Q: **What is Medical Necessity?**

**A:** 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 timely communication between health plans, members and providers to allow for prospective, concurrent and retrospective review as well as appeal rights for adverse determinations.

Q: **What are the Medical Necessity program objectives?**

**A:** The objective of the Medical Necessity program is to improve the appropriateness and affordability of care through an end-to-end strategy that includes prior authorization of services along with inpatient concurrent and retrospective review, as supported by *Generally Accepted Standards of Medical Practice*. The program is being implemented in support of our overall goals for:

- **Enhanced access to quality care:** Applying Medical Necessity criteria based on the best-available clinical science presents an opportunity to improve access to quality health care by raising performance and reducing variation in medical practice. The end result engages consumers in informed decision-making.

- **Health care affordability:** Appropriateness of use will be evaluated based on an individual's illness, injury, condition, disease or symptoms. The process promotes efficient delivery of high-quality care in a cost-effective manner.
Q: How does UnitedHealthcare plan to utilize Medical Necessity?
A: UnitedHealthcare will utilize Medical Necessity principles in our pre-service, concurrent and retrospective clinical reviews.

For benefit plans that require prior authorization as a condition of coverage, we will conduct pre-service reviews using evidence-based guidelines to determine whether the requested service is medically necessary.

We will also utilize Medical Necessity principles in our concurrent inpatient reviews. Where facility contracts permit use of Medical Necessity, we will assess level of care, length of stay and delays in service to help verify that the services provided to our members are medically appropriate.

Where we do not have the opportunity to review a service or inpatient stay on a pre-service or concurrent basis, we reserve the right to utilize Medical Necessity criteria retrospectively if allowed by our contract with the hospital.

Q: What is Prior Authorization?
A: Prior Authorization is the process of determining 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 member-centric review evaluates the clinical appropriateness of requested services in terms of the type, frequency, extent and duration of stay.

Q: What is Inpatient Care Management?
A: Inpatient Care Management is the use of Medical Necessity criteria in an inpatient setting. During an inpatient concurrent review, we will utilize evidence-based medicine to evaluate whether the level of care provided to a member and the length of stay are clinically appropriate, as well as to identify any unnecessary delays in service.

Prior Authorization implementation

Q: What products, plans or service lines are in scope for Prior Authorization as part of the Medical Necessity approach to legacy UnitedHealthcare plans?
A: Medical Necessity is available to self-funded as well as certain fully insured medical plans. Products that are in scope for Prior Authorization are Choice, Choice Plus, products accessing Options PPO, products accessing Non-Differential PPO, Navigate, Navigate Balanced, Navigate Plus, Core, Catalyst, and EDGE products, along with the national generic ASO Summary Plan Description (SPD) for 2011. Medical Necessity plans are available for all business segments including Small Business, Key Accounts, Public Sector and National Accounts customers.

The following are out of scope: UnitedHealth Basics, Student Health Plan, Indemnity/Managed Indemnity, Select/Select Plus, and Individual Conversion.

Q: How does Prior Authorization differ from the current Care Coordination process legacy UnitedHealthcare plans?
A: 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 (COCs) and Summary Plan Descriptions (SPDs) 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).

Q: What clinical criteria will UnitedHealthcare use to determine Medical Necessity?
A: We will utilize 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.
Q: Where can I find the requirements for services and procedures that require Prior Authorization?
A: Prior Authorization requirements will be listed in the COC for fully insured plans and the SPD for self-funded plans. You may also reference a copy of the UnitedHealthcare Prior Authorization Requirements document for more information.

Providers: Providers will continue to follow the advance Care Coordination process to support both the prior authorization and Care Coordination process requirements. The outline of services that require Prior Authorization can be found in the UnitedHealthcare Provider Administrative Guide.

Q: Does an employer have the option to have customized Prior Authorization Requirements?
A: UnitedHealthcare consistently evaluates services on the Prior Authorization Requirements based on the latest clinical data. Because of this analysis and rigor, we strongly promote adoption of our standard Prior Authorization Requirements for all customers. Customer customization is discouraged and requires special approval. (It is typically only granted for self-funded plans and specific fully insured plans (VEBA Trusts, Public Sector accounts or collectively bargained plans)).

Q: Will movement to the 2011 COC impact an employer’s health care reform grandfathered status?
A: In general, migration to the 2011 Certificate of Coverage language alone will not constitute a loss of Health Care Reform Grandfathered Status. See the following chart below for impacts:

<table>
<thead>
<tr>
<th>COC: Moving from...</th>
<th>Plan change?</th>
<th>Impact to status</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007 COC to 2011 COC</td>
<td>No plan change</td>
<td>Do not lose grandfathered status</td>
</tr>
<tr>
<td>2007 COC to 2011 COC</td>
<td>With plan change(s) that exceeds the changes permitted under the grandfather rule</td>
<td>Lose grandfathered status</td>
</tr>
<tr>
<td>Pre-2007 to 2011 COC</td>
<td>With or without plan changes</td>
<td>Lose grandfathered status</td>
</tr>
</tbody>
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For more information regarding grandfathered status, please visit the United for Reform Resource Center or consult your UnitedHealthcare representative.

Q: Can employer groups opt out of Medical Necessity?
A: Adoption of the 2011 COC language, which includes Medical Necessity, is highly recommended for all new and renewing UnitedHealthcare customers, whether fully insured or ASO.

Migration to the 2011 COC will be highly encouraged for all new fully insured employers and existing fully insured plans, where a plan change was made at renewal. Please contact your UnitedHealthcare representative for more information.

ASO clients will be highly encouraged to migrate their plan to the 2011 COC language by adding the language to their SPDs, including Medical Necessity. ASO clients may opt out of the Medical Necessity language if they choose to do so.

Customers with both fully insured and self-funded medical plans have the option to not elect Medical Necessity for their fully insured and self-funded plans.

Q: How will Medical Necessity affect fully insured plan pricing?
A: Pricing of fully insured plans with Medical Necessity is anticipated to reflect the projected Medical Necessity medical cost savings.

Q: Will adoption of Medical Necessity by self-funded plans increase administrative fees?
A: No. The adoption of a Medical Necessity plan will not result in an administrative fee increase for self-funded employers.

Member Experience Questions

Q: Is the member responsible for obtaining prior authorization for products with Medical Necessity?
A: 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. 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 service is on customer-specific (non-standard) prior authorization requirements.
Q: How will the member be notified of the outcome of their prior authorization request?
A: The member and the rendering physician will receive a determination letter by mail 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.

Q: How will members understand what process they need to follow for prior authorization?
A: A member's COC/SPD will specify which process they need to follow for benefits that are subject to the Medical Necessity prior authorization process. A brochure outlining the medical necessity process and additional member communication will be available to help them understand key changes in their plans and will direct them to their COC/SPD for additional information.

Q: Under what circumstances could a member be liable for the cost of services?
A: A member will be held liable for the cost of services under the following scenarios: 1) the service is deemed not covered or not medically necessary per the member's benefit plan, and the determination was communicated before service was rendered and member attestation is on file with the provider, 2) the member was responsible for obtaining prior authorization, but failed to do so; and, 3) an inpatient day is determined to be custodial.

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

Q: How does the Medical Necessity program align with other UnitedHealth Group entities’ Medical Necessity models such as UnitedHealthcare West (PacifiCare), UnitedHealthcare Oxford, UnitedHealthcare Community and State (AmeriChoice)?
A: Our ultimate goal is a standardized medical management model across all of UnitedHealthcare (where possible). This effort will include alignment of medical management practices across the organization, including medical policies, coverage guidelines and prior authorization requirements. The Community & State and Medicare & Retirement Medical Necessity models may vary based on state and/or federal (Centers for Medicare and Medicaid Services) requirements.