1/09	Generics of Calan SR, Adalat CC, Cardizem CD, Dilacor XR, Procardia XL, Plendil, Tiazac
Zegerid – exclusion for PDL	Omeprazole bicarbonate	4/1/09	Nexium, omeprazole, Protonix BRAND

For the most up-to-date information, enrollees can access the full Prescription Drug List look-up tool through **myuhc.com**, click on Prescriptions and Pharmacies. For PacifiCare enrollees, the most current formulary information can be found at **PacifiCare.com**.

PacifiCare Group Products

Arizona, Oregon and Washington PacifiCare Group Products Migrate – Alternate UnitedHealthcare products offered for New Business and Renewals

UnitedHealthcare has begun eliminating some PacifiCare group products in Arizona, Oregon and Washington. We ceased marketing and no longer offer these products for new business as of April 1, 2009, in Oregon, and May 1, 2009, in Arizona and Washington.

A thorough evaluation of several PacifiCare products has resulted in our decision to withdraw some products from the Arizona, Oregon and Washington marketplace. This decision enables us to streamline the product portfolio and help to contain costs for our customers. The following products are being withdrawn:

PacifiCare SignatureOptions℠/SignatureElite℠
PacifiCare SignatureFreedom℠
PacifiCare SignatureIndependence℠
PacifiCare SignatureValue Direct℠
PacifiCare SignaturePOS℠

The PacifiCare SignatureValue℠ product remains available in the marketplace for new and renewing business. This change does not affect Managed Care Organization plans or UnitedHealthcare insurance plans.

Renewing employers and their employees will be offered one of the many other products remaining in the UnitedHealthcare product portfolio beginning August 1, 2009, in Arizona, October 1, 2009, in Oregon and November 1, 2009, in Washington.

Employers and their employees who transition to a UnitedHealthcare product will receive all the enhanced benefit and service options of UnitedHealthcare.

If you have any questions regarding the PacifiCare group product migrations in these states, please contact your Network Account Representative or Provider Advocate assigned to your geographical area.

State	Ceased Marketing for New Business	First Renewal Date (Rolling 12 months)
Arizona	May 1, 2009	August 1, 2009
Oregon	April 1, 2009	October 1, 2009
Washington	May 1, 2009	November 1, 2009

Product	Arizona	Oregon	Washington
PacifiCare SignatureElite	X	X	N/A
PacifiCare SignatureOptions	N/A	N/A	X
PacifiCare SignatureFreedom	X	X	X
PacifiCare SignatureIndependence	X	X	X
PacifiCare SignatureValue Direct	N/A	X	N/A
PacifiCare SignaturePOS	X	X	X
PacifiCare Signature POS Direct	X	N/A	N/A

X = Product will be eliminated
N/A = Product is not currently available in the market

UnitedHealthcare Services Company of the River Valley, Inc.

Changes to In-Network Referral Procedure Effective June 1, 2009

In order to improve the efficiency of the in-network referral procedure, UnitedHealthcare of the River Valley Entities will be changing from nine (9) in-network referral authorization numbers to one (1) universal referral authorization number. The original nine authorization numbers were assigned by geographic office locations operating under the former John Deere Health Care plan, which are no longer relevant.

Effective June 1, 2009, the new universal in-network referral authorization number is 2009061RV.

In addition, the UnitedHealthcare River Valley In-Network Referral Form will no longer be available, or necessary to use.

Note: This pertains to the In-Network referral procedure only. The process for out-of-network referrals remains the same. Please refer to the online UhcRiverValley.com.

In-Network Referral Procedure

- The In-Network Referral Procedure provides a process in which a River Valley Entities' member may access care from a contracted in-network specialist that they **do not** have direct access to at their network benefit levels (i.e. PCP/gate-keeper benefit plans).
- Referral requests must originate from the member's network primary care physician (PCP). The final decision concerning a referral will be the sole responsibility of the contracted PCP. In-network referrals do not require prior authorization by the River Valley Entities.
- Specialist-to-specialist referrals are not allowed. If the treating specialist feels it is necessary for the member to see another specialist, they must contact the member's PCP who will be responsible for all new referrals.

Process to Assure In-Network Coverage for the Member:

- PCP determines the need for referral to an in-network specialist, communicates this with the member, and sends a letter of referral or phones/faxes a referral to the consulting specialist. PCP indicates in the referral what services they are requesting to be provided by the specialist. PCP provides the Specialist with the universal in-network referral authorization number of: **2009061RV**
- Service requests must be a covered benefit under the member's plan and must be made to contracted providers.
- Certain services/procedures must be reviewed by the health plan based on established medical necessity criteria before authorization can be given for coverage. A list of all procedures, durable medical equipment, and drugs requiring preauthorization can be accessed through the online Provider Manual in the Benefit Determination section.
- To assure continuity and coordination of care, the referring PCP should provide timely communication of clinical information to the specialist. Likewise, the specialist should provide written communication to the member's PCP, providing a description of health services rendered to the member at the referrals visit(s).
- Specialist submits claim(s) for services, providing PCP's name and UPIN/NPI number in boxes 17 & 17a of the CMS 1500 form. The River Valley universal in-network referral authorization number **2009061RV** is placed in Box 23 of the HCFA 1500 form to serve as authorization for payment at the member's in-network benefit level.

The UnitedHealthcare Services Company of the River Valley, Inc. Coverage Updates

The UnitedHealthcare Services Company of the River Valley, Inc. Coverage Policy Library is available to all contracted physicians and health care professionals. It can be accessed at **Uhcrivervalley.com/provider**. This library provides the information used in making coverage determinations.

Unless otherwise stated, decisions communicated in the Coverage Updates only apply to River Valley Commercial membership. The Coverage Updates do not apply to any other River Valley membership.

Services Requiring Preauthorization

Retrospective authorization will not be allowed and charges cannot be billed to the member.

- Intensity Modulated Radiation Therapy. Codes: 0073T, 77301 and 77418. **Preauthorization is required through Clinical Coverage Review. Effective: July 1, 2009.**
- Genetic Testing for Breast Cancer – BRCA1, BRCA2 and BART. Codes: S3818, S3819, S3820, S3822 and S3823. **Preauthorization is required through Clinical Coverage Review. Effective: August 16, 2009.**
- Repair of Pectus Deformity. Codes: 21740, 21742 and 21743. **Preauthorization is required through Clinical Coverage Review. Effective: July 1, 2009.**
- Cord blood harvesting for transplantation, allogeneic. Code: S2140. **Preauthorization is required through Clinical Coverage Review. Effective: July 1, 2009.**
- Inpatient Spinal Surgeries. CPT codes: 22100 - 22103, 22210 -22226, 22532 -22855, 63001-63103, 63194 – 63199 and 63300 - 63308. ICD-9 procedure codes: 03.02, 03.09, 03.4, 03.6, 80.50, 80.51, 81.02, 81.03, 81.05, 81.06, 81.07, 81.08, 81.32, 81.33, 81.36, 81.37, 81.38, 81.39, 81.62, 81.63, 81.64 and 84.51. **Preauthorization is required through Clinical Coverage Review. Effective: September 1, 2009.**
- Radiofrequency Ablation for the Treatment of Orthopaedic and Spinal Pain. Codes: 64622, 64623, 64626 and 64627. **Preauthorization is required through Clinical Coverage Review. Effective: September 1, 2009.**

If you do not contract directly with UnitedHealthcare, and participate in our network through an arrangement in which we "Lease" a network from some other entity, some of the information provided in this communication may not be applicable to you and/or impact you differently. If you have questions regarding any of the information or need to better understand its impact on you, please contact your local Network Account Representative.

M44288 5/09

UnitedHealthcare®
Healing health care. Together.®

MN012-N108
P.O. Box 1459
Minneapolis, MN55440-1459