Medical Necessity
Frequently Asked Questions

We believe that both members and providers (physicians and other health care professionals, hospitals and clinics) can be supported in making informed health care decisions by sharing information about what services, tests or procedures are considered clinically appropriate in accordance with Generally Accepted Standards of Medical Practice.

UnitedHealthcare offers both members and providers this information, based on credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community, through the Medical Necessity process.

With this information, we seek to support you and your doctor as you decide what steps to take.

Q1: What is medical necessity?
A1: Based upon a foundation of evidence-based medicine, Medical Necessity is the process for determining benefit coverage and/or 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.
- Utilizes generally accepted standards of good medical practice in the medical community.
- Offers communication between health plans, members and providers, allowing for prospective, concurrent and retrospective review as well as appeal rights for adverse determinations.

Q2: What are the benefits of determining whether a service is medically necessary?
A2: Medical Necessity uses advancements in medical practice standards based on scientific evidence and Generally Accepted Standards of Medical Practice. Medical Necessity is designed to combine these advancements in health information technology to address differences in care and promote efficient delivery of high quality care in a cost-effective manner.

Q3: What is prior authorization?
A3: Prior Authorization is the process of determining benefit coverage prior to a 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 member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Q4: How is Prior Authorization different from the current Care Coordination process in some UnitedHealthcare plans?
A4: Going forward, coverage determinations for those members on the appropriate benefit plan will use Medical Necessity criteria. To support this change, we are introducing language in our new Certificates of Coverage and Summary Plan Descriptions which expands the definition of a covered service as one that is medically necessary. Services determined to be not medically necessary during the pre-service review process will be the member’s liability (assuming a determination of non-coverage was rendered and communicated prior to the date of service and a specific member attestation is on file with the provider).

Q5: Where can I find the requirements for services and procedures that require Prior Authorization?
A5: Prior Authorization requirements will be listed in the Certificate of Coverage and Summary Plan Description.

Q6: How are the services outlined in the UnitedHealthcare Prior Authorization requirements selected?
A6: The Prior Authorization requirements reflect those services where data demonstrates significant variation in care being delivered and the clinical efficacy of the treatment.
Q7: What clinical criteria will UnitedHealthcare use to determine Medical Necessity?
A7: UnitedHealthcare uses Generally Accepted Standards of Medical Practice, which are based on credible scientific evidence published in peer-reviewed medical literature and are generally recognized by the relevant medical community. We may also use standards that are based on physician specialty society recommendations or professional standards of care, or other evidence-based, industry-recognized resources and guidelines, such as the Milliman Care Guidelines®, to determine Medical Necessity and appropriate level of care.

Q8: Who is responsible for obtaining Prior Authorization?
A8: Generally, members in plans with Prior Authorization (e.g., Choice, Choice Plus, Navigate) can rely on their network physician to obtain Prior Authorization for services on the standard Prior Authorization requirements list. Members will be responsible for obtaining Prior Authorization if they access a non-network provider, are in a product accessing our Options PPO network (i.e., Options PPO, Non-Differential PPO), or if the service is on a customer-specific (non-standard) Prior Authorization requirements list.

Q9: What should I do before receiving services that require Prior Authorization?
A9: 1. Contact UnitedHealthcare to request Prior Authorization if you are responsible for obtaining Prior Authorization (see Question and Answer above).

Q10: What process should I follow to obtain Prior Authorization?
A10: Your Certificate of Coverage or Summary Plan Description sets forth the process you should follow for benefits that are subject to the Medical Necessity Prior Authorization process.

Q11: How will I be notified of the outcome of a Prior Authorization request?
A11: UnitedHealthcare will mail a letter to you and your physician for all Prior Authorization requests. If a non-coverage determination is rendered, an Adverse Benefit Determination letter will be generated and will include an explanation for the determination, criteria used and appropriate internal appeal and/or external review rights.

Q12: When am I responsible for the cost of services?
A12: You are responsible for the cost of services in the following situations:

1. The service is deemed not covered or not medically necessary in accordance with your benefit plan, and the determination was communicated before the service was rendered and you have given your provider an attestation acknowledging your responsibility for the service.

2. You were responsible for obtaining Prior Authorization, but failed to do so.

3. During an inpatient (overnight) stay in a hospital or facility, an inpatient day is determined to be custodial. Custodial care includes any of the following services:
   • Non-health-related services, such as assistance in activities of daily living (examples include feeding, dressing, bathing, transferring and ambulating).
   • Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
   • Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

Q13: Are there any changes to the appeal process?
A13: UnitedHealthcare will continue to adhere to all applicable federal and/or state appeal requirements for members.

Q14: Who can I contact if I have more questions?
A14: Please call the Customer Care number on your health plan ID card.