UnitedHealthcare Compass

Frequently asked questions

Overview

UnitedHealthcare® Compass offers several Individual Exchange plans, also referred to as UnitedHealthcare Individual & Family ACA Marketplace plans. Compass plans require that members designate a primary care provider (PCP) to help coordinate their care.

For more information, please see our **UnitedHealthcare Compass plan of New York** quick reference guide.

General

What are the Compass plans?

Plan	Network physicians with required referral	Network physicians without required referral	Out-of-network health services
Compass	Network benefits	No coverage*	No coverage*
Compass Balanced	Network benefits	Lower level of benefits	No coverage*
Compass Plus	Network benefits	Lower level of benefits	Non-network benefits

How do I know if I'm in-network for Compass plans?

If you're a participating UnitedHealthcare commercial plans health care professional, you're also a participating Compass plans provider. This doesn't apply if your Participation Agreement excludes participation in Compass.

To confirm your participation, please sign in to the UnitedHealthcare Provider Portal by visiting **UHCprovider.com** and clicking the sign in button at the top right of the screen. This secure online portal gives you access to patient information and more. To use the portal, you will first need to register for a One Healthcare ID, if you don't already have one. Visit **UHCprovider.com/access** for detailed instructions and training.

Do Compass plans use the same network as UnitedHealthcare Choice and Choice Plus plans?

No. To find network health care professionals, including hospitals and independent labs, please visit **UHCprovider.com/findprovider.**

PCPs

What's the role of the PCP for Compass plans?

PCPs oversee their patients' care and actively manage referrals to network specialists.

*Except for emergency services and related admissions.

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How do members choose a PCP?

Members must select a PCP upon enrollment. Each family member in the plan may select a different PCP, depending on their needs. Subscribers and all dependents must select a PCP in the area where the subscriber lives or works. After the members select their PCP, the member and the PCP can view the selection online. The PCP name will also be on the member's ID card.

Can members change their PCP?

Members may request a new PCP once a month by calling the number on their ID card or by submitting a PCP change request at **myuhc.com®.** These changes are effective the first of the month.

If a PCP practices at more than 1 location, does it matter which location the member visits?

Since some PCPs have multiple tax ID numbers (TINs) and all TINS may not be in-network for a plan, members should see their PCP or a covering physician at the location that shares the same TIN as the member's assigned PCP. To see the member's PCP TIN, please visit the portal and use the Eligibility and Benefits tool.

Where can I find a list of members assigned to my practice?

You can generate a PCP roster report by selecting Documents & Reporting in the portal.

Specialist referral requirements

Who's responsible for generating referrals?

Only the member's PCP or a PCP within the same TIN can submit referrals.

Which services don't require a referral?

The following services don't require a referral:

- Services from network health care professionals who share the same TIN as the member's PCP or the PCP's covering health care professional
- Services from network obstetricians, gynecologists, nurse practitioners, nurse midwives and physician assistants
- Routine refractive eye exams from network providers
- Services from network optometrists
- Mental health and substance use disorder services with network behavioral health clinicians
- Services rendered in emergency rooms, network urgent care centers, network convenience care clinic or network online virtual visits
- Services you bill as "observation"
- Services that admitting physicians provide for emergency and unscheduled admissions
- Services from facility-based inpatient and outpatient network consulting physicians, network assisting surgeons, network co-surgeons or network team surgeons
- Services from network pathologists, network radiologists or network anesthesia physicians
- Outpatient network labs, network X-rays and network diagnostic services. Note that services billed by a network specialist require referral.
- Network rehabilitative services (e.g., physical therapy, occupational therapy, speech-language therapy, aural therapy, cognitive therapy), except for manipulative treatment and vision therapy (physician services). Note that services billed by a network specialist require referral.
- All other network services, as required by state mandates

Can members seek care outside the state in which they live?

The PCP may refer members to network physicians in other states if they follow our referral and prior authorization requirements.

What if a member requires care that isn't available from a network specialist or facility?

When services aren't available from a network care provider, the member's PCP can request services from an out-of-network health care professional at the in-network benefit level. Please request this type of exception by calling the phone number on the member's ID card. We'll review your request and determine if a health care professional in the member's network is available to treat the condition. We'll send written confirmation of the final decision to the PCP and member.

How many visits do you include with each referral to a specialist?

Each specialist referral may include up to 6 visits. Visits expire 6 months from the referral start date if they don't use them. After the member uses the 6 visits or they expire, the PCP may submit another referral to the network specialist for up to 6 visits.

For members with the following chronic conditions, PCPs can enter standing referrals for up to 99 visits if the member's diagnosis code is included in the Referrals for Chronic Conditions policy:

- Allergy rhinitis
- Acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV)
- Anemia
- Cancer
- Cystic fibrosis
- Epileptic seizure
- Fracture care*
- Glaucoma
- Myasthenia gravis
- Multiple sclerosis
- Parkinson's disease
- Acute renal failure
- Seizure
- Thrombotic microangiopathy

Can I view referrals online?

Yes, you can view the member's referrals in the portal. You can see the network specialist referral information, number of visits we've authorized and number of remaining visits. Please note that referrals may take up to 48 hours after entry to appear.

Do specialists and facilities have to confirm if the PCP has a referral on file before they see the member?

Yes, specialists must confirm a referral is on file before seeing the member. If the PCP doesn't submit a referral, the member will either have no coverage or a higher service cost.

For planned admissions, facilities should also confirm the referral is on file for the member to see the admitting specialist. If the member doesn't have a referral, we'll deny the facility and specialist claims for the Compass plans, and the member will have higher service costs with Compass Balanced and Compass Plus plans.

Referral requirements

How can PCPs submit specialist referrals?

For a member to see a specialist, the member's PCP must submit an electronic referral in the portal or using the **electronic data interchange** (EDI). Please use EDI278R for the transaction.

Referrals can have start dates up to 5 calendar days prior to the date of entry. The referral is effective immediately and viewable in the portal within 48 hours. We can't accept referrals by phone, fax or mail, unless required by state law.

*You don't need to specify the fracture care procedure in the referral.

Does my office staff need security access to submit and view referrals?

Yes. Please assign your staff the "All transactions on UHCprovider.com" role type to give them access to submit and view members referrals. If your practice has custom roles, please be sure the appropriate staff members in your practice have the "Referral Submission" role.

Prior authorization/notification

Do Compass plans require prior authorization or notification?

We require prior authorization or notification for some services. We approve prior authorization only for services we determine to be medically necessary, according to the member's plan and applicable policies and guidelines. For more information, please see the Notification Requirements section of the UnitedHealthcare Administrative Guide at **UHCprovider.com/guides.**

Do you require admission notification?

Yes. We require the hospital to provide us with admission notification for all inpatient admissions, even if a referral or prior authorization is already on file.

Billing

Can I bill members for non-covered services?

Yes. According to the terms of your Participation Agreement, you may bill members for non-covered services under certain circumstances. For example, while we generally cover joint replacement procedures, our medical necessity review may find that we don't cover a particular joint replacement under the member's plan.

If we don't cover the services you provide under the member's plan because they aren't medically necessary, you may bill the member. We require a written agreement that indicates the member understands we won't cover the service and they choose and that they'll be financially responsible for payment.

Questions

If you have questions, please visit our **New York Commercial Health Plans** page and select UnitedHealthcare Compass or call Provider Services at **877-842-3210.**

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