Medical Necessity: Advance Notification and Prior Authorization
Protocols for Physicians

Overview
A key component of helping UnitedHealthcare members
have access to quality, affordable health care is evaluating
whether services, tests and procedures are medically
appropriate through clinical coverage reviews. Medical
necessity is the principle by which 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 mainly for convenience of the member or health
care provider
• Not more costly than an alternative diagnostic and
  therapeutic option, medication, service or supply that
  is at least as likely to produce equivalent therapeutic
  or treatment results

Our medical necessity model includes advance notification
and prior authorization and 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 benefit 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 uniformity 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 MCG®. For Medicare Advantage and Medicaid
customers, we also use any applicable state and federal
coverage guidelines and requirements.

Q2. What are the advance notification requirements?
A. Participating physicians, other health care professionals,
non-facility providers or facilities are required to contact
us prior to performing certain services or procedures.
Advance notification facilitates benefit and clinical
reviews and enhances our ability to provide supportive
care coordination and related services to our members.

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<tr>
<th>Advance Notification Requirement</th>
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<td>Advance Notification</td>
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<td>For services that appear on the Advance Notification List, you must</td>
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<td>provide advance notification at least five business days prior to</td>
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<td>the planned service date (or as soon as scheduled).</td>
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<tr>
<td>Admission Notification</td>
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<tr>
<td>Physicians and health care professionals have NO admission</td>
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| notification requirement. Admission Notification applies to facilities.
| Observation                                                            |
| Currently, there is NO advance notification requirement for            |
| observation.                                                           |
| Unstable, Unconscious or Uncommunicative Patients                      |
| Since admission of such patients is generally unplanned, there is NO   |
| advance notification requirement for unstable, unconscious or          |
| uncommunicative patients.                                              |
| Member provides incorrect or no insurance information                 |
| If you do not provide advance notification in these cases, please      |
| refer to your agreement, and prompt us to notify us after obtaining    |
| the correct information.                                               |
Q3. Where can I find the Advance Notification List?
A. For a full list of services requiring advance notification, reference the Advance Notification List on UnitedHealthcareOnline.com > Clinician Resources > Advance and Admission Notification Requirements. The Advance Notification List is subject to change. 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 far in advance is notification required?
A. You should submit advance notification as early as possible, but at least five business days prior to the planned service date (unless otherwise specified with the Advance Notification List) with supporting clinical documentation, to allow enough time for coverage review. Advance notification for home health services and durable medical equipment is required within 48 hours after the start of service.

For urgent requests, call the number on the member’s ID card. You must state that the case is clinically urgent and explain why. Urgent requests for benefits are those that require notification or a benefit determination before receiving medical care, where a delay in treatment could seriously jeopardize the member’s life or health, or the ability to regain maximum function, or in the opinion of a physician with knowledge of the member’s medical condition, could cause severe pain.

Q5. How can I submit advance notification?
A. There are several ways 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.)
• Call Care Coordination at the number on the member’s ID card (self-service available after hours) and select “Care Notifications.”
• Submit notification by fax:
  – For commercial members, fax to 866-756-9733.
  – For Medicare Advantage members, fax to 800-676-4798.

You will receive a service reference number upon advance notification submission. This is not an indication that an authorization has been approved. You must wait until the coverage review process and determination of coverage are complete before proceeding with the service.

Q6. What information is required?
A. You will need to provide the following:
• Member name and member 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 (for dates of service before Oct. 1, 2015) or ICD-10 (for dates of service on Oct. 1, 2015 and after) diagnosis code for the diagnosis for which the service is requested
• Anticipated date(s) of service
• Type of service, including 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 in cases of end stage renal disease (ESRD)

Additional information may be required for some services. You can find more information on the evaluation criteria used when rendering a coverage decision at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides.

Q7. How will I know if a procedure requires prior authorization?
A. When you submit advance notification, we will tell you if clinical review is required and request the information necessary to complete it. Once a coverage determination is rendered, we will share that decision with you, so that you and your patient can make informed decisions before services are performed.

Q8. What are the components of the prior authorization process?
A. 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.

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.
Q9. What is the turnaround time for an authorization?
A. We are committed to timely reviews and comply with applicable regulatory response timeframes. It may take up to 15 calendar days to render a decision (14 calendar days for Medicare Advantage benefit plans). Time may be extended if additional information is needed. Urgent requests may receive a shorter turnaround time as required by the circumstances as well as state and federal regulations.

Q10. What clinical information is required for clinical review?
A. Required clinical documentation is outlined in the Coverage Determination Guidelines and/or Medical Policy. You can find this information at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines. The guidelines include a detailed list of specific items that support medical necessity for each service. In addition, when you are required to provide clinical documentation, you will be advised what information is necessary for the review.

Q11. What non-clinical information is evaluated in performing the coverage review?
A. The member’s eligibility for coverage and specifics of their benefit plan are confirmed during the review process. In addition, applicable state and federal laws, mandates and regulations, as well as accreditation standards, are all referenced during the review.

Q12. How can I submit clinical documentation for clinical review?
A. There are multiple ways to submit this documentation:

Option 1: UnitedHealthcareOnline.com
Go to UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines. Using UnitedHealthcareOnline.com is an easy way to manage prior authorization requests and is the preferred method for many practices.

Option 2: Secure Email Submission
Submit the required documentation by secure email to CCR@uhc.com. Please note:

- The secure email system requires a one-time user registration and set-up process.
- Registration and set-up instructions are provided to first-time users upon receipt and review of their advance notification request.
- To set up an account in advance, email CCR@uhc.com and note the word “Setup” in the subject line. A system-generated response will include registration and set-up instructions.

- You must include the service reference number obtained during the advance notification process in the subject line for clinical documentation.
- Upon submission, you will receive a system-generated delivery receipt advising you to refer to UnitedHealthcareOnline.com for information on the status of the request.

Option 3: Fax Submission
Fax the required documentation to 800-628-0654. Be sure to list the service reference number received during the advance notification 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 4: 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

Q13. How can I verify the status of a notification?
A. You can confirm notification status at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Medical & Drug Policies and Coverage Determination Guidelines. The guidelines include a detailed list of specific items that support medical necessity for each service. In addition, when you are required to provide clinical documentation, you will be advised what information is necessary for the review.

Q14. When can I update a notification/prior authorization?
A. You may make changes to a prior authorization request up until a decision is made regarding the service. Once an approval is rendered, you may update the notification with a change in date of service only (as long as the date has not passed). You may update the date of service on UnitedHealthcareOnline.com, or by calling the number on the back of the member’s health plan ID card. If you do not have a definite date for rescheduling the service, you may be advised to cancel and re-notify when the date is known.

Q15. Can I change the notification/prior authorization after the service has been delivered?
A. No updates can be made to an existing notification/prior authorization after the service has been delivered.

Q16. Is there an expiration date on the authorization of an approved service?
A. Approved authorizations are valid for the date of service only. If the date of service has passed and the service has not been rendered, a new notification/authorization must be obtained.
Q17. When is a new notification/prior authorization required vs. updating an existing notification?

A. A new advance notification and/or prior authorization is required when:
   • Updates to an existing notification are needed (e.g., adding new services), but the services for which the existing advance notification and/or prior authorization received have already been rendered
   • There is a change in services being provided
   • The rendering physician has changed

Q18. If I submit advance notification, does the facility still have to notify you about an inpatient admission?

A. Yes, hospitals and other health care facilities must follow the Admission Notification Protocol even if an advance notification has been submitted or prior authorization is on file.

Q19. 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 adverse determination 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 in accordance with the physician’s contract.

If you have questions, please call 877-842-3210. Thank you.