Overview

The objective of our medical management program is to improve the appropriateness and affordability of care through an end-to-end model that includes Advance Notification and Prior Authorization, as supported byGenerally Accepted Standards of Medical Practice. As such, we are updating and aligning our medical management model to promote quality, affordability and administrative consistency. One aspect of this initiative is expanded use of consistent Medical Necessity criteria for physician-rendered services and facility inpatient care. Based on our experience with various approaches to medical management, feedback from the clinical community, and the evolving regulatory and marketplace context, we believe this updated and aligned approach will promote better, more coordinated care, resulting in greater administrative consistency and reduced uncertainty for hospitals, physicians, and other health care professionals when rendering services.

Given the 24/7 nature of health care, we believe that timely care coordination combined with an evidence-based approach to care can positively influence health outcomes, and contribute to lower overall costs for the patient and greater cost efficiencies for the entire health care system.

1. What is Medical Necessity?

Set in a foundation of evidence-based medicine, Medical Necessity is the process for determining benefit coverage and/or health care provider payment for services, tests or procedures that are medically appropriate and cost-effective for the individual member. The Medical Necessity process:

- Provides an opportunity to address covered services at the individual level to support enhanced access to quality care for the member, and
- Uses generally accepted standards of good medical practice in the medical community.
Physician Frequently Asked Questions

2. What clinical criteria will UnitedHealthcare use to determine if services are medically necessary?
UnitedHealthcare will review services for Medical Necessity by applying criteria that focuses on whether the services are: (a) scientifically proven to be effective, (b) clinically appropriate for individual members with their respective and specific conditions and diagnoses, and (c) cost-effective when compared to alternative diagnostic or therapeutic options. We will use generally accepted standards of medical practice, which are based on credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community. We may also use standards that are based on physician specialty society recommendations, professional standards of care, or other evidence-based, industry recognized resources and guidelines, such as the Milliman Care Guidelines®. Medical Necessity guidelines determine coverage decisions. Treatment decisions are always between a physician and his/her patient.

3. How does UnitedHealthcare plan to incorporate Medical Necessity into its advance notification process?
UnitedHealthcare will use Medical Necessity principles in our pre-service coverage review process. For benefit plans that require prior authorization as a condition of coverage, we will conduct clinical coverage reviews using evidence-based guidelines to determine whether the requested service is medically necessary. Services deemed emergent should be handled as needed to ensure optimal patient outcomes.

4. What is Prior Authorization?
Prior Authorization is the determination of benefit coverage prior to service being rendered to an individual member. A determination is made based on Medical Necessity criteria for services, tests or procedures that are appropriate and cost-effective for the member. This prior authorization review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration.

5. When will Prior Authorization take effect?
We have introduced language in our new Certificates of Coverage (COCs) and Summary Plan Descriptions (SPDs) which expands the definition of a covered service as one that is medically necessary. In support of these coverage documents, clinical coverage reviews incorporating prior authorization will occur gradually over time as members move from our current benefit documents to new coverage documents. Our membership has started moving to the new coverage documents and additional members will move as their current contracts renew and as their employers decide to adopt the new coverage documents. We expect most members will move to the new coverage documents by the end of 2012, but the migration process will continue beyond that time.

While the transition is ongoing, Medical Necessity-based clinical coverage reviews will be performed for only those members on the new coverage documents. You will not need to determine which members are subject to prior authorization, because for all members, you will continue to provide Advance Notification using the same process you use today for the same list of services that require Advance Notification.

6. How do I know whether a clinical coverage review is required?
You do not need to determine which member or service may require a clinical coverage review. Instead, once you inform us of a service on the Advance Notification List, we will tell you whether a clinical coverage review is required and we will request the specific information necessary to complete the coverage review. Once a coverage determination is rendered, you will be informed of the decision. It is important that you and the member are fully aware of coverage decisions before services are rendered.
7. **What type of information will be required for a clinical coverage review?**

Clinical documentation as outlined in the Coverage Determination Guidelines and/or Medical Policy will be necessary for clinical coverage review when needed. You can find this information at UnitedHealthcareOnline.com > Tools & Resources > Policies and Protocols > Medical & Drug Policies and Coverage Determination Guidelines. In addition, when you are requested to provide clinical documentation, you will be advised what information is necessary for the review.

8. **How can I submit clinical documentation for clinical coverage reviews?**

The required documentation may be submitted electronically (the preferred method), by fax, or hard copy. The service reference number obtained during the advance notification process must be included on all document submissions. Submission options include:

**Option 1: Secure Email Submission**
Submit the required documentation via secure email to CCR@uhc.com. This option provides the fastest processing. Please note the following:
- Use of the secure email system requires a one-time user registration and set-up process.
- The registration and set-up instructions will be provided to first-time users upon receipt and review of their advance notification request.
- Physicians who wish to set up their account in advance may send an email to CCR@uhc.com and note the word “Setup” in the subject line of their email. Upon receipt, a system-generated response containing the registration and set-up instructions will then be provided.
- Providers will be required to include the service reference number obtained during the advance notification process in the subject line of their email prior to submission.
- Upon submission of their email, the provider will receive a system-generated delivery receipt advising him/her to refer to UnitedHealthcareOnline.com for information on the status of their request.

**Option 2: Fax Submission**
Fax the required documentation to 800-628-0654. The service reference number obtained during the advance notification must be listed in the subject line of the fax cover sheet for proper routing. Please note that we cannot accept faxed photos that are not of sufficient quality.

**Option 3: Hard Copy Submission**
Mail the required documentation to the following address. Please note that the physical transfer of hard copy prints requires longer processing time, in addition to mailing time.

UnitedHealthcare
P.O. Box 30555
Salt Lake City, UT 84130-0555
9. **What is Advance Notification?**

Advance Notification is a requirement that physicians, other health care professionals, non-facility providers, or facilities contact us related to certain services or procedures, prior to rendering service. Advance Notification is important because it facilitates benefit and clinical coverage reviews and enhances our ability to provide supportive care coordination and related services to our members as part of our efforts to improve health care outcomes.

10. **What is the Advance Notification requirement?**

Physicians, other health care professionals and non-facility providers rendering services that appear on the Advance Notification List are required to provide Advance Notification to UnitedHealthcare. The list of services requiring Advance Notification includes both certain inpatient services and certain outpatient services. Inpatient services requiring Advance Notification (by the physician) also require Admission Notification (by the hospital). Unless otherwise specified, Advance Notification is required at least five business days before inpatient admission or outpatient service on the Advance Notification List (or as soon as scheduled). Certain services may not be covered within an individual member's plan. Notification should be submitted as far in advance of the planned service as possible to allow for coverage review.

<table>
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<tr>
<th>Physician</th>
<th>Advance Notification</th>
<th>Admission Notification</th>
<th>Observation</th>
<th>Unstable, Unconscious or Uncommunicative Patients</th>
<th>Member provides incorrect or no insurance information</th>
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<tr>
<td>Physicians and other health care professionals rendering services that appear on the Advance Notification List must provide Advance Notification at least five business days prior to the planned service date (or as soon as scheduled). See the Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide (Administrative Guide) for a full list of services requiring Advance Notification by physicians and health care professionals.</td>
<td>Physicians and health care professionals have NO Admission Notification requirement.</td>
<td>There is NO Advance Notification requirement for observation.</td>
<td>Since admission of such patients is generally unplanned, there is NO Advance Notification requirement for unstable, unconscious or uncommunicative patients.</td>
<td>We will not penalize you for failing to provide Advance Notification in these cases, provided you promptly notify us after getting the correct information.</td>
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11. Where can I find the Advance Notification List?
For a full list of services requiring Advance Notification, see the Advance Notification list in the UnitedHealthcare Administrative Guide at UnitedHealthcareOnline.com > Tools & Resources > Policies & Protocols > Administrative Guides.

Please note that a separate protocol describes the Notification Requirements for certain Radiology and Cardiology services. For specifics regarding these notification requirements, please see UnitedHealthcareOnline.com > Clinician Resources.

12. Will there be changes to the Advance Notification List?
Effective April 1, 2012, the Advance Notification List will be updated to include additional services requiring notification. Additional information is available for your reference at UnitedHealthcareOnline.com > Clinician Resources > Care Management > Advance and Admission Notification.

13. What information is required when I provide Advance Notification?
- Member name and member health care identification (ID) number
- Ordering physician or health care professional name and tax identification number (TIN) or National Provider Identification (NPI)
- Rendering physician or health care professional name and TIN or NPI
- ICD-9-CM (or its successor) diagnosis code for the diagnosis for which the service is requested
- Anticipated date(s) of service
- Type of service (procedure code(s) and volume of service (when applicable))
- Facility name and TIN or NPI where service will be performed (when applicable)
- Original start date of dialysis (End Stage Renal Disease (ESRD) only)

Specific, additional required information is noted for individual services on the Advance Notification List. You may also find more information on the evaluation criteria utilized when rendering a coverage decision at UnitedHealthcareOnline.com > Tools & Resources > Policies and Protocols.

14. How can I submit Advance Notification?
There are several ways that a physician or other health care professional can submit Advance Notification:
- Online at UnitedHealthcareOnline.com
- EDI 278 Transactions (contact your local Network Management Representative or Physician Advocate for more information)
- If you do not have electronic access, please call Care Coordination at the number on the back of the member's health care ID card (self-service available after hours), or submit notification by fax:
  - For Commercial members, fax 866-756-9733
  - For Medicare Advantage members, fax 800-676-4798
15. Where can I obtain the status of a notification?
Notification/coverage approval status can be obtained by calling the phone number on the back of the member’s health care ID card or at UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Notification/Prior Authorization Status with the following inquiry options:

16. What happens when I submit Advance Notification?
Upon receipt of the Advance Notification, we will determine and communicate whether a coverage review is required. You will be issued a service reference number upon Advance Notification submission. This is not an authorization number, or any indicator of coverage approval.

17. If I submit Advance Notification, does the facility also have to contact me about the service?
Effective April 1, 2012, the following notification requirements will be included in our 2012 Administrative Guide:

- Physicians, other health care professionals, and ancillary providers are responsible for Advance Notification for services listed in the Advance Notification List.
- Facilities are responsible for confirming the coverage approval resulting from the Advance Notification is on file prior to the date of service.
- Facilities are responsible for Admission Notification for inpatient services even if the coverage approval is on file.
18. If I submit Advance Notification, does the facility still have to notify you about an inpatient admission?
Yes, acute care hospitals, skilled nursing facilities and acute rehabilitation facilities must continue to adhere to the Admission Notification Protocol even if an Advance Notification has been submitted or Prior Authorization is on file.

19. When can a member be billed?
If services are deemed not covered during pre-service coverage review, and the member decides to proceed with the service, you can bill the member only if he or she was informed of the determination of non-coverage prior to the service being performed and signed a specific attestation accepting financial responsibility (see the UnitedHealthcare Administrative Guide for details regarding information that must be part of that specific attestation).

If no coverage determination is completed because you failed to provide Advance Notification, or a required coverage review was still in process on the service date, (and the service is deemed not covered), the member must be held harmless in accordance with your contract.

20. How will state regulatory rules be applied?
In the event of a conflict or inconsistency between applicable regulations and the notification requirements, the notification process will be administered in accordance with applicable regulations.

21. Where can I go for questions regarding the notification requirements?
Most questions can be answered by referencing the materials posted at UnitedHealthcareOnline.com > Clinician Resources > Care Management > Advance and Admission Notification. If you have additional questions of a clinical nature, please contact your UnitedHealthcare Market Medical Director, or speak with the intake coordinator when you call to provide notification. If you have contract-related questions, please contact your local Network Management Representative or Physician Advocate. For other questions, please call 877-842-3210.