



161 N. Clark Street, Suite 4200, Chicago, IL 60601-3316 • 312.819.1900

April 7, 2016

Via Federal Express

Anne M. Cooper
(312) 873-3606
(312) 276-4317 Direct Fax
acooper@polsinelli.com

RECEIVED

APR 08 2016

**HEALTH FACILITIES &
SERVICES REVIEW BOARD**

Mr. Michael Constantino
Illinois Health Facilities and Services Review
Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

**Re: Southern Illinois Gastrointestinal Endoscopy Center (Proj. No. 15-061)
Response to Request for Additional Information
Type A Modification**

Dear Mr. Constantino:

This office represents Southern Illinois Gastrointestinal Endoscopy Center, LLC and Southern Illinois GI Specialists (collectively, the "Applicants"). In that capacity, we are responding to the Illinois Health Facilities and Services Review Board (the "State Board") request for additional information regarding the certificate of need ("CON") application for the above referenced project dated February 17, 2016 as well as comments from Southern Illinois Healthcare ("SIH"). Thank you for the opportunity provide more detail regarding this vital service which provides residents of Carbondale and surrounding areas the opportunity to receive quality and cost-effective endoscopy services which are critical to stopping colorectal cancer in its tracks at its earliest stages before it becomes highly fatal and very costly to treat. Like so many other communities with convenient and cost-effective access to endoscopy services, the people of Southern Illinois should not be deprived of endoscopy services particularly when communities in more affluent parts of the state have ready access and multiple options for this care.

1. Additional Information Regarding Project

- a. Addition of Dr. Zahoor Makhdoom as a Co-Applicant and Financial Information for Southern Illinois GI Specialists, LLC

The February 17, 2016 letter stated Dr. Makhdoom must be a co-applicant on the Southern Illinois Gastrointestinal Endoscopy Center CON application and Dr. Makhdoom must

Mr. Michael Constantino
April 7, 2016
Page 2

include data evidencing his financial condition. Enclosed are the requisite application pages to include him as a co-applicant. See Attachment – 1. Related to his financial condition, Dr. Makhdoom can demonstrate his ability to fund the project with verification of his available financial resources from Regions Bank, where he holds these funds. See Attachment – 2.

As I have reviewed with State Board staff, Dr. Makhdoom will submit his personal financial statements to the State Board’s General Counsel for *in camera* review. Similarly, Southern Illinois G.I. Specialists, L.L.C. (“SIGIS”) is a limited liability company affiliated with the project as the site owner and not the operating entity. As such, we do not believe its financial statements are germane to the CON process. However, the Applicants are willing to submit SIGIS financial statements and financial viability ratios to the State Board’s General Counsel for *in camera* review as well. Based upon discussions with the State Board’s General Counsel, typical of the treatment by State of Illinois agencies of sensitive financial information, State Board staff will treat Dr. Makhdoom’s personal financial statements and SIGIS’s data as confidential information not subject to disclosures of such information under the Illinois Freedom of Information Act. Relatedly, the information submitted for *in camera* inspection will not become part of the CON application. After State Board staff’s review, such materials will be returned to us.

b. Line of Credit

The sources of funds for the project include a line of credit of \$1,500,000. Borrowing money, however, is a back-stop to funding the project with cash. Dr. Makhdoom anticipates the project costs will be funded with revenues from his related practice, SIGIS, and he will not draw on the line of credit but he wants it as an option. As interest is only accrued when draws are made on the line of credit, Dr. Makhdoom does not anticipate any interest expense will be paid for the working capital line of credit. As a result, interest expense was not included in the pro forma financial statement.

Dr. Makhdoom obtained a pre-qualification letter for a line of credit for the project to provide flexibility in funding the project. The terms of the line of credit are attached at Attachment – 3. While capital contributions from his affiliated practice will fund the project, historically, the State Board requires such funds to be escrowed while the application is pending and throughout the course of the project. Escrowing approximately \$1.2 million dollars for nearly two years will adversely impact Dr. Makhdoom’s ability to manage his practice’s cash flow. The line of credit provides financial flexibility as it will allow Dr. Makhdoom to utilize his available cash to address issues at both his physician practice as well as the proposed endoscopy center. Further, it ensures sufficient financial resources will be available to fund the project.

Mr. Michael Constantino
 April 7, 2016
 Page 3

c. Credit Facilities

Regions Bank has confirmed that credit it will make available for the project may be used for working capital or capital improvements. The term sheet for the line of credit is attached at Attachment – 3.

d. Projected Payor Mix

Southern Illinois Gastrointestinal Endoscopy Center is not an existing facility and has no historical payor mix data; however, the Applicants anticipate the payor mix will be similar to its affiliated practice, SIGIS. 2015 Payor mix data for SIGIS is provided below.

Southern Illinois GI Specialists 2015 Payor Mix	
Payor	Percent
Medicare	45%
Medicaid	5%
Private Insurance	40%
Self-Pay	10%

e. Size of the Procedure Room

In the February 17, 2016 letter, the State Board requested additional information regarding the size of the procedure rooms and recovery stations. Prior to filing the CON application, the Applicants engaged a licensed architect familiar with the Illinois Department of Public Health (“IDPH”) ambulatory surgical treatment center (“ASTC”) code requirements. The architect confirmed the size of the procedure rooms and recovery stations would be compliant with IDPH requirements.

As noted in the CON application, the endoscopy center will consist of two gastrointestinal procedure rooms and seven recovery stations in a total of 1,085 gross square feet of clinical space. The State Board standard provides for a range of 1,660 to 2,220 gross square feet to accommodate a variety of uses from Class A operating rooms to procedure rooms. Unlike a Class A operating room, which must accommodate anesthesia equipment and other surgical equipment, a gastrointestinal procedure room does not need to house a significant amount of equipment for endoscopic procedures. Accordingly, the IDPH minimum clear area for gastrointestinal procedure rooms is 200 gross square feet. See 77 Ill. Admin. Code

Mr. Michael Constantino
April 7, 2016
Page 4

205.1360(c)(2)(A). Additionally, the IDPH minimum clear area for a Stage II recovery room is 50 gross square feet. See 77 Ill. Admin. Code 205.1360(d)(1)(B)(ii). As the Applicant's architect confirmed, there is sufficient space pursuant to IDPH licensure requirements to accommodate the two procedure rooms and seven recovery stations.

f. Patient Assistance Program

While not requested in the February 17, 2016 letter, we wanted to take this opportunity to provide the State Board with information on the Applicants' patient assistance programs. The Applicants have committed to provide 5 free colonoscopy screenings per month for patients referred by Shawnee Health Service. See Attachment – 4.

In addition to free colonoscopy screenings, the Applicants provide reduced cost colonoscopies through their Colonoscopy Assist Program. This program was designed to improve the colorectal cancer screening rates in Southern Illinois. It targets uninsured and underinsured patients, e.g., patients with high deductibles who could not otherwise afford a lifesaving colonoscopy. Under the Colonoscopy Assist Program, eligible patients can receive a colonoscopy for \$1,500, which is less than one third of the average the cost of a colonoscopy at Memorial Hospital of Carbondale. See Attachment – 5. As noted in the letter from SIH dated December 30, 2013, a colonoscopy at Memorial Hospital of Carbondale can range from \$2,017 to \$25,567.26, with an average charge of \$4,745.09. See Attachment – 6. Unlike the hospital charge, which only includes the facility fee and does not include fees for the physician, anesthesiologist, pathologist, or radiologist, the \$1,500 flat rate is an all-inclusive rate. Similarly, the Upper GI Endoscopy Assist Program seeks to improve access to these procedures. Patients eligible for assistance under this program can receive an upper GI endoscopy for a flat rate of \$900. See Attachment – 7. Like the Colonoscopy Assist Program, this is an all-inclusive rate and includes not only the physician fee, but sedation, polyp removal and pathology costs.

Last year, SIGIS provided reduced cost endoscopic procedures to 228 people through these two vital programs, and that number is projected to increase in 2016. Importantly, these programs will be implemented at the proposed Southern Illinois Gastrointestinal Endoscopy Center. The Applicants anticipate the number of patients treated will be similar to the number at SIGIS.

2. Response to Southern Illinois Healthcare Comments

Mr. Michael Constantino
April 7, 2016
Page 5

2. Response to Southern Illinois Healthcare Comments

On February 25, 2016, SIH submitted comments to the State Board regarding the proposed Southern Illinois Gastrointestinal Endoscopy Center CON application. The Applicants would like to address the issues raised in SIH's February 25, 2016 letter.

a. Purpose of the Project

Based upon the historical data provided in the application, SIH asserts SIGIS may be operating as an unlicensed surgery center. While SIGIS' office based endoscopy volumes have increased over the past several years, they do not exceed 50 percent of the practice activities. The Applicants seek a CON to ensure the practice complies with IDPH ASTC requirements. According to Section 205.110 of the IDPH ASTC regulations,

a place is located within, and operated in conjunction with, the offices of a single physician . . . shall not be considered an ambulatory surgical treatment center unless: it meets the definition of and has expressed an intent to apply for certification as an ambulatory surgical center under the rules of the federal Centers for Medicare & Medicaid Services; or it is used by physicians . . . who are not part of the practice; or it is utilized by the physicians . . . for surgical procedures that constitute more than 50 percent of the activities at that location.

SIGIS does not meet the IDPH requirements of an ASTC. It is not an ambulatory surgical center as defined by Medicare as it does not have an agreement with the Centers for Medicare and Medicaid Services to participate in Medicare as an ASTC. See 42 C.F.R. § 416.2. Endoscopy procedures are not performed by physicians who are not part of SIGIS. Finally, endoscopy procedures do not constitute 50 percent of the activities at SIGIS.

While endoscopy procedures do not presently constitute 50 percent of the activities of the practice, due to the direct access program, endoscopy could constitute a majority of SIGIS' activities in the near future, which is a primary basis for requesting licensure. As discussed more fully in the CON application, SIGIS offers patients direct access for screening colonoscopies. Under the direct access program, patients who are in good or stable health can arrange for a colonoscopy without first having a face-to-face consultation with a gastroenterologist. A patient's primary care physician can determine his/her suitability for the endoscopy procedure during a general physical exam where patients over 50 years of age are counseled on colorectal cancer screening. Due to changing referral patterns under the direct access program, SIGIS anticipates the ratio of surgical to non-surgical procedures will increase especially as payors

Mr. Michael Constantino
April 7, 2016
Page 6

become more involved in establishing “direct access” benefits in their plan design. Further, effective in December 2015, United Healthcare (“UHC”), one of the major national payors will no longer pay for certain of the primary endoscopy procedures in the hospital setting due to the surgery center being the most cost-effective environment for this procedure. Thus, our client needs to segregate its endoscopy services into an IDPH licensed surgery center which is separate from its medical practice.

b. Alternatives to the Project

SIH states there are nine licensed facilities within the geographic service area performing gastrointestinal procedures, and five are operating significantly below target utilization, including St. Joseph Memorial Hospital (“SJM”), which recently added two gastrointestinal procedure rooms. See SIH Ltr p2. Importantly, seven of the nine facilities are hospitals and are not viable options. Payors, like UHC, seeking to improve cost efficiencies have implemented prior authorization guidelines aimed at encouraging physicians to utilize more cost-effective sites of service for certain outpatient surgical procedures, where medically appropriate. As stated above, UHC now requires a prior authorization for upper and lower gastrointestinal procedures performed in an outpatient hospital setting. No prior authorization is required if such procedures are performed at a participating network ASTC. See Attachment – 6. Coverage of gastrointestinal procedures in outpatient hospital departments is based on several factors: (1) availability of a participating network facility, (2) specialty requirements, (3) physician privileges, and (4) whether a patient needs access to more intensive services. See Attachment – 8. Based on the guidelines, UHC will only approve those procedures that are medically inappropriate for an ASTC to be performed in an outpatient hospital department. Most gastrointestinal procedures are medically appropriate for an ASTC. While our competitor might argue that this conclusion should not be reached because of the coverage determination of one major payor, the fact is that from a health planning perspective, hospital outpatient departments are no longer viable options for most of these procedures and employers, government payors, commercial payors and patients should not be responsible to pay fees that are not medically necessary.

With regard to the facilities cited in Mr. Shaeffer’s letter, only two of those nine are ASTCs. While there may be some capacity at these facilities, they are not viable options for Dr. Makhdoom based on their location, which are not convenient and immediately accessible to him. Gastroenterologist efficiency is essential to supply of these providers to their communities. According to a 2009 study from Olympus and The Lewin Group, the United States is facing a shortage of 1,050 gastroenterologists by the year 2020. See Attachment – 9. Due to the aging of the population and the increased rates of colorectal cancer screenings, gastroenterologists will

Mr. Michael Constantino
April 7, 2016
Page 7

not be able to meet demand, which could limit access to adequate screening and treatment for colorectal cancer, the second leading cause of cancer deaths in the United States. See Attachment – 9. Improved efficiency is critical to ensure residents of the community have access to much needed endoscopy services. This can be achieved if Dr. Makhdoom can perform procedures at an endoscopy center located adjacent to his existing practice. Dr. Makhdoom can be more efficient due to faster turnover of procedure rooms, designated surgical times without risk of delay due to more urgent procedures, and specialized nursing staff. As a result of these efficiencies, more time can be spent with patients thereby improving the quality of care. When there are shortages of physicians in a particular specialty, physician efficiency is really a critical issue to ensuring that access to care is not impeded by physician downtime.

c. Size of the Project

SIH claims the size of the proposed endoscopy center is insufficient to accommodate equipment, staff and patients. As discussed more fully above, the Applicants engaged a licensed architect familiar with IDPH ASTC licensure standards who determined the proposed endoscopy center would be compliant with IDPH ASTC size standards. There is no need to have a facility larger than required as long as the licensure requirements are addressed as the project's architect has again confirmed this month based on the inquiry.

d. Service Demand

The Applicants acknowledge that based upon the State Board's rules, they did not provide projected referrals from licensed ASTCs or hospitals. Like many other endoscopy centers in Illinois approved before this one, this project evolved from an office-based surgical practice and seeks to convert to a licensed surgery center to comply with IDPH licensure requirements. Last year, Dr. Makhdoom performed 2,815 endoscopic procedures (or 2,017 surgical hours) at SIGIS, which is more than sufficient to justify the need for two procedure rooms. Due to the large volume of endoscopy procedures being performed in his office and the direct access program, which enables most patients to receive screening colonoscopy without a related initial consultation or follow-up, endoscopy volumes will continue to increase without a corresponding increase in non-surgical encounters. Thus, Dr. Makhdoom believes surgical procedures will exceed 50 percent of the activities of the practice running contrary to the in-office surgery exception.

Importantly, the referrals are for procedures Dr. Makhdoom is currently performing at SIGIS' office. He is not pulling the volumes away from the opposing hospital and the hospital appears to be meddling in this matter for the sheer purpose of trying to impede competition.

Mr. Michael Constantino
April 7, 2016
Page 8

Endoscopy procedures that are medically appropriate for a hospital outpatient department will continue to be performed in a hospital. Importantly, Southern Illinois Gastrointestinal Endoscopy Center will not adversely impact any other health care provider in the area.

e. Projected Service Demand

As discussed more fully above, the project seeks to convert an office-based surgical practice to a licensed surgery center to comply with IDPH licensure requirements. Importantly, the referrals used to justify the two procedure rooms are currently performed in SIGIS' office. Accordingly, the project will not adversely affect other health care providers in the area.

f. Treatment Room Need Assessment

As discussed above, the referrals used to justify the two procedure rooms are currently performed in SIGIS' office. SIGIS currently operates two procedure rooms. Operating a single procedure room would cause significant inefficiencies and delays. Importantly, the project will not adversely affect existing licensed ASTCs and hospitals.

g. Service Accessibility

As more fully discussed in Section 2.b, hospitals are not a viable alternative to an ASTC for these relatively uncomplicated procedures because a hospital's resources are overkill for endoscopy. You heard this from Northwest Community Hospital, which expanded its endoscopy program at the last meeting by obtaining a permit to establish an endoscopy surgery center to "respond to the demands for patients with high-cost deductibles by providing lower cost settings." Also, Presence Health received a permit for an outpatient endoscopy center last Summer citing "lower cost care and more effective management of a fairly straight forward outpatient surgical procedure which is becoming more and more common giving the aging of the baby boomer population which is recommended to have testing beginning at age 50-60 based on risk factors. This population is expected to grow by approximately 10-15% between 2010 and 2020." Because these are relatively simple outpatient procedures, payors are requiring prior authorization for gastrointestinal endoscopy procedures to be performed in an outpatient hospital department. Additionally, due to the gastroenterologist shortage, Dr. Makhdoom can only maintain efficiency and improve access to life saving colonoscopies if those procedures are performed in a surgery center adjacent to his medical practice.

Mr. Michael Constantino
April 7, 2016
Page 9

h. Unnecessary Duplication/Maldistribution

This project will not result in unnecessary duplication/maldistribution. Last year, Dr. Makhdoom performed 2,815 endoscopy cases (2,017 surgical hours) at SIGIS. Endoscopy procedures that are medically appropriate for a hospital outpatient department will continue to be performed in a hospital. Accordingly, Southern Illinois Gastrointestinal Endoscopy Center will not adversely impact any other health care provider in the area.

i. Conditions of Licensure

As discussed more fully above, the medical practice's endoscopy volumes do not yet constitute over 50 percent of SIGIS' activities. Due to improved screening education provided by primary care physicians and the direct access program, endoscopy volumes have increased significantly over the past several years, and the Applicants anticipate endoscopy volumes will continue to increase as more medically appropriate patients elect to participate in the direct access program. To ensure compliance with the ASTC licensure requirements, the Applicants seek permission from the State Board to establish an endoscopy center limited to gastrointestinal procedures.

j. Application for Initial License

SIH contends the Applicants do not have and have not requested a patient transfer agreement from a licensed hospital within 15 minutes travel time of the facility. Importantly, this is a requirement for an application for initial licensure of an ASTC. This requirement is not germane to the Applicants' CON application to establish an endoscopy center. Assuming the State Board approves the Applicants' CON application, they will obtain a patient transfer agreement from a licensed hospital as part of their initial license application. As a mission-based non-profit health system, we would not expect that it would resist entering into a written agreement to provide for the smooth transition of any patient who may post-surgically require admission to its hospital as that would be detrimental to the community it serves. Further, absent such a transfer arrangement, a provider can simply call 911 for an ambulance and that patient would be taken to the nearest emergency department which is further reason that we would expect it would not object to a transfer agreement when the time comes.

I think we have addressed all of the material comments of SIH but frankly given that they employ their own primary care physicians and gastroenterologists and generally require those physician to refer within a closed system unless a patient or payor requires otherwise, we are not certain why SIH believes it is unreasonable for Southern Illinois Gastrointestinal Endoscopy



Mr. Michael Constantino
April 7, 2016
Page 10

Center to freely operate in the manner that is most appropriate outside of the health system's constructs. While there are not nearly the health care provider choices for Southern Illinois patients as you would see in a more metropolitan area, certainly the residents of this area deserve some options in physician services and related care.

Thank you for your assistance on this matter. If you have any questions or need any additional information regarding Southern Illinois Gastrointestinal Endoscopy Center, please feel free to contact me

Sincerely,

A handwritten signature in black ink that reads "Anne M. Cooper".

Anne M. Cooper

Attachments

cc: Juan Morado, Jr.

SOUTHERN ILLINOIS G.I. SPECIALISTS, LLC

1100 WEST DIANN LANE
CARBONDALE, IL 62901
618-549-8006

REGIONS BANK

70-2266/711

3428

3/21/2016

PAY TO THE ORDER OF Illinois Department of Public Health

\$ **2,000.00

Two Thousand and 00/100*****

DOLLARS

 Security features included. Details on back.

Illinois Department of Public Health
525 West Jefferson Street, 2nd Floor
Springfield, IL 62761


AUTHORIZED SIGNATURE MP

MEMO 15-051 Southern Illinois Gastrointestinal Endoscopy Center

⑈003428⑈ ⑆071122661⑆ 0087729806⑈

SOUTHERN ILLINOIS G.I. SPECIALISTS, LLC

Illinois Department of Public Health

3/21/2016

3428

Initial Processing fee for SO IL Endoscopy Center

2,000.00

checking - Regions

2,000.00

**ILLINOIS HEALTH FACILITIES AND SERVICES REVIEW BOARD
APPLICATION FOR PERMIT**

SECTION I. IDENTIFICATION, GENERAL INFORMATION, AND CERTIFICATION

This Section must be completed for all projects.

Facility/Project Identification

Facility Name: Southern Illinois Gastrointestinal Endoscopy Center			
Street Address: 1100 West Diann Lane			
City and Zip Code: Carbondale 62901			
County: Jackson County	Health Service Area	5	Health Planning Area:

Applicant /Co-Applicant Identification

[Provide for each co-applicant [refer to Part 1130.220].

Exact Legal Name: Zahoor Makhdoom, M.D.
Address: : 1100 West Diann Lane, Carbondale, Illinois 62901
Name of Registered Agent:
Name of Chief Executive Officer:
CEO Address:
Telephone Number:

Type of Ownership of Applicant/Co-Applicant

<input type="checkbox"/> Non-profit Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> For-profit Corporation	<input type="checkbox"/> Governmental
<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Sole Proprietorship
	<input checked="" type="checkbox"/> Other

- o Corporations and limited liability companies must provide an **Illinois certificate of good standing**.
- o Partnerships must provide the name of the state in which organized and the name and address of each partner specifying whether each is a general or limited partner.

APPEND DOCUMENTATION AS ATTACHMENT-1 IN NUMERIC SEQUENTIAL ORDER AFTER THE LAST PAGE OF THE APPLICATION FORM.

Primary Contact

[Person to receive ALL correspondence or inquiries)

Name: Kara M. Friedman
Title: Attorney
Company Name: Polsinelli P.C.
Address: 161 North Clark Street, Suite 4200, Chicago, Illinois 60601
Telephone Number: 312-873-3639
E-mail Address: KFriedman@polsinelli.com
Fax Number:

Additional Contact

[Person who is also authorized to discuss the application for permit]

Name:
Title:
Company Name:
Address:
Telephone Number:
E-mail Address:
Fax Number:

CERTIFICATION

The application must be signed by the authorized representative(s) of the applicant entity. The authorized representative(s) are:

- in the case of a corporation, any two of its officers or members of its Board of Directors;
- in the case of a limited liability company, any two of its managers or members (or the sole manager or member when two or more managers or members do not exist);
- in the case of a partnership, two of its general partners (or the sole general partner, when two or more general partners do not exist);
- in the case of estates and trusts, two of its beneficiaries (or the sole beneficiary when two or more beneficiaries do not exist); and
- in the case of a sole proprietor, the individual that is the proprietor.

This Application for Permit is filed on the behalf of Zahoor A. Makhdoom, M.D.* in accordance with the requirements and procedures of the Illinois Health Facilities Planning Act. The undersigned certifies that he or she has the authority to execute and file this application for permit on behalf of the applicant entity. The undersigned further certifies that the data and information provided herein, and appended hereto, are complete and correct to the best of his or her knowledge and belief. The undersigned also certifies that the permit application fee required for this application is sent herewith or will be paid upon request.

	
SIGNATURE	SIGNATURE
Zahoor A. Makhdoom, M.D.	
PRINTED NAME	PRINTED NAME
Manager	
PRINTED TITLE	PRINTED TITLE
Notarization: Subscribed and sworn to before me this <u>25th</u> day of <u>March, 2016</u>	Notarization: Subscribed and sworn to before me this _____ day of _____
	
Signature of Notary	Signature of Notary
"OFFICIAL SEAL" Seal SAMANTHA KRIEGER	Seal

NOTARY PUBLIC - STATE OF ILLINOIS
MY COMMISSION EXPIRES SEPT. 16, 2017

*Insert EXACT legal name of the applicant

March 21, 2016

Kathryn J. Olson
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Dear Chair Olson:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 that no adverse action has been taken against any facility owned or operated by me during the three years prior to filing this application.

Further, I (a) have not been cited, arrested, taken into custody, charged with, indicted, convicted or tried for, or pled guilty to the commission of (1) any felony or misdemeanor or violation of the law, except for minor parking violations or (2) the subject of any juvenile delinquency or youthful offender proceeding; (b) have not been charged with fraudulent conduct or any act involving moral turpitude; (c) have not had any unsatisfied judgments against me; or (d) am not in default in the performance or discharge of any duty or obligation imposed by a judgment, decree, order, or directive of any court or governmental agency.

Additionally, pursuant to 77 Ill. Admin. Code § 1110.1540(b)(3)(J), I hereby authorize the Health Facilities and Services Review Board ("HFSRB") and the Illinois Department of Public Health ("IDPH") access to any documents necessary to verify information submitted as part of this application for permit. I further authorize HFSRB and IDPH to obtain any additional information or documents from other government agencies which HFSRB or IDPH deem pertinent to process this application for permit.

Sincerely,



Zahoor A. Makhdoom, M.D.

Subscribed and sworn to me
This 21st day of March, 2016



Notary Public



March 21, 2016

Kathryn J. Olson
Chair
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Reasonableness of Financing Arrangements

Dear Chair Olson:

I hereby certify under penalty of perjury as provided in § 1-109 of the Illinois Code of Civil Procedure, 735 ILCS 5/1-109 and pursuant to 77 Ill. Admin. Code § 1120.140(a) that a portion or all of the cash and equivalents must be retained in the balance sheet asset accounts in order to maintain a current ratio of at least 1.5 times and borrowing is less costly than the liquidation of existing investments, and the existing investments being retained may be converted to cash or used to retire debt within a 60-day period.

I further certify pursuant to 77 Ill. Admin. Code § 1120.140(b) that the selected form of debt financing for the project will be at the lowest net cost available.

Sincerely,



Zahoor A. Makhdoom, M.D.

Subscribed and sworn to me
This 21st day of March, 2016.



Notary Public

April 7, 2016



Mr. Michael Constantino
Illinois Health Facilities and Services Review
Board
525 West Jefferson Street, 2nd Floor
Springfield, Illinois 62761

Re: Southern Illinois Gastroenterology Endoscopy Center (Proj. No. 15-061)

Dear Mr. Constantino:

I am writing on behalf of Regions Bank to confirm that as of March 30, 2016, Dr. Zahoor Makhdoom is owner/signatory to a business account ending in *_9806__ that has funds available in excess of \$1,196,400. Dr. Makhdoom has maintained various depository accounts with Regions Bank since at least 2009, and all accounts have been handled as agreed and in a satisfactory manner. Please feel free to contact me with any questions.

As of 4/7/2016 the Southern IL GI Specialists LLC Regions checking account has sufficient balances to fund the entire project costs.

Sincerely,

A handwritten signature in black ink, appearing to read "Jacek Wiltowski". The signature is written in a cursive style with a large loop at the end.

Jacek Wiltowski
Assistant Vice President
Regions Bank
1706 W. DeYoung
Marion, IL. 62959
Ph: 618-997-4323



Dr Zahoor Makhdoom
1100 Diann Ln
Carbondale, IL 62901

TERM SHEET

This Summary of Terms and Conditions is for discussion purposes only and is not a commitment to lend by Regions Bank ("Bank"). Any commitment is subject to Bank due diligence and Bank management approval. The following is a basic outline of the terms and conditions which are generally available at this time. These terms and conditions are subject to change, in Bank's sole and absolute discretion, at any time prior to the execution of a binding commitment or agreement, based on market, underwriting, collateral or other conditions.

Borrower: Southern IL GI Specialists LLC

Amount: \$1,500,000

Type: Revolving LOC

Term: 12 months

Purpose: Working Capital/Capital Expenditures

Interest Rate: LIBOR +350 basis points currently 3.65% rate
FLOOR RATE- 4.00%

Repayment: Interest Monthly, Line must pay to \$0 and remain for a minimum of 30 days

Fees: \$3,500 in addition of appraisal and title work for OORE

Collateral: First Position on OORE practice building(1100 Diann Ln Carbondale, IL 62901)



A first priority lien on: Inventory and Accounts Receivable if applicable

Line of credit will be set up on a borrowing basis secured by A/R at an advance rate of 80% and Inventory at an advance rate of 50%.

Financial Covenants:

Financial covenants will include the following:

Borrower must provide, A/R Aging, Inventory Aging and A/P aging reports quarterly

Borrower must provide Quarterly Financials

Borrower must furnish CPA Compiled financial statements no later than 90 days after the end of each fiscal year.

Borrower must provide CPA prepared tax returns no later than 90 days after the applicable filing date.

Covenant to maintain \$1MM in practice operating account.

Guarantor(s):

Unlimited guarantees by Zahoor A Makhdoom and Sumera Makhdoom

Documentation:

This term sheet is only a limited summary of certain points of a possible transaction. If the credit is approved and agreed upon, the documentation will contain other of Bank's customary provisions, including, but not limited to, representations and warranties, affirmative covenants, negative covenants, cross-collateralization and cross-default, all of which must be satisfactory to Bank in all respects. Certain due diligence items will also be required by Bank.

Closing Costs:

Bank will not incur any expenses whatsoever in connection with the application or the closing. Borrower will be required to pay all costs and expenses incurred in the preparation of the application and for the closing of the transaction, whether ultimately closed or not, including, without limitation, appraisal fees, inspection fees (including the fees of any independent inspector), surveys, legal fees (including the fees of Bank's counsel), intangible taxes, mortgage taxes, origination fees, recording costs, license and permit fees, and title insurance and other insurance premiums.



Confidentiality:

The Borrower agrees to keep this term sheet and all of its material terms confidential. The Borrower is not to disclose this term sheet or any of its material terms to anyone except as such disclosure is required by law or regulation or as a result of any legal or administrative procedure.

This term sheet is not to be construed as a commitment letter, but is for discussion purposes only. This term sheet and each of the terms contained herein may be rescinded or modified at any time by Bank in its sole and absolute discretion.

A handwritten signature in cursive script that reads "Jacek Wiltowski".

Jacek Wiltowski

Southern Illinois Business Banker

T:(618) 997-4323 ext 213

F:(618) 993-8737



SHAWNEE HEALTH SERVICE

A Non-Profit Organization Serving Southern Illinois Since 1972

109 California Street
P.O. Box 577
Carterville, IL 62918-0577
Phone (618) 985-8221
Fax (618) 985-6860

April 6, 2016

Southern Illinois GI Specialists
Dr. Zahoor Makhdoom
1100 West Diann Lane
Carbondale, IL 62901

RE: Offer for Free Colonoscopy Screenings

Dear Dr. Makhdoom:

I received your generous offer to provide five (5) free colonoscopy screenings per month to Shawnee Health Service's patients. Your offer is greatly appreciated and will provide opportunities for our uninsured and low-income patients to receive colonoscopy screenings.

Shawnee Health Service gratefully accepts your offer. We look forward to working with you in the implementation of your offer.

Sincerely,

Patsy R. Jensen
Executive Director

COLONOSCOPY ASSIST PROGRAM

What is the Colonoscopy Assist program for the uninsured?

If you are uninsured, the Colonoscopy Assist program offers colonoscopy procedures at a much discounted rate of \$1500. Please read this page in its entirety for additional details.

Why is the cost of a colonoscopy lower through the program?

We started this program on the principle that more people will get screened if the procedure is made affordable. In the State of Illinois only 39% of the population is being screened and when they are diagnosed with colon cancer it is usually in the later stages with 33% of those diagnosed dying due to colon cancer. The cost of a colonoscopy is low through the program to encourage uninsured individuals to get screened.

What does the \$1500 flat rate include?

The \$1500 flat rate is truly an all-inclusive rate. It includes all costs related to the procedure. There are **no hidden charges or fine print** and there is virtually no situation where you could see an additional charge. The price includes:

- Physician fees
- Facility fees including nursing costs
- Sedation/Anesthesia costs
- Removal of polyps
- Pathology costs (lab fees)
- **NO HIDDEN FEES**

What does the \$1500 flat rate not include?

Consultations - A physician will briefly talk to you prior to your procedure and after the procedure and this is included in the program.

However, if a patient would like a formal pre-procedure consultation or follow-up consultation they will be responsible for charges associated with any consults they request.

How much does a colonoscopy cost on average?

Prices for colonoscopies can vary greatly depending on the city and facility you go to. You have to keep in mind that a colonoscopy results in the patient being billed by 3-4 different entities. A patient should expect bills from:

- Consultation charge/office visit
- Physician Charge
- Facility fee
- Anesthesia fee
- Pathology fee
- Imaging fee (if applicable)

Without insurance, a patient should on average expect to pay \$4700 to \$12,000 for a colonoscopy and this is only the facility fee costs. A considerable savings can be achieved if you schedule through our office.

I'd like to get a colonoscopy. What is the process?

- 1) Call our appointment line at (618) 549-8006 during business hours.
- 2) A set of forms will be mailed to you for completion.
- 3) You will receive an appointment confirmation within 3-5 business days after your paperwork is completed. You will receive your prep instructions at the same time.
- 4) You go for your scheduled colonoscopy procedure.

What are the payment terms?

Payments can be made with a debit card, credit card, HAS (Health Savings Acct) card, FSA (Flexible Spending Acct) check or money order and are due prior to the appointment date.

Can I cancel or reschedule my appointment?

We understand that life is unpredictable. There is no obligation to go through with an appointment once scheduled. You can cancel your appointment up to one business day prior to your appointment without any penalty. If you have made a payment, you will receive a full refund.

When will I get my procedure reports and results?

The physician and nursing staff will briefly inform you about the findings directly following the procedure. You will receive a copy of your report upon leaving the facility and a copy of your report, along with the pathology report, will also be sent to your primary physician within 7-10 days.

Can I use my Health Savings Account (HSA) or Flexible Spending Account (FSA) to pay for my colonoscopy?

YES. You will receive a receipt from our office that should be used when filing for your money. We highly recommend using your HAS and FSA accounts to pay for your colonoscopy.

Will the procedure hurt?

Colonoscopies do not hurt. They do make you feel uncomfortable. To make the experience pleasant, we have included sedation/anesthesia costs into the price. You most likely won't remember your procedure.

How do I get started?

Getting started is very simple, call our office to request an appointment (618) 549-8006.

UPPER GI ENDOSCOPY ASSIST PROGRAM

What is an Upper GI Endoscopy/EGD?

An Upper GI Endoscopy or an EGD (Esophagogastroduodenoscopy) is a procedure where a physician will insert a scope through the throat to examine the lining of the esophagus, stomach and the first part of the small intestine. The procedure is different from a colonoscopy.

What is the Upper GI Endoscopy Assist program for the uninsured?

If you are uninsured, the Upper GI Assist program offers endoscopy procedures at a much discounted rate of \$900. Please read this page in its entirety for additional details.

Why is the cost of an Upper GI endoscopy lower through the program?

We started this program on the principle that more people will seek medical attention if the procedure is made affordable. This program allows patients who are uninsured to obtain an Upper GI endoscopy at a reasonable cost so that their symptoms may be addressed.

What does the \$900 flat rate include?

The \$900 flat rate is truly an all-inclusive rate. It includes all costs related to the procedure. There are **no hidden charges or fine print** and there is virtually no situation where you could see an additional charge. The price includes:

- Physician fees
- Facility fees including nursing costs
- Sedation/Anesthesia costs
- Removal of polyps (if applicable)
- Pathology costs (lab fees)
- **NO HIDDEN FEES**

What does the \$900 flat rate not include?

Consultations - A physician will briefly talk to you prior to your procedure and after the procedure and this is included in the program.

However, if a patient would like a formal pre-procedure consultation or follow-up consultation they will be responsible for charges associated with any consults they request.

How much does a Upper GI endoscopy cost on average?

Prices for Upper GI Endoscopy/EGD can vary greatly depending on the city and facility you go to. You have to keep in mind that an Upper GI Endoscopy/EGD results in the patient being billed by 3-4 different entities. A patient should expect bills from:

- Consultation charge/office visit
- Physician Charge
- Facility fee
- Anesthesia fee
- Pathology fee
- Imaging fee (if applicable)

Without insurance, a patient should on average expect to pay \$4700 to \$12,000 for an Upper GI Endoscopy/EGD and this is only the facility fee costs. A considerable savings can be achieved if you schedule through our office.

I'd like to get a Upper GI Endoscopy. What is the process?

- 1) Call our appointment line at (618) 549-8006 during business hours.
- 2) A set of forms will be mailed to you for completion.
- 3) You will receive an appointment confirmation within 3-5 business days after your paperwork is completed. You will receive your prep instructions at the same time.
- 4) You go for your scheduled Upper GI Endo procedure.

What are the payment terms?

Payments can be made with a debit card, credit card, HAS (Health Savings Acct) card, FSA (Flexible Spending Acct) check or money order and are due prior to the appointment date.

Can I cancel or reschedule my appointment?

We understand that life is unpredictable. There is no obligation to go through with an appointment once scheduled. You can cancel your appointment up to one business day prior to your appointment without any penalty. If you have made a payment, you will receive a full refund.

When will I get my procedure reports and results?

The physician and nursing staff will briefly inform you about the findings directly following the procedure. You will receive a copy of your report upon leaving the facility and a copy of your report, along with the pathology report, will also be sent to your primary physician within 7-10 days.

Can I use my Health Savings Account (HSA) or Flexible Spending Account (FSA) to pay for my colonoscopy?

YES. You will receive a receipt from our office that should be used when filing for your money. We highly recommend using your HAS and FSA accounts to pay for your colonoscopy.

Will the procedure hurt?

Upper GI Endoscopy/EGD procedures do not hurt. They do make you feel uncomfortable. To make the experience pleasant, we have included sedation/anesthesia costs into the price. You most likely won't remember your procedure.

How do I get started?

Getting started is very simple, call our office to request an appointment (618) 549-8006.



SOUTHERN ILLINOIS HEALTHCARE

Response to your Price Question

December 30, 2013

Dear [REDACTED]

Thank you for your recent inquiry into the price for a **Colonoscopy**. We are pleased that you are considering **Memorial Hospital of Carbondale**.

Hospital Price Information:

Based on the information you provided the *estimated average price for a Colonoscopy* is **\$4,745.09**. The price ranges from a maximum of \$25,567.26 to a minimum of \$2,017.00.

General Disclaimer:

The price information provided reflects the average hospital charge for all patients receiving this service during the last 12 months. The price provided is for hospital services only and does not include any professional fees for your physician, anesthesiologist, pathologist, or radiologist. The price is intended as an estimate and is not a guarantee of the price you will pay. Factors that can influence the price of your hospital procedure or stay include severity of illness and intensity of care needed, length of stay, or diagnostic tests or treatments ordered by your physician. Most surgical procedures and tests have risks involved. These risks will be explained to you by your physician; however, if any complication occurs after your procedure, this may result in more tests and/or a longer stay in the hospital. A longer stay in the hospital or additional tests would result in more charges.

If you have additional questions about the price of this service, please feel free to contact us again. Thank you for considering Memorial Hospital of Carbondale as your health care provider. If you are unable to pay your hospital bill financial assistance is available for those who qualify. To apply, call 618-549-0721 ext 65128 or 65123 and ask to speak to the Financial Counselor.

Sincerely,

Chelsea Burke

MHC Financial Counselor



Network Bulletin: September 2015

work bulletin

An important message from UnitedHealthcare to health care professionals and facilities



enter

UnitedHealthcare
plans to continue
to support its efforts
updates regarding a
new

*Where information is
applicable for the
plan

Front & Center

- Introducing Link—a New Site for UnitedHealthcareOnline.com and Optum Cloud Dashboard Users
- New Requirement for Inflammatory Medications
- Synagis (palivizumab) Procurement Process for the 2015-16 RSV Season
- Prior Authorization Required for Certain Radiology and Cardiology Services for UnitedHealthcare Life Insurance Company and Golden Rule Insurance Company Members
- Reminder Regarding UnitedHealthcare West Radiology and Cardiology Prior Authorization Program Requirements
- Care Providers Earn More Than \$54 Million in Bonus Payments from UnitedHealthcare for Improving Health Outcomes and Closing Gaps in Care
- Reminder: Updated Site of Service Guidelines for Certain Outpatient Surgical Procedures
- Prior Authorization and Advance Notification Requirement Updates
- Health Insurance Marketplace Participation for 2016
- UnitedHealthcare Physician and Practice Manager Satisfaction Survey
- Updated Resource for UnitedHealthcare's Clinical Data Submission Protocol now Available
- ICD-10 Update

UnitedHealthcare Commercial

- UnitedHealthcare Medical Policy, Coverage Determination Guideline (CDG) and Utilization Review Guideline (URG) Updates

UnitedHealthcare Community Plan

- Medical Policy & Coverage Determination Guideline Updates

UnitedHealthcare Medicare Solutions

- National Medicare Education Week: Helping to Make Medicare Easier to Understand
- 2016 Medicare Advantage Service Area Reductions and Member Dis-enrollments
- UnitedHealthcare Wins Group Medicare Advantage (PPO) Bid for California Public Employee's Retirement System (CalPERS)
- Referral Requirements for Certain Medicare Advantage Plans
- Updated Referral Exclusion List for Medicare Advantage Gated Plans
- UnitedHealthcare Medicare Advantage Coverage Summary Updates

UnitedHealthcare Military & Veterans

- PGBA TriCare ICD-10 Frequently Asked Questions
- UnitedHealthcare Military & Veterans Patient Safety Program Reminder

Doing Business Better

- Evidenced-Based Clinical Practice Guidelines
- Health Management Programs: Case and Disease Management
- Online Preventive Health Programs Available

UnitedHealthcare Affiliates

- UnitedHealthcare Oxford Medical and Administrative Policy Updates
- UnitedHealthcare of the River Valley Preauthorization List and Coverage Policy Updates
- SignatureValue Benefit Interpretation Policy Updates
- SignatureValue Medical Management Guideline Updates
- New York Participating Provider Laboratory and Pathology Protocol, Effective Sept. 1, 2015



Front & Center

Introducing Link—a New Site for UnitedHealthcareOnline.com and Optum Cloud Dashboard Users

Care providers and their administrative staff have told us they want a better way to get the information they need to check benefits and eligibility, determine claim status, submit claims reconsideration and more.

Later this year, we're introducing *Link*—an intuitive self-service experience that can help make your work measurably faster and easier.* *Link* is your digital health information connection.

- User tested: *Link* was created to support the way you work, based on feedback from users who face your same challenges.
- Streamlined workflow: Common tasks are just one click away.
- Next-generation technology: *Link* will have enhanced features and new applications.

You'll need an Optum ID to access *Link*. If you currently have access to Optum Cloud Dashboard, you already have an Optum ID. If you need help remembering your Optum ID or password, the *Link* sign-in screens will guide you through the process.

We'll be sending UnitedHealthcareOnline.com and Optum Cloud Dashboard users more details about the transition to *Link* and Optum ID, so watch your email inbox in the coming weeks for more information.

* Based on ongoing usability studies using keystroke-level modeling when comparing *Link* to UnitedHealthcareOnline.com and Optum Cloud Dashboard.



Front & Center

New Requirement for Inflammatory Medications

Effective Oct. 1, 2015, UnitedHealthcare will require prior authorization for administering the following specialty medications for inflammatory conditions in hospital outpatient facilities.

- Actemra[®]
- Entyvio[®]
- Orencia[®]
- Remicade[®]
- Simponi Aria[®]

Administering these medications in a hospital setting means higher out-of-pocket costs for UnitedHealthcare members managing inflammatory conditions, and we aim to ease their financial burden when medically appropriate

The new requirement applies to both new and current UnitedHealthcare Commercial plans, Mid-Atlantic, Oxford, Neighborhood Health Partnership (NHP) and UnitedHealthcare of the River Valley members. To minimize member costs, physicians may need to transition members to an alternate site of service, when there is a clinically appropriate more cost-effective option available, to continue benefit coverage.

Prior authorization is not required for members to receive these medications through more cost-effective sites of service including home infusion, infusion in a doctor's office or ambulatory infusion centers. UnitedHealthcare has a network of National Infusion Providers.

Failure to complete the new process prior to administering infusion services for inflammatory conditions will result in claims denial. Providers cannot bill members for services that are denied due to lack of prior authorization.

For more information about the requirement for inflammatory medications

- **UnitedHealthcare Commercial Plans:** please refer to the 2015 Administrative Guide under Specialty Drug Prior Authorization process (for commercial members only) found on [UnitedHealthcareOnline.com > Clinician Resources > Specialty Drugs > Commercial Specialty Drug Prior Authorization Program](#).
- **Mid-Atlantic:** Information about our evidence-based medical policies is available at [UnitedHealthcareOnline.com > Clinician Resources > Specialty Drugs > Commercial Specialty Drug Prior Authorization Program](#).
- **NHP:** Please refer to the 2015 Administrative Guide under Neighborhood Health Partnership Supplement found on [UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides](#).
- **Oxford:** Information is available at [oxfordhealth.com > Providers > Tools & Resources > Medical and Administrative Policies > Medical & Administrative Policies](#).
- **UnitedHealthcare of the River Valley:** Information is available at [UHCRiverValley.com > Providers > Coverage Policy Library > Services Requiring Preauthorization](#).



Front & Center

Synagis (palivizumab) Procurement Process for the 2015-16 RSV Season

According to the UnitedHealthcare Administrative Guide protocol for contracted providers, OptumRx Specialty Pharmacy is the only contracted specialty pharmacy vendor* for the medication, Synagis. Synagis is an injectable medication to help prevent serious lung infections and potential hospitalizations caused by respiratory syncytial virus (RSV) in high-risk infants and young children.

Requests for Synagis should be completed using the **UnitedHealthcare Synagis Enrollment Form: Season Respiratory Syncytial Virus**, available through [UnitedHealthcareOnline.com > Tools & Resources > Pharmacy Resources > Specialty Pharmacy Program > Prescription Enrollment Forms, Protocols & Administrative Guidelines](#). Submit forms to OptumRx by fax at 800-853-3844. This is the same procedure required during the 2014-15 RSV season.

OptumRx works with UnitedHealthcare's Care Management Center on clinical coverage reviews and follows the drug policy criteria for Synagis. The UnitedHealthcare Synagis policy reflects current guidelines and recommendations from the American Academy of Pediatrics and its Committee on Infectious Diseases. A copy of our drug policy can be obtained at [UnitedHealthcareOnline.com > Tools & Resources > Policies & Protocols & Guides > Medical & Drug Policies and Coverage Determination Guidelines > Synagis Policy](#).

UnitedHealthcare does not participate in MedImmune's sponsored RSV Connection Program.

*This does not apply to the State of New York (Empire Plan).



Front & Center

Prior Authorization Required for Certain Radiology and Cardiology Services for UnitedHealthcare Life Insurance Company and Golden Rule Insurance Company Members

As previously communicated in the July Network Bulletin, UnitedHealthcare will introduce new prior authorization requirements for certain radiology and cardiology services for UnitedHealthcare Life Insurance Company group number 755870 and UnitedHealthcare Golden Rule Insurance Company group number 902667. **The effective date for these requirements has been changed from Oct. 1, 2015 to Oct. 15, 2015.** These requirements apply to care providers that are subject to the UnitedHealthOne Individual Plans Supplement of UnitedHealthcare's Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide.

The requirements are set forth in the Outpatient Radiology Notification Prior Authorization Protocol for Commercial Customers and the Cardiology Notification Prior Authorization Protocol for Commercial Customers. These protocols can be found in the Administrative Guide at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols & Guides > Administrative Guides.

For more information about the requirements, please go to the following:

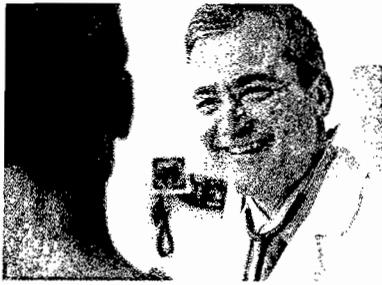


For radiology services: UnitedHealthcareOnline.com > Clinician Resources > Radiology > Radiology Notification & Prior Authorization > Resources: Reference Materials



For cardiology services: UnitedHealthcareOnline.com > Clinician Resources > Cardiology > Cardiology Notification & Prior Authorization > Resources: Reference Materials

If you have questions, please contact your Physician Advocate.



Front & Center

Reminder Regarding UnitedHealthcare West Radiology and Cardiology Prior Authorization Program Requirements

As previously communicated in the July 2015 Network Bulletin, UnitedHealthcare West has new Radiology and Cardiology Prior Authorization Program requirements.

Radiology Prior Authorization Requirements

Effective Oct. 1, 2015, ordering care providers who are subject to the UnitedHealthcare West Non-Capitated Supplement to the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for Commercial and Medicare Advantage Products, and practice in the states of California, Oklahoma, Oregon, Texas and Washington will use a new phone number and website to obtain a prior authorization number and notify UnitedHealthcare prior to scheduling certain CT, MRI, MRA, PET scan, Nuclear Medicine, and Nuclear Cardiology procedures for UnitedHealthcare West Commercial members. This requirement will also apply for UnitedHealthcare West Medicare Advantage members in the state of California.



A complete listing of Radiology CPT codes for which prior authorization is required is available at UnitedHealthcareOnline.com > Clinician Resources > Radiology > Radiology Notification & Prior Authorization.

Cardiology Prior Authorization Requirements

Effective Oct. 1, 2015, ordering care providers who are subject to the UnitedHealthcare West Non-Capitated Supplement to the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for Commercial and Medicare Advantage Products, and practice in the states of California, Oklahoma, Oregon, Texas and Washington must obtain prior authorization

before scheduling diagnostic catheterizations, electrophysiology implants, echocardiograms and stress echocardiograms for UnitedHealthcare West Commercial members. This requirement will also apply for UnitedHealthcare West Medicare Advantage members in the state of California.



A complete listing of Cardiology CPT codes for which prior authorization is required is available at UnitedHealthcareOnline.com > Clinician Resources > Cardiology > Cardiology Notification & Prior Authorization

Completing the Prior Authorization process

Effective Oct. 1, 2015, care providers must complete the prior authorization process and confirm that a coverage decision has been made as follows:

- Online at UnitedHealthcareOnline.com > Notifications Prior Authorizations > Radiology Notification & Authorization – Submission & Status;
- Online at UnitedHealthcareOnline.com > Notifications Prior Authorizations > Cardiology Notification & Authorization – Submission & Status;
- Phone: call 866-889-8054 from 7 a.m. to 7 p.m. local time, Monday through Friday

Rendering care providers must confirm that a coverage decision has been issued before rendering the radiology or cardiology procedure or payment since the services may be denied.

Continued >

**Front & Center**

Reminder Regarding
UnitedHealthcare
West Radiology and
Cardiology Prior
Authorization Program
Requirements

< Continued

Additional information regarding the requirements to follow can be found on UnitedHealthcareOnline.com

- For radiology services: UnitedHealthcareOnline.com > Clinician Resources > Radiology > Radiology Notification & Prior Authorization
- For cardiology services: UnitedHealthcareOnline.com > Clinician Resources > Cardiology > Cardiology Notification & Prior Authorization

If you have questions after viewing the online articles, please contact your UnitedHealthcare Network Management representative, or Provider Services at 800-637-5792, or email radiology@customerelation.com, or cardiology@customerelation.com.



Front & Center

Care Providers Earn More Than \$54 Million in Bonus Payments from UnitedHealthcare for Improving Health Outcomes and Closing Gaps in Care

UnitedHealthcare recently awarded more than \$54 million in bonus payments to more than 4,000 care providers named winners of the PATH Excellence in Patient Service Awards.

The recipients achieved the highest adherence levels for key quality measures by successfully closing gaps in care when treating UnitedHealthcare Medicare Advantage members.

The PATH program annually rewards physicians who meet certain performance-based criteria, including achieving or exceeding compliance targets for 17 specific Healthcare Effectiveness Data and Information Set (HEDIS) measures, including the percentages of eligible UnitedHealthcare Medicare Advantage members who received a breast cancer screening or colorectal cancer screening. Other measures evaluate the percentages of members who adhere to their medications to help manage their diabetes, high blood pressure or cholesterol.

Health plans and the Centers for Medicare & Medicaid Services (CMS) use HEDIS as a tool to measure performance on important dimensions of health care and service.

According to the Centers for Disease Control and Prevention, fewer than half of adults ages 65 and older were up to date with core preventive services, such as tests and screenings, despite getting regular check-ups from their doctors.

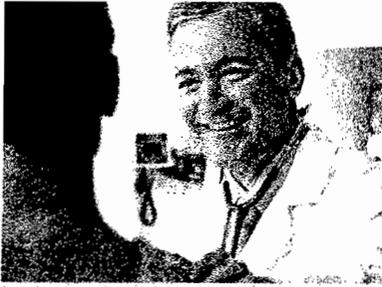
UnitedHealthcare created the PATH program to help its Medicare Advantage members be as healthy as possible by encouraging greater use of preventive health care services and proactive monitoring of chronic conditions.

The program provides support and incentives for both care providers and Medicare Advantage members to enhance their engagement in their health care and willingness to take action on their doctors' treatment plan, thereby closing gaps in care.

The PATH program has four components:

- **Patient Support and Communication:**
UnitedHealthcare supplements care providers' patient engagement efforts through comprehensive communications to educate Medicare Advantage members about the importance of taking proactive steps to keep their health on track. Mailings, emails and phone calls to members emphasize the importance of working with their doctors to create a personalized preventive care plan as well as getting their annual care visit and any recommended tests and screenings. Reminders and financial incentives offer further encouragement to follow through on scheduling appointments and tests.
- **Actionable Patient Data and Reporting:**
UnitedHealthcare provides participating care providers with monthly Patient Care Opportunity Reports that include detailed patient-level and practice-level data in a format that is easy to use. The data facilitate the delivery of coordinated care by giving care providers a more complete picture of their patients' health, including their hospitalizations, care they receive from other doctors and adherence to prescribed medications. On an ongoing basis, care providers can see at a glance the number of UnitedHealthcare Medicare Advantage patients who are overdue for an annual care visit or cancer screenings, for example, so they can take action to engage these patients and close their gaps in care.

Continued >



Front & Center

Care Providers Earn
More Than \$54 Million
in Bonus Payments
from UnitedHealthcare
for Improving Health
Outcomes and Closing
Gaps in Care

< Continued

- **Financial Compensation for Doctors:** Because this type of patient engagement can require extra effort on the part of care providers, the PATH program offers financial compensation to care providers who exceed quality-based performance targets. Care providers who improve specific HEDIS measures for eligible UnitedHealthcare Medicare Advantage members can earn an annual bonus payment.
- **Practice-Based Support:** UnitedHealthcare collaborates with care providers to provide additional tools, resources and support that can help facilitate care coordination and improve health outcomes. Given that every practice is different and has unique needs, UnitedHealthcare engages with practices in a variety of ways to offer customized support, such as joint communication efforts and on-site administrative and clinical resources.

In 2015, nearly 1 million UnitedHealthcare Medicare Advantage members are being treated by doctors who participate in the PATH program.

The PATH program is part of UnitedHealthcare's commitment to help shift the nation's health care system to one that rewards quality and value instead of the volume of procedures performed. To facilitate this shift, the company offers a variety of fee-for-value payment arrangements, including incentive programs like PATH.

For more information about UnitedHealthcare's full spectrum of value-based initiatives, please visit AccountableCareAnswers.com.



Front & Center

Reminder: Updated Site of Service Guidelines for Certain Outpatient Surgical Procedures

In an effort to minimize out-of-pocket costs for UnitedHealthcare members and to improve cost efficiencies for the overall health care system, we are implementing prior authorization guidelines that aim to encourage more cost-effective sites of service for certain outpatient surgical procedures, when medically appropriate. These guidelines were previously communicated in the July Network Bulletin.

These procedures will require prior authorization if performed in an outpatient hospital setting. No prior authorization will be required if they are performed at a participating network ambulatory surgery center. Coverage determinations will consider availability of a participating network facility, specialty requirements, physician privileges and whether a patient has an individual need for access to more intensive services. To help ease this transition, we encourage you to familiarize yourself with ambulatory surgery centers in your area and obtain privileges to perform procedures in those settings, if you do not already have them.

These guidelines are effective for dates of service on or after Oct. 1, 2015, in most states, except for Colorado, where the effective date is Nov. 1, 2015, and for Illinois and Iowa, where the effective date is Dec. 1, 2015.

The prior authorization requirement applies to the UnitedHealthcare Commercial and Exchange membership, including the following plans:

- Golden Rule Insurance Company (group 902667)
- Mid-AtlanticMD Healthplan
- Individual Practice Association, Inc. ("M.D. IPA") or Optimum Choice Inc. ("Optimum Choice") products
- Neighborhood Health Partnership

- UnitedHealthcare of the River Valley Health Plan
- Health Exchanges
- UnitedHealthcare Oxford Health Plans*
- UnitedHealthcare
- UnitedHealthcare Life Insurance Company (group 755870)

It was previously communicated that UnitedHealthcare West would be included in scope for these new guidelines. However, those plans will not be included.

The guidelines apply to the following codes and procedures:

Procedures & Services	Codes for UnitedHealthcare Commercial Plans
Abdominal Paracentesis	49083
Carpal Tunnel Surgery	64721
Cataract Surgery	66821 66982 66984
Hernia Repair	49585 49587 49650 49651 49652 49653 49654 49655
Liver Biopsy	47000
Tonsillectomy & Adenectomy	42821 42826
Upper & Lower Gastrointestinal Endoscopy	43235 43239 43249 45378 45380 45384 45385
Urologic Procedures	50590 52000 52005 52204 52224 52234 52235 52260 52281 52310 52332 52351 52352 52353 52356 57288

Continued >



Front & Center

Reminder: Updated Site of Service Guidelines for Certain Outpatient Surgical Procedures

< Continued

Prior authorization requests can be filed in multiple ways, including online or by phone

- Go to **UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Notification/Prior Authorizations Submission.**

Using UnitedHealthcareOnline.com is an easy way to initiate prior authorization and is the preferred option.

- Call the Provider Services number on the back of your patient's member health care ID card.

If you do not obtain prior authorization before performing these procedures in an outpatient hospital, claims may be denied. Providers cannot bill members for services that are denied due to lack of prior authorization.



For more information on this requirement, please see the frequently asked questions and answers at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Protocols > Site of Service for Outpatient Surgical Procedures FAQ.



If you have questions, please contact your local Network Management representative or call the Provider Services number on the back of the member's ID card. Thank you.



Front & Center

Prior Authorization and Advance Notification Requirement Updates

Effective for dates of service Dec. 7, 2015 and after, certain services will be added or eliminated from the Prior Authorization and Advance Notification Lists for UnitedHealthcare, UnitedHealthcare West, UnitedHealthcare Commercial, UnitedHealthcare Medicare Advantage, UnitedHealthcare Community Plan (including LTSS) and UnitedHealthcare Medicare/Medicaid (MMP) plans.

The most up-to-date Advance Notification lists may be accessed as follows

- **UnitedHealthcare Commercial:** UnitedHealthcareOnline.com > Clinician Resources > Advance & Admission Notification
- **UnitedHealthcare and UnitedHealthcare West Medicare Advantage plans (including UnitedHealthcare Community Plan Dual SNP Medicare):** UnitedHealthcareOnline.com > Clinician Resources > Advance & Admission Notification
- **UnitedHealthcare Community Plans including Medicaid, LTSS, and MMP:** UHCommunityPlan.com > For Health Care Professionals > Select your State.

Unless otherwise stated, the following code changes are effective Dec. 7, 2015

UnitedHealthcare Prior Authorization (PA) Program Requirements

Category	Products Impacted	Removed from PA	Added to PA
Breast Reconstruction	Medicare, MMP	19355	
Bone Growth Stimulator	Medicaid (including LTSS)		E0760
Cochlear Implant	Commercial	69711	
Cochlear Implant	Medicare, MMP	69799	
Cochlear Implant	Medicaid (including LTSS)	69711, 92601 through 92604	
Cosmetic & Reconstructive	Medicare, MMP	11950 through 11952, 11954, 15832 through 15839, 15876, 15878, 15879, 19300, 21270, 30120, 36469	11960, 11971, 15847, 17106 through 17108, 67914 through 67917, 67921 through 67924, 67950, 67966, Q2026
Cosmetic & Reconstructive	Commercial; Medicaid (including LTSS)	40500, 69320, Q2027	
Sleep Apnea	Medicare, MMP	42299	

Continued >



Front & Center

Prior Authorization and Advance Notification Requirement Updates

< Continued

Category	Products Impacted	Removed from PA	Added to PA
Vagus Nerve Stimulator	Medicare		L8680, L8682, L8685 through L8688
Vagus Nerve Stimulator	Commercial, Medicaid (including LTSS)	L8681, L8689	
Vein Procedures	Medicare, MMP	37735, 37785	
DME	Commercial, Medicaid (including LTSS), Medicare, MMP	L8629	
Potentially Unproven/Experimental	Commercial, Medicaid (including LTSS)	78350, 78351	



Front & Center

Health Insurance Marketplace Participation for 2016

UnitedHealthcare has re-filed with the Health Insurance Marketplace to offer qualified health plans through the Individual Exchange in 35 states for the 2016 enrollment period. The Open Enrollment period runs from Nov. 1, 2015, through Jan. 31, 2016, with coverage effective as soon as Jan. 1, 2016.

Your participation

Care providers participating in these new benefit plans will receive a welcome kit by Oct. 1, 2015. View the online provider directory to see if you are listed as a network provider for these plan names.

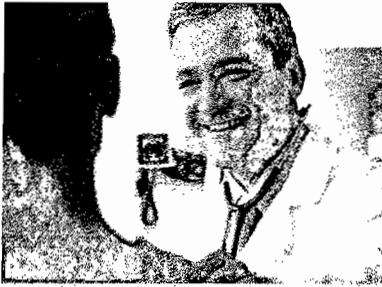


To learn more about our UnitedHealthcare Commercial plans, please go to UnitedHealthcareOnline.com > Tools & Resources > Products & Services.

2016 Individual Exchange proposed product offerings

State	Product	2016 Geography	New, Expansion or No Change for 2016
Alabama	Compass	Statewide	No changes
Alabama	Choice	Statewide	New
Arizona	Compass	Statewide	No changes
Arizona	Choice Plus Advanced	Statewide	No changes
Arkansas	Compass Plus	Statewide	New
California	Core and Core Essentials	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Fresno, Glenn, Humboldt, Inyo, Imperial, Kings, Lake, Lassen, Madera, Mendocino, Modoc, Mono, Monterey, Nevada, Plumas, Santa Barbara, San Benito, Santa Cruz, San Luis Obispo, Siskiyou, Shasta, Sierra, Sutter, Tuolumne, Trinity, Tehama, Ventura, Yuba	New
Connecticut	Choice Plus	Statewide	No change
Colorado	Compass	Statewide	Expansion
Florida	Compass	Statewide	Expansion

[Continued >](#)



Front & Center

Health Insurance
Marketplace Participation
for 2016

< Continued

State	Product	2016 Geography	New, Expansion or No Change for 2016
Georgia	Compass	All counties, except for Paulding, Cobb, and Douglas.	No Change
Illinois	Compass	Cook, Bureau, DuPage, Fulton, Grundy, Hancock, Henderson, Henry, Kane, Kankakee, Kendall, Knox, Lake, LaSalle, Marshall, McDonough, McHenry, Mercer, Peoria, Putnam, Rock Island, Stark, Tazewell, Warren, Whiteside, Will, Woodford	Expansion
Illinois	Choice Plus	Cook, DuPage, Grundy, Kane, Kankakee, Kendall, Lake, McHenry, Will	New
Indiana	Choice	Statewide	No Change
Iowa	Compass	Adair, Adams, Appanoose, Audubon, Benton, Black Hawk, Boone, Bremer, Buchanan, Buena Vista, Butler, Calhoun, Carroll, Cass, Cedar, Cerro Gordo, Chickasaw, Clarke, Clayton, Clinton, Crawford, Dallas, Davis, Decatur, Delaware, Dubuque, Fayette, Floyd, Franklin, Fremont, Greene, Grundy, Guthrie, Hamilton, Hancock, Hardin, Harrison, Howard, Iowa, Jackson, Jasper, Jefferson, Johnson, Jones, Keokuk, Kossuth, Linn, Lucas, Madison, Mahaska, Marion, Marshall, Mills, Mitchell, Monona, Monroe, Montgomery, Muscatine, Page, Pocahontas, Polk, Poweshiek, Scott, Shelby, Story, Tama, Union, Wapello, Warren, Wayne, Webster, Winnebago, Woodbury, Worth, Wright	New
Kansas	Compass	Statewide	New
Kentucky	Compass	Statewide	New
Louisiana	Compass	Statewide	No change
Louisiana	Choice	Statewide	New
Maryland	Compass	Anne Arundel, Baltimore City, Baltimore, Frederick, Harford, Howard, Montgomery, Prince Georges, St. Mary's, Washington, Wicomico	No change
Maryland	Choice	Statewide	No change
Massachusetts	Choice	Statewide	No change
Michigan	Compass	Calhoun, Cass, Kalamazoo, Macomb, Oakland, Van Buren, Wayne	Expansion counties
Mississippi	Compass	Statewide	Expansion counties
Mississippi	Choice	Statewide	New

Continued >



Front & Center

Health Insurance
Marketplace Participation
for 2016

< Continued

State	Product	2016 Geography	New, Expansion or No Change for 2016
Missouri	Compass	Statewide	Expansion
Nebraska	Compass	Statewide	New
Nevada	MyHPN	Clark, Nye, Washoe	No change
New Jersey	Compass	Statewide	No change
New York	Compass	Bronx, Brooklyn/Kings, Dutchess, Nassau, New York, Orange, Putnam, Queens, Rockland, Staten Island/Richmond, Suffolk, Sullivan, Ulster, Westchester	No change
North Carolina	Compass	Alamance, Alexander, Alleghany, Anson, Ashe, Avery, Bladen, Brunswick, Buncombe, Burke, Cabarrus, Caldwell, Caswell, Catawba, Chatham, Cherokee, Clay, Cleveland, Columbus, Cumberland, Davidson, Davie, Duplin, Durham, Forsyth, Franklin, Gaston, Graham, Granville, Greene, Guilford, Harnett, Haywood, Henderson, Hoke, Iredell, Jackson, Johnston, Lee, Lincoln, Macon, Madison, McDowell, Mecklenburg, Mitchell, Montgomery, Moore, Nash, New Hanover, Onslow, Orange, Pender, Person, Polk, Randolph, Richmond, Robeson, Rockingham, Rowan, Rutherford, Sampson, Scotland, Stanly, Stokes, Surry, Swain, Transylvania, Union, Vance, Wake, Warren, Watauga, Wayne, Wilkes, Wilson, Yadkin, Yancey	No change
Ohio	Compass	Statewide	Expansion
Ohio	Navigate Plus	Statewide	New
Oklahoma	Compass	Statewide	New
Pennsylvania	Compass	Allegheny, Armstrong, Beaver, Bedford, Blair, Bucks, Butler, Cambria, Chester, Delaware, Fayette, Greene, Indiana, Lawrence, Lehigh, Mercer, Montgomery, Northampton, Philadelphia, Somerset, Venango, Washington, Westmoreland	Expansion
Rhode Island	Compass	Statewide	No change
Rhode Island	Choice	Statewide	New
South Carolina	Compass	Aiken, Darlington, Florence, Lexington, Richland	New
Tennessee	Compass	Statewide	New

Continued >



Front & Center

Health Insurance
Marketplace Participation
for 2016

< Continued

State	Product	2016 Geography	New, Expansion or No Change for 2016
Texas	Compass Balanced	Bexar, Brazoria, Cameron, Collin, Comal, Crosby, Dallas, Denton, El Paso, Fort Bend, Galveston, Guadalupe, Harris, Harrison, Gregg, Hays, Hidalgo, Hunt, Lubbock, Lynn, Nueces, San Patricio, Rusk, Tarrant, Smith, Travis, Upshur, Williamson, Montgomery, Wise	Expansion
Texas	Choice	Statewide	New
Virginia	Compass	Alexandria City, Arlington, Caroline, Chesterfield, Clarke, Colonial Heights City, Dinwiddie, Fairfax, Fairfax City, Falls Church City, Fauquier, Frederick, Fredericksburg City, Goochland, Greene, Hanover, Henrico, Hopewell City, King George, King William, Loudoun, Louisa, Manassas City, Manassas Park City, New Kent, Orange, Page, Petersburg City, Powhatan, Prince George, Prince William, Richmond City, Shenandoah, Spotsylvania, Stafford, Sussex, Warren, Winchester City	New
Wisconsin	Compass	Adams, Brown, Buffalo, Calumet, Clark, Columbia, Dodge, Door, Florence, Fond, Du Lac, Forest, Green, Green Lake, Iowa, Iron, Jackson, Jefferson, Juneau, Kenosha, Kewaunee, La Crosse, Lafayette, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Marquette, Menominee, Milwaukee, Monroe, Oconto, Oneida, Outagamie, Ozaukee, Pepin, Portage, Price, Racine, Richland, Rock, Rusk, Sauk, Shawano, Sheboygan, Taylor, Trempealeau, Vernon, Vilas, Walworth, Washington, Waukesha, Waupaca, Waushara, Winnebago, Wood	No change
Washington	Charter	Statewide	New
Washington	Navigate	Statewide	New



Front & Center

Updated Resource for UnitedHealthcare's Clinical Data Submission Protocol now Available

UnitedHealthcare is taking a prioritized approach to the collection of clinical information as part of the Clinical Data Submission Protocol, which became effective July 1, 2015. We are focusing our data collection efforts on the receipt of lab result values for Medicare members, specifically HbA1c result values. You can view updated information about submission channels and data being requested in our FAQ at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Protocols > UnitedHealthcare Clinical Data Submission Protocol FAQ.

We will continue to engage more providers over time to support the receipt of additional clinical information as requested. If you have questions regarding how to submit Medicare lab results to UnitedHealthcare, please contact your UHN network management representative and they will work with you to assess your current data-sharing capability and the best way for you to submit the requested data.

UnitedHealthcare Physician and Practice Manager Satisfaction Survey

Each year, we ask for your participation in our Physician Satisfaction Survey. Our annual survey is an important tool that provides us insight to your experience working with us. Your opinions help us identify opportunities to enhance our services to align with your practice's needs.

In August, we mailed invitations to participate in our survey to a random sample of UnitedHealthcare physicians and practice managers. If you received an invitation, we encourage you to take a few minutes to share your opinions with us. As always, we appreciate your participation.



Front & Center ICD-10 Update

In preparation for the transition to ICD-10 coding as the new HIPAA standard for reporting diagnosis and inpatient procedures on claims beginning Oct. 1, 2015, the Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) released a **joint announcement** in July. This announcement notified professionals who bill claims under the Medicare Fee-For-Service Part B physician fee schedule of additional guidance "that will allow for flexibility in the claims auditing and quality reporting process as the medical community gains experience using the new ICD-10 code set."

CMS has stated that coverage policies currently requiring a specific diagnosis under ICD-9 will continue to require a specific diagnosis under ICD-10. UnitedHealthcare will also require all facilities, physicians and other health care professionals to use valid ICD-10 codes for all claim submissions for services provided to our health plan members starting October 1.

UnitedHealthcare is in the process of assessing the potential impacts of the remaining guidance as it relates to medical and reimbursement policies. "We have a responsibility to quality and accuracy and need some time to understand the downstream affects the coding guidance will have on quality areas such as CMS Star Ratings, HEDIS and other important measures," says Aaron Sapp, National ICD-10 Program Director for UnitedHealthcare.

UnitedHealthcare also continues to remind its network care providers that they are expected to code to the highest level of specificity as supported in their clinical documentation. "Coding specificity is important to ensuring UnitedHealthcare receives accurate and complete claim submissions so we can properly process our care providers' claims," says Sapp.

UnitedHealthcare has developed two new tools to assist network care providers with the transition to ICD-10.

"We have developed an Early Warning System (EWS) for facilities that will help identify potential coding errors specifically related to ICD-10 that could result in underpayments or overpayments and allow us to proactively connect with the submitter to review," said Sapp.

"Additionally, for our network physicians and specialists, we created an ICD-10 Physician Coding Practice Tool to help them better understand how to use ICD-10 coding. The tool allows physicians to practice coding in various clinical scenarios across 35 medical specialties," he added. Each clinical scenario for commonly used diagnosis codes includes a medical example, medical history and office notes. Users can compare codes used by peer physicians within each specialty.

UnitedHealthcare is committed to providing ongoing support to our network care providers to help with the transition to ICD-10 and has built an **ICD-10 Online Resource Center**, which includes the Physician Coding Practice Tool, webinars, fact sheets and other resources.



If you have questions, please send them via email to ICD10questions@uhc.com.



UnitedHealthcare Commercial

UnitedHealthcare Medical Policy, Coverage Determination Guideline (CDG) and Utilization Review Guideline (URG) Updates



For complete details on the policy updates listed in the following table, please refer to the **August 2015 Medical Policy Update Bulletin** at **UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines > Medical Policy Update Bulletin.**

Continued >



**UnitedHealthcare
Commercial**

UnitedHealthcare
Medical Policy, Coverage
Determination Guideline
(CDG) and Utilization
Review Guideline (URG)
Updates

< Continued

Policy Title	Policy Type	Effective Date
NEW		
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome	Medical	Sept. 1, 2015
Molecular Profiling to Guide Cancer Treatment	Medical	Oct. 1, 2015
UPDATED/REVISED		
Attended Polysomnography for Evaluation of Sleep Disorders	Medical	Oct. 1, 2015
Chemosensitivity and Chemoresistance Assays in Cancer	Medical	Aug. 1, 2015
Cytological Examination of Breast Fluids for Cancer Screening	Medical	Aug. 1, 2015
Discogenic Pain Treatment	Medical	Aug. 1, 2015
Electrical Bioimpedance for Cardiac Output Measurement	Medical	Aug. 1, 2015
Infertility Diagnosis and Treatment	Medical	Oct. 1, 2015
Magnetic Resonance Spectroscopy (MRS)	Medical	Aug. 1, 2015
Meniscus Implant and Allograft	Medical	Oct. 1, 2015
Neuropsychological Testing Under the Medical Benefit	Medical	Aug. 1, 2015
Omnibus Codes	Medical	Oct. 1, 2015
Pectus Deformity Repair	CDG	Sept. 1, 2015
Skilled Care and Custodial Care Services	CDG	Aug. 1, 2015
Specialty Medication Administration – Site of Care Review Guidelines	URG	Oct. 1, 2015
Spinal Ultrasonography	Medical	Aug. 1, 2015

Note: The appearance of a service or procedure on this list does not imply that UnitedHealthcare provides coverage for the service or procedure. In the event of an inconsistency between the information provided in this Bulletin and the posted policy, the posted policy will prevail.



UnitedHealthcare Community Plan

Medical Policy & Coverage Determination Guideline Updates



For complete details on the policy updates listed in the following table, please refer to the **August 2015 Medical Policy Update Bulletin** at **UHCommunityPlan.com > Provider Information > UnitedHealthcare Community Plan Medical Policies and Coverage Determination Guidelines.**

Continued >



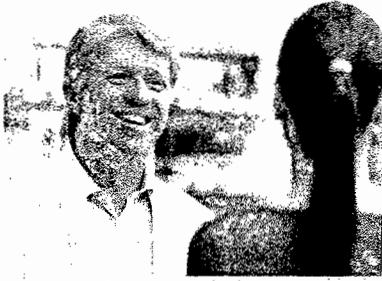
**UnitedHealthcare
Community Plan**

Medical Policy &
Coverage Determination
Guideline Updates

< Continued

Policy Title	Policy Type	Effective Date
NEW		
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome	Medical	Sept. 1, 2015
Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC)	Medical	Sept. 1, 2015
UPDATED/REVISED		
Apheresis	Medical	Sept. 1, 2015
Attended Polysomnography for Evaluation of Sleep Disorders	Medical	Oct. 1, 2015
Bronchial Thermoplasty	Medical	Sept. 1, 2015
Chemosensitivity and Chemoresistance Assays in Cancer	Medical	Oct. 1, 2015
Cytological Examination of Breast Fluids for Cancer Screening	Medical	Oct. 1, 2015
Discogenic Pain Treatment	Medical	Oct. 1, 2015
Electrical Bioimpedance for Cardiac Output Measurement	Medical	Aug. 1, 2015
Home Traction Therapy	Medical	Sept. 1, 2015
Intensity-Modulated Radiation Therapy	Medical	Sept. 1, 2015
Light and Laser Therapy for Cutaneous Lesions and Pilonidal Disease	Medical	Sept. 1, 2015
Magnetic Resonance Spectroscopy (MRS)	Medical	Oct. 1, 2015
Meniscus Implant and Allograft	Medical	Oct. 1, 2015
Motorized Spinal Traction	Medical	Sept. 1, 2015
Neuropsychological Testing Under the Medical Benefit	Medical	Oct. 1, 2015
Omnibus Codes	Medical	Sept. 1, 2015 Oct. 1, 2015
Pectus Deformity Repair	CDG	Oct. 1, 2015
Private Duty Nursing Services (PDN)	CDG	Sept. 1, 2015

Continued >



**UnitedHealthcare
Community Plan**

Medical Policy and
Coverage Determination
Guideline Updates

< Continued

UPDATED/REVISED		
Skilled Care and Custodial Care Services	CDG	Aug. 1, 2015
Spinal Ultrasonography	Medical	Oct. 1, 2015
Transcatheter Heart Valve Procedures	Medical	Sept. 1, 2015
Umbilical Cord Blood Harvesting and Storage for Future Use	Medical	Sept. 1, 2015

Note: The appearance of a service or procedure on this list does not imply that UnitedHealthcare provides coverage for the service or procedure. In the event of an inconsistency between the information provided in this Bulletin and the posted policy, the posted policy will prevail.



UnitedHealthcare Medicare Solutions

National Medicare Education Week: Helping to Make Medicare Easier to Understand

UnitedHealthcare's National Medicare Education Week will be celebrated Sept. 15-21 as a way of helping meet the growing consumer and patient demand for clear information about Medicare; and to help empower your patients to make informed, confident decisions about their Medicare coverage

According to the Medicare Made Clear Index, a 2013 survey conducted by UnitedHealthcare, one in five Medicare beneficiaries describe Medicare as confusing, and most are not able to correctly identify the health care expenses that Medicare Parts A, B, C and D cover.

Proud supporters of the week include: AARP, the Caregiver Action Network, the National Association of Area Agencies on Aging (n4a), Walgreens, Albertsons and Safeway, in addition to local health care providers, senior centers and other organizations nationwide.

National Medicare Education Week begins exactly one month before the start of Medicare Open Enrollment (Oct. 15 – Dec. 7). You can participate by:

- Visiting **MedicareMadeClear.com** where you can find information about the week and learn about Medicare
- Attending a National Medicare Education Week event, which will be held in select cities across the country
- Asking your Provider Advocate for materials to share with your patients.



UnitedHealthcare Medicare Solutions

2016 Medicare Advantage Service Area Reductions and Member Dis-enrollments

Less than two percent of our UnitedHealthcare Medicare Advantage members across the country will be impacted by service area reductions in 2016. These members will receive an official non-renewal notice from UnitedHealthcare by Oct. 2, 2015.

The non-renewal notice will give members information about their special election period eligibility for 2016 coverage and their Medicare Supplement guaranteed rights, as well as replacement plans for all Medicare Advantage organizations and Prescription Drug Plan sponsors available in their area.

In many cases, these members will receive additional outreach by phone or mail to inform them of other health plan options offered by UnitedHealthcare. The majority of care providers and facilities contracted for UnitedHealthcare Medicare Advantage products will not be affected by these changes. In most areas, we will still offer network-based Medicare Advantage plans, so provider contracts will remain in place. In markets where contracts are affected, UnitedHealthcare network account managers will contact providers with more details.



To learn more, please visit UnitedHealthcareOnline.com > Tools & Resources > Medicare. You may also contact your local Network Account Manager or Provider Advocate.

UnitedHealthcare Wins Group Medicare Advantage (PPO) Bid for California Public Employee's Retirement System (CalPERS)

The California Public Employee's Retirement System (CalPERS) Board of Administration approved the Group Medicare Advantage (PPO) Plan to be offered to CalPERS' Medicare-eligible retirees, effective Jan. 1, 2016.

We will offer our UnitedHealthcare Group Medicare Advantage (PPO) plan to CalPERS' Medicare-eligible retirees. The plan is available to all retirees living in all 58 counties in California.

The UnitedHealthcare Group Medicare Advantage (PPO) Plan is open access with no referrals or gatekeeper. In addition, under this plan, the member's cost share is the same whether using an in-network or out-of-network provider.

- Providers who are in-network for UnitedHealthcare's Medicare Advantage (PPO) products will be paid according to their current agreement for these members.
- Out-of-network providers for UnitedHealthcare's Medicare Advantage (PPO) products will be paid according to Medicare's allowable fee schedule.

The UnitedHealthcare Group Medicare Advantage (PPO) plan does not require prior authorizations or prior notifications for out-of-network physicians who see our members.





UnitedHealthcare Medicare Solutions

Referral Requirements for Certain Medicare Advantage Plans

In January 2015, UnitedHealthcare introduced Medicare Advantage referral required plans that focus on coordination of care through the primary care physician (PCP) with referrals to network specialists.

No referral indicator on electronic eligibility response transactions (271)

Electronic eligibility response transactions (271) for payer ID 87726 do not identify when referrals are required for gated plans at this time. Please ensure your systems and business processes are set up accordingly to recognize these plans as requiring a referral. Refer to the **Medicare Referral Required Plan List** for a complete list of plans that require electronic referral submissions.

PCP referral submissions on UnitedHealthcareOnline.com

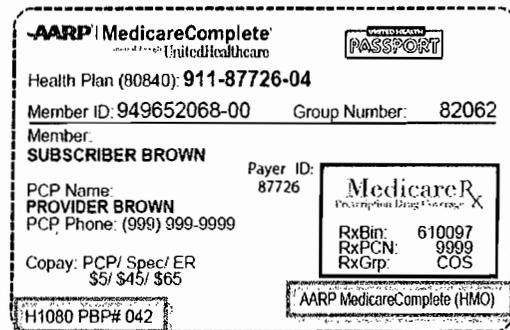
The member's assigned PCP must submit electronic referrals at UnitedHealthcareOnline.com for patients that need to see a network specialist. A new submission is required if the member needs to see a different specialist that is not in the same tax ID or when the referral requires an extension to the same physician.

Specialist liability for lack of referrals

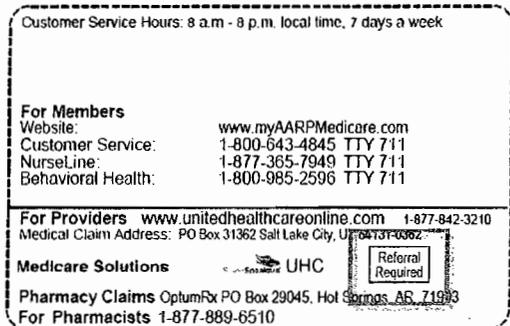
Specialists are required to confirm an active referral is recorded on UnitedHealthcareOnline.com before services are rendered. If UnitedHealthcare Medicare Advantage members are seen without a referral, then services are not eligible for payment and the claim will be denied. The member cannot be balanced billed for such services as outlined in the Provider Administrative Guide, section titled "Medicare Advantage referral required plans".

Three ways to identify referral required plans

1. The member's identification card will indicate referral required on the back.
2. A referral required message is highlighted on the patient eligibility screen on UnitedHealthcareOnline.com.
3. Contact Provider Services at 877-842-3210 and enter the Medicare Member ID, when prompted, to ensure you are routed to the appropriate agent.



AARP MedicareComplete
 Health Plan (80840): **911-87726-04**
 Member ID: **949652068-00** Group Number: **82062**
 Member: **SUBSCRIBER BROWN** Payer ID: **87726**
 PCP Name: **PROVIDER BROWN**
 PCP Phone: (999) 999-9999
 Copay: PCP/ Spec/ ER
 \$5/ \$45/ \$65
 RxBin: 610097
 RxPCN: 9999
 RxGrp: COS
 H1080 PBP# 042
 AARP MedicareComplete (HMO)



Customer Service Hours: 8 a.m. - 8 p.m. local time, 7 days a week

For Members
 Website: www.myAARPMedicare.com
 Customer Service: 1-800-643-4845 TTY 711
 NurseLine: 1-877-365-7949 TTY 711
 Behavioral Health: 1-800-985-2596 TTY 711

For Providers www.unitedhealthcareonline.com 1-877-842-3210
 Medical Claim Address: PO Box 31362 Salt Lake City, UT 84131-0362

Medicare Solutions UHC
 Pharmacy Claims OptumRx PO Box 29045, Hot Springs AR, 71903
 For Pharmacists 1-877-889-6510

Referral Required

Resources



To learn more about these plans and how to submit or verify referrals, go to UnitedHealthcareOnline.com > Tools & Resources > Products & Services > Medicare.



UnitedHealthcare Medicare Solutions

Updated Referral Exclusion List for Medicare Advantage Gated Plans

UnitedHealthcare Medicare Advantage has expanded the list of services that do not require a referral for the remainder of 2015. The following list is in addition to the referral exclusion list in the **Administrative Guide**:

- 23 – Rehabilitation Centers/Facilities (2015 only)
- 89 - Hospitalist
- 73 - Family Practice Specialist
- 74 - OB/GYN Specialist
- 75 - Pediatric Specialist
- 76 - Internal Medicine Specialist
- 80 - Accidental Dental/Medical Dental
- 08-Ophthalmologist
- 26-Podiatrist
- 24-Therapeutic Radiology
- AS Modifier for assistant at surgery services provided by a Physician Assistant (PA), Nurse Practitioner (NP), or Clinical Nurse Specialist (CNS).
- 38 - Nuclear Medicine
- 30 - Hematologist
- 36 – Oncologist
- 46 – Speech Therapy (2015 only)
- 64 – Occupational/Physical Therapy (2015 only)
- 91 - Disease Management
- 92 - Infectious Disease Specialist
- 21-Optician
- 22-Optometrist
- Allergy shots (95115- 95170, 95199)
- Observation codes-99218-99220 and 99224-99226
- CPT ranges 70000-79999 and 80000-89999



UnitedHealthcare Medicare Solutions

UnitedHealthcare Medicare Advantage Coverage Summary Updates



For complete details on the policy updates listed in the following table, please refer to the **August 2015 Medicare Advantage Coverage Summary Update Bulletin** at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Medicare Advantage Coverage Summaries > Update Bulletin.

Policy Title
UPDATED/REVISED (Approved on July 21, 2015)
Age Related Macular Degeneration (AMD) Therapy (Macugen®, Lucentis®, Avastin®, EYLEA®)
Arthroscopic Lavage and Debridement Treatment of the Knee(s)
Biofeedback
Carotid Procedures and Testing
Complementary and Alternative Medicine
Cryosurgery for Prostate Cancer
Durable Medical Equipment (DME), Prosthetics, Corrective Appliances/Orthotics (Non-Foot Orthotics) and Medical Supplies Grid
Durable Medical Equipment, Prosthetics, Corrective Appliances/Orthotics and Medical Supplies
Laboratory Tests and Services
Pain Management and Pain Rehabilitation
Preventive Health Services and Procedures
Rehabilitation - Medical Rehabilitation (OT, PT and ST, including Cognitive Rehabilitation)
REPLACED (Approved on July 21, 2015)
Dialysis Treatment

Note: The appearance of a service or procedure on this list does not imply that UnitedHealthcare provides coverage for the service or procedure. In the event of an inconsistency between the information provided in this Bulletin and the posted policy, the posted policy will prevail.



UnitedHealthcare Military & Veterans

PGBA TriCare ICD-10 Frequently Asked Questions



The effective date for ICD-10 is Oct. 1, 2015. To view frequently asked questions and answers regarding the ICD-10 implementation for TRICARE, please go to <http://www.mytricare.com/internet/tric/tri/tricare.nsf> > Providers > ICD-10 Implementation FAQ.



UnitedHealthcare Military & Veterans

UnitedHealthcare Military & Veterans Patient Safety Program Reminder

All TRICARE providers who have contact with beneficiaries by telephone, in person, or handle beneficiary medical records and claims are required by contract to participate in quality activities. The UnitedHealthcare Military & Veterans Patient Safety Program includes a wide-spectrum of activities, ranging from promotion, implementation and tracking of provider compliance with evidence-based medicine guidelines to monitoring clinical information that identifies and addresses quality issues. The program is designed to reduce medical errors and increase patient safety by implementing actions appropriate to the concern. Identified potential quality issues (PQIs) should be referred to the Clinical Quality Management (CQM) Department. A PQI is clinical or system variance warranting further review for determination of the presence of a quality issue. Reviews are conducted by CQM staff to confirm or negate the issue; not all PQIs will be determined to be a quality issue.

All PQI reviews are confidential and protected. Potential quality issues that relate to a Military Treatment Facility (MTF) service will be forwarded to the MTF quality point of contact for review and resolution. To submit a PQI, please do the following:



Go to UHCMilitaryWest.com > Popular Topics > Provider Forms > Form Category > Clinical Programs > PQI Issue Referral. Please print the form, fill it out and submit it to the CQM Department via fax at 877-895-9055.



If you encounter any difficulty submitting a PQI with the form, please call 602-293-4472.

Doing Business Better

Evidenced-Based Clinical Practice Guidelines

UnitedHealthcare uses evidenced-based clinical guidelines from nationally recognized sources to guide our quality and health management programs.



The clinical practice guidelines listed on the following page are available at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines > Clinical Guidelines.

[Continued >](#)



Doing Business Better

Evidenced-Based Clinical Practice Guidelines

< Continued

Please note that there have been significant changes to the guidelines that are marked with an asterisk in the following table:

Topic	Organization
Acute Myocardial Infarction with ST Elevation	American College of Cardiology / American Heart Association
Acute Myocardial Infarction without ST Elevation	American College of Cardiology / American Heart Association
Asthma	National Heart, Lung and Blood Institute
Attention Deficit Hyperactivity Disorder (ADHD)	American Academy of Child and Adolescent Psychiatry
Bipolar Disorder: Adults	American Psychiatric Association
Bipolar Disorder: Children & Adolescents	American Academy of Child and Adolescent Psychiatry
Cardiovascular Disease: Prevention in Women	American Heart Association
Cardiovascular Disease: Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease	American College of Cardiology / American Heart Association
Cholesterol Management	American College of Cardiology / American Heart Association
Chronic Obstructive Lung Disease*	Global Initiative for Chronic Obstructive Lung Disease (GOLD)
Depression / Major Depressive Disorder	American Psychiatric Association
Diabetes*	American Diabetes Association
Dietary Guidelines	U.S. Department of Health and Human Services
Heart Failure	American College of Cardiology / American Heart Association
Hemophilia and von Willebrand Disease	World Federation of Hemophilia and National Heart, Lung & Blood Institute
Human Immuno-deficiency Virus (HIV)	HIV Medicine Association of the Infectious Diseases Society of America

Continued >



Doing Business Better

Evidenced-Based
Clinical Practice
Guidelines

< Continued

Topic	Organization
Hyperbilirubinemia in Newborns	American Academy of Pediatrics
Hypertension	Panel Members Appointed to the Eighth Joint National Committee (JNC8)
Lifestyle Management to Reduce Cardiovascular Risk	American Heart Association/American College of Cardiology
Obesity	American Heart Association/American College of Cardiology/The Obesity Society
Physical Activity	U.S. Department of Health and Human Services
Preventive Services	Agency for Healthcare Research and Quality
Schizophrenia	American Psychiatric Association/PsychiatryOnline Guideline Watch
Sickle Cell Disease*	National Heart, Lung and Blood Institute
Spinal Stenosis	North American Spine Society
Stable Ischemic Heart Disease*	American College of Cardiology/American Heart Association et al
Substance Use Disorders	American Psychiatric Association/PsychiatryOnline Guideline Watch
Tobacco Use	U.S. Department of Health and Human Services



Doing Business Better

Health Management Programs: Case and Disease Management

UnitedHealthcare offers case and disease management programs to support physicians' treatment plans and assist members in managing their conditions. Using medical, pharmacy and behavioral health claims data, our predictive model systems help us identify members who are at high risk and directs them to our programs.

Patients can also be identified at time of hospital discharge via a Health Risk Assessment, Nurseline referral, or member or caregiver referral. If you have patients who are UnitedHealthcare members who would benefit from case or disease management, you can refer them to the appropriate program by calling the number on the back of the member's health insurance ID card.

Participation in these programs is voluntary. Upon referral, each member is assessed for the appropriate level of care for their individual needs. Programs vary depending on the member's benefit plan.

Case Management

At the core of case management is identifying high-cost, complex, at-risk members who can benefit from these services. We partner with members and their physicians or other health care professionals to facilitate health care access and decisions that can have a dramatic impact on the quality and affordability of their health care.

Specifically, our programs are designed to assist in ensuring individuals:

- Receive evidenced-based care
- Have necessary self-care skills and/or caregiver resources
- Have the right equipment and supplies to perform self-care

- Have requisite access to the health care delivery system
- Are compliant with medications and the physician's treatment plan

Our case managers are registered nurses who engage the appropriate internal, external or community-based resources needed to address members' health care needs. When appropriate, we provide referrals to other internal programs such as disease management, complex condition management, behavioral health, employee assistance and disability. Case management services are voluntary and a member can opt out at any time.

Disease Management Programs

We offer disease management programs designed to provide members with specific conditions the appropriate level of intervention.

Depending on the member's health plan and benefit plan design, disease management programs vary and may include:

- Coronary artery disease
- Diabetes
- Heart failure
- Asthma
- Chronic obstructive pulmonary disease
- Cancer
- High-risk pregnancy
- Kidney disease
- Acute MI*
- Hemophilia*

*Limited to eligible UnitedHealthcare River Valley and Neighborhood Health Program members.

Continued >



Doing Business Better

Health Management Programs: Case and Disease Management

< Continued

Our programs include:

- Screening for depression and helping members access the appropriate resources.
- Addressing lifestyle-related health issues and referring to programs for weight management, nutrition, smoking cessation, exercise, diabetes care and stress management.
- Helping members understand and manage their condition and its implications.
- Education on how to reduce risk factors, maintain a healthy lifestyle, and adhere to treatment plans and medication regimens.

For some programs, members may receive:

- A comprehensive assessment by specialty-trained registered nurses to determine the appropriate level and frequency of interventions.
- Educational mailings, newsletters and tools such as a HealthLog to assist them in tracking their physician visits, health status and recommended targets or other screenings.
- Information on gaps in care and encouragement to discuss treatment plans, goals and results with the physician.
- Physicians with patients in moderate intensity programs may receive information on their patient's care opportunities.
- Transitional case management when high-risk patients are discharged from a hospital
- Outbound calls for the highest risk individuals to address particular gaps in care. You will be notified when patients are identified for the high-risk program.

These programs complement the physician's treatment plan, reinforce instructions you may have provided, and offer support for healthy lifestyle choices.

Online Preventive Health Programs Available

United Behavioral Health has developed an online preventive health program which offers information and practice tools to support your treatment of patients with major depressive disorder, alcohol and drug abuse/addiction and attention-deficit/hyperactivity disorder (ADHD). A convenient, reliable and free source of pertinent health information, the preventive health program includes a library of articles addressing aspects of each condition, information about co-morbid conditions, links to nationally-recognized practice guidelines, a printable self-appraisal to use or refer your patients to and a listing of support resources for you, your patients and their families. Physicians and other health care professionals may access the program at <http://prevention.liveandworkwell.com>.

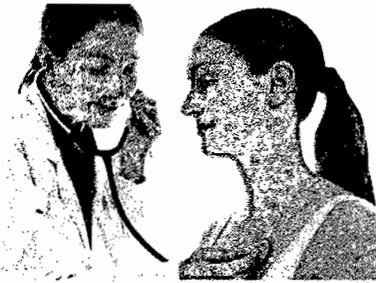
UnitedHealthcare Affiliates

UnitedHealthcare Oxford Medical and Administrative Policy Updates



For complete details on the policy updates listed in the table on the following page, please refer to the **August 2015 Policy Update Bulletin** at **OxfordHealth.com > Providers > Tools & Resources > Medical Information > Medical and Administrative Policies > Policy Update Bulletin.**

[Continued >](#)



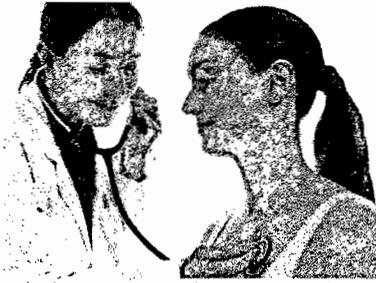
UnitedHealthcare Affiliates

UnitedHealthcare
Oxford Medical and
Administrative Policy
Updates

< Continued

Policy Title	Policy Type	Effective Date
NEW		
Actemra® (Tocilizumab)	Clinical	Oct. 1, 2015
Buprenorphine/Naloxone Products (Bunavail, Suboxone Film, Generic Buprenorphine/Naloxone)	Clinical	Sept. 1, 2015
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome	Clinical	Sept. 1, 2015
Entresto (Valsartan-Sacubitril)	Clinical	Sept. 1, 2015
Entyvio™ (Vedolizumab)	Clinical	Oct. 1, 2015
Follicle Stimulating Hormone (FSH) Gonadotropins	Clinical	Nov. 1, 2015
Human Menopausal Gonadotropins (hMG)	Clinical	Nov. 1, 2015
New York Participating Provider Laboratory & Pathology Protocol	Administrative	Sept. 1, 2015
Procedure and Place of Service	Reimbursement	Sept. 1, 2015
UPDATED/REVISED		
Accreditation Requirements for Radiologists and Radiology Centers	Administrative	Aug. 1, 2015
Ambulance Policy	Reimbursement	Sept. 1, 2015
Apheresis	Clinical	Aug. 1, 2015
B Bundle Codes	Reimbursement	Sept. 1, 2015
Breast Imaging for Screening and Diagnosing Cancer	Clinical	Aug. 1, 2015
Bronchial Thermoplasty	Clinical	Aug. 1, 2015
Cardiology Procedures Requiring Precertification for eviCore Healthcare Arrangement	Clinical	Aug. 1, 2015
Credentialing Guidelines: Participation in the eviCore Healthcare Network	Administrative	Aug. 1, 2015
Drug Coverage Criteria - New and Therapeutic Equivalent Medications	Clinical	Sept. 1, 2015

Continued >



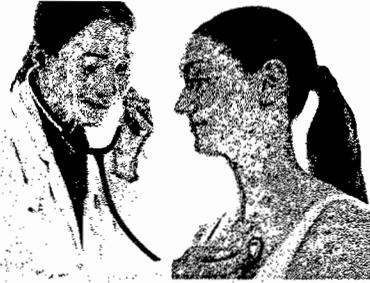
UnitedHealthcare Affiliates

UnitedHealthcare
Oxford Medical and
Administrative Policy
Updates

< Continued

UPDATED/REVISED		
Drug Coverage Guidelines	Clinical	July 21, 2015 July 27, 2015 Sept. 1, 2015
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation	Clinical	Sept. 1, 2015
Fetal Aneuploidy Testing Using Cell-Free Fetal Nucleic Acids in Maternal Blood	Clinical	Sept. 1, 2015
From - To Date	Reimbursement	Sept. 1, 2015
Glaucoma Surgical Treatments	Clinical	Sept. 1, 2015
Global Days	Reimbursement	Aug. 17, 2015
Home Traction Therapy	Clinical	Aug. 1, 2015
In Utero Fetal Surgery	Clinical	Sept. 1, 2015
Light and Laser Therapy for Cutaneous Lesions and Pilonidal Disease	Clinical	Aug. 1, 2015
Lyme Disease	Clinical	Sept. 1, 2015
Macular Degeneration Treatment Procedures	Clinical	Sept. 1, 2015
Maximum Frequency Per Day	Reimbursement	July 27, 2015
Moderate Sedation	Reimbursement	Aug. 1, 2015
Motorized Spinal Traction	Clinical	Sept. 1, 2015
Multiple Procedures	Reimbursement	July 27, 2015
Neurophysiologic Testing	Clinical	Sept. 1, 2015
Obstetrical Ultrasonography	Clinical	Aug. 1, 2015
Omnibus Codes	Clinical	Sept. 1, 2015
One or More Sessions	Reimbursement	Aug. 1, 2015
Oxford's Outpatient Imaging Self-Referral	Clinical	Aug. 1, 2015
Proton Pump Inhibitors	Clinical	Sept. 1, 2015

Continued >



**UnitedHealthcare
Affiliates**

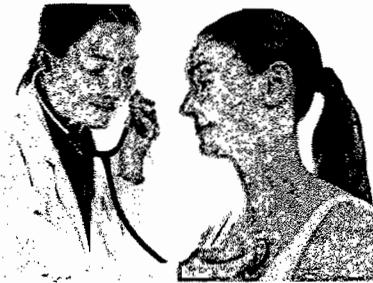
UnitedHealthcare
Oxford Medical and
Administrative Policy
Updates

< Continued

UPDATED/REVISED		
Radiation Therapy Procedures Requiring Precertification for eviCore Healthcare Arrangement	Clinical	Aug. 1, 2015
Radiology Procedures Requiring Precertification for eviCore Healthcare Arrangement	Clinical	Aug. 1, 2015
Radiopharmaceuticals and Contrast Media	Clinical	Aug. 1, 2015
Specialty Medication Administration - Site of Care Review Guidelines	Clinical	Oct. 1, 2015
Time Span Codes	Reimbursement	Aug. 1, 2015
Transcatheter Heart Valve Procedures	Clinical	Sept. 1, 2015
Umbilical Cord Blood Harvesting and Storage for Future Use	Clinical	Aug. 1, 2015
Vision Services	Administrative	Aug. 1, 2015
Xolair (Omalizumab)	Clinical	Sept. 1, 2015
REPLACED/RETIRED		
Follicle Stimulating Hormones (FSH) Used in the Treatment of Infertility	Clinical	Nov. 1, 2015
Human Immunodeficiency Virus (HIV) Tropism Testing	Clinical	Aug. 1, 2015
Human Menopausal Gonadotropins (hMG) Used in the Treatment of Infertility	Clinical	Nov. 1, 2015

Note: The appearance of a service or procedure on this list does not imply that Oxford provides coverage for the service or procedure. In the event of an inconsistency between the information provided in this Bulletin and the posted policy, the posted policy will prevail.

Oxford HMO products are underwritten by Oxford Health Plans (NY), Inc., Oxford Health Plans (NJ), Inc. and Oxford Health Plans (CT), Inc. Oxford insurance products are underwritten by Oxford Health Insurance, Inc.



UnitedHealthcare Affiliates

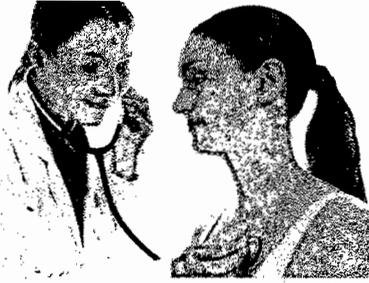
UnitedHealthcare of the River Valley Preauthorization List and Coverage Policy Updates



For complete details on the policy updates listed in the following table, please refer to the **August 2015 Policy Update Bulletin** at UHCRiverValley.com > [Providers](#) > [Coverage Policy Library](#) > [Policy Update Bulletin](#).

Policy Title	Effective Date
NEW	
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome	Sept. 1, 2015
Entyvio™ (Vedolizumab)	Oct. 1, 2015
Simponi® Aria™ (Golimumab)	Oct. 1, 2015
UPDATED/REVISED	
Attended Polysomnography for Evaluation of Sleep Disorders	Oct. 1, 2015
Benlysta® (Belimumab)	Aug. 1, 2015
Cardiology- Diagnostic Catheterization, Electrophysiology (EP) Implants, Echocardiogram and Stress Echocardiogram	Aug. 1, 2015
Chemosensitivity and Chemoresistance Assays in Cancer	Aug. 1, 2015
Complementary and Alternative Medicine	Sept. 1, 2015
Cytological Examination of Breast Fluids for Cancer Screening	Aug. 1, 2015
Discogenic Pain Treatment	Aug. 1, 2015
Electrical BioImpedance for Cardiac Output Measurement	Aug. 1, 2015
Light and Laser Therapy for Cutaneous Lesions and Pilonidal Disease	Aug. 1, 2015
Magnetic Resonance Spectroscopy (MRS)	Aug. 1, 2015
Meniscus Implant and Allograft	Oct. 1, 2015
Neuropsychological Testing under the Medical Benefit	Aug. 1, 2015

[Continued >](#)



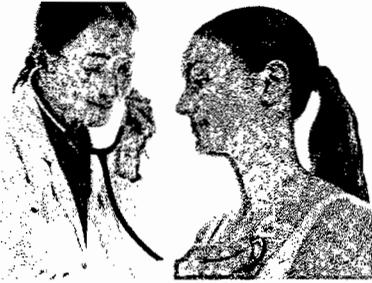
UnitedHealthcare Affiliates

UnitedHealthcare of the River Valley Preauthorization List and Coverage Policy Updates

< Continued

UPDATED/REVISED	
Omnibus Codes	Oct. 1, 2015
Pectus Deformity Repair	Sept. 1, 2015
Radiology/Advanced Outpatient Imaging Procedures	Aug. 1, 2015
Repository Corticotropin Injection (HP Acthar Gel)	Aug. 1, 2015
Skilled Care and Custodial Care Services	Aug. 1, 2015
Soliris® (Eculizumab)	Sept. 1, 2015
Specialty Medication Administration - Site of Care Review Guidelines	Oct. 1, 2015
Spinal Ultrasonography	Aug. 1, 2015
Tysabri (Natalizumab)	Aug. 1, 2015
Xolair (Omalizumab)	Aug. 1, 2015

Note: The appearance of a service or procedure on this list does not imply that UnitedHealthcare provides coverage for the service or procedure. In the event of an inconsistency between the information provided in this Bulletin and the posted policy, the posted policy will prevail.



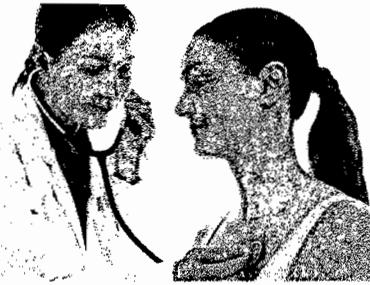
UnitedHealthcare Affiliates SignatureValue Benefit Interpretation Policy Updates



For complete details on the policy updates listed in the following table, please refer to the **August 2015 SignatureValue™ Benefit Interpretation Policy Update Bulletin** at UHCWest.com > Provider Log In > Library > Resource Center > Guidelines & Interpretation Manuals.

Policy Title	Applicable States
REVISED (Effective Sept. 1, 2015)	
Ambulance Transportation	All (California, Oklahoma, Oregon, Texas, & Washington)
Blood and Blood Products	All
Emergency and Urgent Services	All
Home Health Care	All
Pervasive Developmental Disorder and Autism Spectrum Disorder	Oregon & Washington
Services/Complications Related to Non-Covered Services	All
Shoes and Foot Orthotics	All

Note: The appearance of a service or procedure on this list does not imply that UnitedHealthcare provides coverage for the service or procedure. In the event of an inconsistency between the information provided in this Bulletin and the posted policy, posted policy will prevail.



UnitedHealthcare Affiliates

SignatureValue Medical Management Guideline Updates



For complete details on the policy updates listed in the following table, please refer to the **August 2015 SignatureValue Medical Management Guideline Update Bulletin** at UHCWest.com > Provider Log In > Library > Resource Center > Guidelines & Interpretation Manuals.

Policy Title	Effective Date
NEW	
Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome	Sept. 1, 2015
REVISED	
Attended Polysomnography for Evaluation of Sleep Disorders	Oct. 1, 2015
Chemoresponsivity and Chemoresistance Assays in Cancer	Aug. 1, 2015
Cytological Examination of Breast Fluids for Cancer Screening	Aug. 1, 2015
Discogenic Pain Treatment	Sept. 1, 2015
Electrical Bioimpedance for Cardiac Output Measurement	Aug. 1, 2015
Magnetic Resonance Spectroscopy (MRS)	Aug. 1, 2015
Meniscus Implant and Allograft	Oct. 1, 2015
Neuropsychological Testing Under the Medical Benefit	Aug. 1, 2015
Omnibus Codes	Oct. 1, 2015
Specialty Medication Administration – Site of Care Review Guidelines	Oct. 1, 2015
Spinal Ultrasonography	Sept. 1, 2015
RETIRED	
Private Duty Nursing	Aug. 1, 2015

Note: The appearance of a service or procedure on this list does not imply that UnitedHealthcare provides coverage for the service or procedure. In the event of an inconsistency between the information provided in this Bulletin and the posted policy, the posted policy will prevail.



UnitedHealthcare Affiliates

New York Participating Provider Laboratory and Pathology Protocol, Effective Sept. 1, 2015

New York State law requires physicians and other qualified health care professionals to inform patients when referring them to a non-participating provider, or including a non-participating provider in that patient's health plan.

To aid in that disclosure process and help UnitedHealthcare Oxford New York Members receive cost-effective laboratory and pathology services, we created the New York Participating Provider Laboratory and Pathology Protocol.

Beginning Sept. 1, 2015, UnitedHealthcare network physicians and other qualified health care professional in New York State are required to refer to or use network laboratories and pathologists for UnitedHealthcare Oxford New York Members. This includes:

- Specimens collected in office and sent to a out-of-network laboratory or pathologist for processing; AND
- Providing a member with a prescription, requisition or other form to obtain laboratory or pathology services outside your office

If you collect specimens in your office and use a participating laboratory or pathologist for processing, there will be NO additional requirements after Sept.1, 2015.

Prior to any referral to, or the inclusion of an out-of-network laboratory or pathologist in a UnitedHealthcare Oxford New York Member's care, you must:

1. Discuss in- and out-of-network care provider options with the UnitedHealthcare Oxford New York Member and provide them with a copy of UnitedHealthcare Oxford's Laboratory and Pathology Services Consent Form.
2. After the discussion, the UnitedHealthcare Oxford New York Member must complete the Laboratory and Pathology Services Consent Form indicating whether they wish to use

an in-network or out-of-network laboratory or pathologist.

- If the UnitedHealthcare Oxford New York Member has out-of-network benefits, the out-of-network laboratory/pathology claim will be paid according to their out-of-network benefits and any out-of-network cost shares will be applied
- If the UnitedHealthcare Oxford New York Member does not have out-of-network benefits, they will be responsible for the full cost of the out-of-network laboratory/pathology services

3. A standard or electronic copy of the consent form must be kept in the UnitedHealthcare Oxford New York Member's medical record. We may request a copy of the completed form.

Protocol Compliance: If we request a copy of the consent form, please follow these steps:

- Return a copy of the signed and completed consent form within 15 days of the request.
- If you do not send a copy of the consent form, the Evaluation & Management (E&M) code from the office visit will be reversed and denied for noncompliance with this protocol.
- Any payment previously made for the associated E&M service will be subject to recovery. Per your agreement with us, you are prohibited from balance billing the UnitedHealthcare Oxford New York Member.

If you do not have an account with a UnitedHealthcare Oxford participating laboratory, please set one up by Sept. 1, 2015. To find a local network laboratory, please go to: OxfordHealth.com > Browse our Provider/Facility Resources: Search for an Oxford doctor, hospital or lab > Hospital Search > Facility Type. In the Facility Type drop-down box, select Ancillary Facility. Then, under the Specialty Type drop-down box, select Laboratory or Pathology.

Growing Shortage of Gastroenterologists to Affect Screening Capacity for #2 Cancer Killer

Jan 07, 2009, 11:00 ET from Olympus (<http://www.prnewswire.com/news/olympus>)

"GI Gap" To Worsen as the U.S. Population Ages; Projected Demand for Gastroenterologists is Growing at Nearly Double the Rate of Supply

Olympus Seeks Legislative Solution and Increased Awareness to Proactively Increase Number of Gastroenterology Fellowships

WASHINGTON, Jan. 7 /PRNewswire-USNewswire/ -- The United States is facing a shortage of gastroenterologists (GIs) that will total at least 1,050 of these specialty physicians by 2020, according to a first of its kind study from Olympus and The Lewin Group, a national healthcare and human services consulting firm. The new research illustrates that the aging population and increased colorectal cancer (CRC) screening rates will overwhelm the supply of GI physicians, challenging the nation's ability to provide adequate screening and treatment for the nation's number two cancer killer.

The Lewin research was commissioned by Olympus, the global leader in endoscopy, as part of a campaign to raise awareness about colorectal cancer screening and ensure screening is available to all who seek it. The new data was unveiled today and is available at www.olympusamerica.com/crcadvocacy (<http://www.olympusamerica.com/crcadvocacy>).

"This GI shortage is a major concern for the U.S. healthcare system and Olympus is dedicated to finding solutions that increase the number of gastroenterologists and make CRC screening widely accessible," said F. Mark Gumz, president and CEO of Olympus Corporation of the Americas. "With approximately 149,000 new cases of colorectal cancer projected to be diagnosed in 2008, and an estimated 50,000 Americans projected to die from this treatable and beatable disease each year, it is critical to ensure that the U.S. has a sufficient workforce of trained gastroenterologists." In 2008, the supply of GI physicians active in patient care was estimated to be 10,390.

Gumz continued, "While the current shortage of gastroenterologists is not vastly different from other medical disciplines, the only feasible method for closing the 'GI gap' is to start expanding the number of GI fellowships now, a process that will take several years to show results." The Lewin study found that training approximately 130 additional GIs per year (a 33 percent increase from current planned levels) starting in 2011 would increase supply by 1,550 gastroenterologists by 2020.

Olympus is committed to broad efforts to address the growing shortage of trained gastroenterologist and increase colorectal cancer screening rates by helping to educate, inform and create awareness about colorectal cancer through direct consumer outreach, collaborating with professional medical societies and advocacy groups and coordinating efforts with federal health agencies. One legislative option Olympus is spearheading would dedicate federal funding for additional GI fellowships, including a public service component for physicians trained under the program, and direct the Department of Health and Human Services to study the GI workforce going forward. The estimated cost of new CRC cases was \$8.3 billion in 2007, with Medicare paying at least \$2.4 billion of this total. A federal investment in GI fellowships today can not only overcome the physician shortage, it can yield significant healthcare cost savings in the near term by making preventative screening more widely available.

The Lewin study employed two proprietary simulation models--the National Colorectal Screening Model and the Physician Supply and Demand Model--to arrive at the unique GI workforce and CRC screening projections such as:

- If current age and gender screening rates remain constant, the aging population alone will create a shortage of 1,050 gastroenterologists by 2020. Under a scenario where national CRC screening rates increase by 10 percent, the shortage of gastroenterologists rises to approximately 1,550 over the same timeframe.
- If the nation sees a 10 percent increase in CRC screening rates over the next decade, the total annual number of screenings (beyond the anticipated growth associated with

an aging population) increases by approximately 600,000 in the short term and by approximately 1,500,000 by 2020.

"This study finds that the projected demand for gastroenterologists is growing at nearly double the rate of supply," said Tim Dall, vice president at The Lewin Group and the study's author. "The shortfall of gastroenterologists could limit the nation's ability to implement national guidelines for CRC screening, particularly in traditionally underserved communities."

"ASGE recognizes and appreciates the service Olympus has provided in commissioning this report. The population is aging, therefore the numbers of people who will be candidates for colorectal cancer screening is increasing, making screening capacity a critical issue," said John L. Petrini, MD, FASGE, president, American Society for Gastrointestinal Endoscopy. "To keep the most highly qualified and cost-efficient colorectal cancer screening in effect, we need to address the upcoming shortage of qualified colonoscopists."

"The American College of Gastroenterology applauds Olympus and The Lewin Group for shining a light on the nation's anticipated need for well-trained and highly skilled endoscopists to enhance and improve our ability to screen for colorectal cancer, a deadly killer," observed Eamonn M.M. Quigley, MD, FACG, President of the American College of Gastroenterology. "There is no question that policymakers need to focus on the challenges gastroenterologists and other physicians will face as the American population ages."

"The confluence of an aging population, improvements in technology, fluxes in the economic milieu and changes in disease prevalence/impact will act in concert to place new unprecedented pressure on GI service delivery," said Patrick I. Okolo III, MD, MPH, Chief of Endoscopy, Division of Gastroenterology at the Johns Hopkins University School of Medicine. "A comprehensive focused national approach to broaden the number and quality of physicians trained in gastroenterology will be necessary to

obviate this divide."

About Olympus

Olympus is a precision technology leader, creating innovative opto-digital solutions in healthcare, life science and consumer electronics products. Olympus works collaboratively with its customers and its affiliates worldwide to leverage R&D investment in precision technology and manufacturing processes across diverse business lines. These include:

- Gastrointestinal endoscopes, accessories, and minimally invasive surgical products;
- Advanced clinical and research microscopes;
- Lab automation systems, chemistry-immuno and blood bank analyzers and reagents;
- Digital cameras and voice recorders.

Olympus serves healthcare and commercial laboratory markets with integrated product solutions and financial, educational and consulting services that help customers to efficiently, reliably and more easily achieve exceptional results. Olympus develops breakthrough technologies with revolutionary product design and functionality for the consumer and professional photography markets, and also is the leader in gastrointestinal endoscopy and clinical and educational microscopes. For more information, visit www.olympusamerica.com (<http://www.olympusamerica.com/>).

About The Lewin Group

The Lewin Group is a premier national health care and human services consulting firm with more than 35 years' experience finding answers and solving problems for leading organizations in the public, nonprofit, and private sectors. With its industry experience and knowledge, The Lewin Group provides its clients with high-quality products and insightful support to help them maximize the delivery of programs and services that make a difference in the lives of their constituents. For more information on The Lewin Group, visit <http://www.lewin.com> (http://www.lewin.com/?utm_source=PR&utm_medium=PressRelease&utm_campaign=HealthCareReformReport).