Medical Necessity: Hospital and Health Care Facility Protocols for Inpatient Care Management, Admission Notification, Advance Notification and Prior Authorization

Frequently Asked Questions

Please note that this is general information that pertains primarily to UnitedHealthcare commercial plans. Medical necessity reviews for Medicaid and Medicare incorporate applicable state or federal requirements. Contact your provider advocate for specific details.

Overview

A key component to helping UnitedHealthcare members get access to quality, affordable health care is evaluating whether services, tests and procedures are medically appropriate through clinical coverage reviews. Medical necessity review is how we determine coverage, based on generally accepted standards of medical practice, to evaluate whether services are:

- Scientifically proven to be effective
- Clinically appropriate in terms of type, frequency, extent, site and duration
- Considered effective for the member’s condition, disease or symptoms
- Not administered mainly for convenience of the member or health care provider
- Not more costly than an alternative diagnostic and therapeutic options, medication, service or supply that is at least as likely to produce equivalent therapeutic or treatment results

Our medical necessity model includes inpatient care management, admission notification, advance notification and prior authorization. This model supports enhanced access to quality care, with timely communication among health plans, members, physicians and other health care professionals to allow for prospective, concurrent and retrospective care review. Coverage determinations reflect whether or not a service is covered under the provisions of the member’s plan, so that patients and their treating physicians can make informed decisions about their medical care.

The following answers to frequently asked questions provide more details on how our medical necessity model promotes quality, affordability and greater consistency across UnitedHealthcare benefit plans.
Q1. What clinical criteria does UnitedHealthcare use to determine medical necessity?
A. We use generally accepted standards of medical practice, 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 MCG®. For Medicare Advantage and Medicaid customers, we also use any applicable state and federal coverage guidelines and requirements.

Q2. What are the notification protocols for hospitals and other health care facilities?
A. Hospitals and other health care facilities are responsible for:

Confirming Coverage Approval is on File
- For services on the advance notification list, facilities must confirm that coverage approval is on file before performing a service. This allows the facility, treating physician and member to have an informed pre-service conversation to help the member decide whether to receive and pay for the service if the service will not be covered.
- If the facility does not confirm that the coverage approval is on file or performs the service before a coverage decision is rendered, the following apply:
  - If a coverage approval is not on file, we may deny the facility’s claim for the non-covered service and the member must be held harmless.
  - If a coverage approval is on file, we will not deny the facility’s claim despite the facility’s failure to take specific action to confirm the coverage approval.

Admission Notification
If timely admission notification is not provided, reimbursement reductions may apply according to the terms of the participation agreement.

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<thead>
<tr>
<th>Notification Timeframe</th>
<th>Reimbursement Reduction</th>
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<tr>
<td>Admission Notification received after it was due, but not more than 72 hours after admission.</td>
<td>100% of the average daily contract rate¹ for the days preceding notification.²</td>
</tr>
<tr>
<td>Admission Notification received after it was due, and more than 72 hours after admission.</td>
<td>100% of the contract rate (entire stay).</td>
</tr>
<tr>
<td>No Admission Notification received.</td>
<td>100% of the contract rate (entire stay).</td>
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¹ The average daily contract rate is calculated by dividing the contract rate for the entire stay by the number of days for the entire length of stay.

² Reimbursement reductions will not be applied to “case rate facilities” if admission notification is received after it was due, but not more than 72 hours after admission. As used here, “case rate facilities” means those facilities in which reimbursement is determined entirely by a MS-DRG or other case rate reimbursement methodology for every inpatient service for all benefit plans subject to these Admission Notification requirements.

Please note:
- Reimbursement reductions do not apply for maternity admissions.
- Facilities are responsible for admission notification for services rendered on an inpatient basis, even if a pre-service coverage approval is on file.

Q3. Where can I find more information about the notification requirements?
A. Most questions can be answered by referencing the materials posted at UnitedHealthcareOnline.com > Clinician Resources > Advance and Admission Notification. If you have clinical questions, please contact your UnitedHealthcare Market Medical Director, or speak with the intake coordinator when you call to provide notification.

Please note that separate protocols exist for certain radiology and cardiology services:
- For specifics regarding the Radiology Notification/Prior Authorization Protocol, go to UnitedHealthcareOnline.com > Clinician Resources > Radiology > Radiology Notification & Prior Authorization.
- For specifics regarding the Cardiology Notification/Prior Authorization Protocol, go to UnitedHealthcareOnline.com > Clinician Resources > Cardiology > Cardiology Notification & Prior Authorization.

Q4. How can I confirm coverage approval is on file?
A. To confirm notification and coverage approval status, call the number on the member’s ID card.

Or you can verify this information at UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Notification/Prior Authorization Status. You can search by:
- Notification/Prior Authorization Number
- Member #, Date of Birth (DOB)
- Member #, Name Search
- Alpha Search (Patient Last Name, First Name, DOB, and State)

The notification status will show if a service is “Covered/Approved,” “Not Covered/Not Approved,” or “Pending.” If the review is still in progress, the status will show as “Active (still under review).”

Q5. What happens when I submit admission notification?
A. You will be issued a service reference number upon submission of the notification. This number is used for tracking purposes; it is not an authorization number or any indicator of coverage approval. Admission notification is important because it initiates inpatient care management activities.
Q6. What are the components of the prior authorization process?
A. For services that require prior authorization, we conduct clinical reviews to determine whether the requested service is medically necessary per the member’s benefit plan. Our patient-centered prior authorization process determines benefit coverage on a case-by-case basis, using medical necessity criteria to evaluate whether services, tests or procedures are safe, appropriate and cost-effective for the individual member. The clinical review considers the type, frequency, extent and duration of the proposed treatment or procedure, and whether there might be alternate diagnostic or therapeutic options that might be more appropriate. The clinical review considers applicable state or federal requirements.
We are committed to timely reviews and complying with applicable regulatory response timeframes. Coverage determinations reflect only whether or not a service is covered under the provisions of the plan and do not replace treatment decisions made by physicians and their patients.

Q7. What is inpatient care management?
A. Inpatient care management uses medical necessity criteria to evaluate whether the level of care provided to a member and the length of stay for an inpatient admission are clinically appropriate, as well as to identify any delays in service.
Our inpatient care management program includes:
• Expanded opportunities to coordinate on patient pre-admission and post-discharge care.
• More consistent application of medical necessity principles for UnitedHealthcare members prior to and during inpatient admissions.

Q8. How does a hospital participate in inpatient care management?
A. Our notification protocols are part of our standard medical management model. We also offer contract amendments to network hospitals that reflect our position of paying for services that are medically necessary, and not paying for services that are not, with the member held harmless. The contract amendment, for those hospitals that choose to sign it, accomplishes the following:
• Implements our inpatient care management program.
• Creates a new reconsideration right that enables hospitals to request reconsideration on medical necessity grounds of claims denied administratively for failure to comply with our notification protocols, or denied due to services being rendered when coverage approval was not on file. If the hospital demonstrates that the services provided were medically necessary, we will overturn the administrative denial.

Q9. What notification should I provide if there is a change regarding the services or level of care?
A. As noted above, admission notification is required for all inpatient admissions. In addition, admission notification is required when:
• There is a change in the level of care, such as from a surgical unit to a skilled nursing facility.
• A transfer occurs from the admitting facility to a different facility.

Q10. What should be used as the admission date if the patient is admitted after outpatient surgery or observation?
A. Admission notification is required any time an individual is admitted after outpatient surgery or observation. You must notify Care Coordination by calling the number on the back of the member’s health plan ID card within 24 hours of any admission after ambulatory or outpatient surgery. The admission date should reflect the actual date of the inpatient admission.

Q11. How are adverse benefit determinations communicated?
A. We will send a letter to the member, with a copy to the rendering physician/facility, that includes an explanation for the determination, the criteria used and the appropriate internal appeal and/or external review rights. In addition, we will verbally inform the facility’s representative, a member of Care Management, immediately after the decision is made.

Q12. When can a member be billed?
A. If services are deemed not covered during prior authorization pre-service coverage review, and the member decides to proceed with the service, you can bill the member only if:
• The member was informed of the determination of non-coverage prior to the service being performed.
  – Note that for Medicare Advantage members, the member must receive a pre-service denial notice from the plan before the member can be billed.
• The member signed a specific attestation accepting financial responsibility. Reference the current Administrative Guide at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides for details regarding information that must be part of that specific attestation.
If no coverage determination is completed because the physician 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 per the physician’s contract.
Q13. How are state regulatory rules applied?
A. We align our policies and procedures with applicable regulatory requirements. In the event that a conflict or inconsistency arises between applicable regulations and UnitedHealthcare notification requirements, we defer to applicable regulations.

Q14. Who can I contact if I have questions regarding the hospital contract amendment?
A. If you have contract related questions, please contact your local Network Management representative. For other questions, please call 877-842-3210.