UnitedHealthcare Medical Necessity Overview
Tools for Improving Quality and Cost Outcomes

**Physician and Hospital-Focused Tools**
- Pre-service / Concurrent / Retrospective Review and Physician Education
- Outpatient, Inpatient, and Pharmacy Utilization Review
- Physician and Hospital Performance Measurement
- Physician and Hospital Quality Improvement Programs
- Value-based Provider Payments
- High-performance Networks, incl. Centers of Excellence
- Delivery System Innovation, such as Patient-Centered Medical Homes and Accountable Care Organizations
  - Electronic Medical Records, apply Meaningful Use criteria
  - Electronic Prescribing
  - Health Information Exchanges

**Member-Focused Tools**
- Health and Wellness Programs
- Case Management
- Disease Management
- Care Coordination
- Consumer Price Transparency - Cost Estimator
- Consumer-directed Incentives for Healthier Behavior
- Value-based Benefits, including Tiered Benefits

**Provider- and Member-Focused Tools**
- Health Care Information Technology
- Sophisticated Clinical Analytics to Identify Gaps in Care and in Affordability
- Collaborative Measurement Projects, using Multi-Payer Claims Databases
- Administrative Simplification through Automation

**Core Tools**
- Benefit Plan Design
- Medical Necessity
- Clinical Guidelines and Medical Policies
- Coverage Determination Guidelines
- Appeals and Grievances for Members and for Providers
- Medical Technology Assessment
What is Medical Necessity?

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 which are medically appropriate and cost-effective for the individual member.

Key attributes of Medical Necessity:
• Evidence-based medicine
• Member-centric clinical review
• Timely communication of coverage determinations

UnitedHealthcare uses the power of information and innovative thinking to provide employers, doctors and individuals the opportunity to make better health care decisions.
Medical Necessity Principles

- **Clinical evidence**
  - Credible, published, scientific evidence supported by controlled clinical trials or observational studies

- **Rigorous and consistent clinical management of:**
  - **Clinical effectiveness** - Treatment of illness, injury, disease or symptom must be proven to be clinically effective.
  - **Clinical appropriateness** - Type, frequency, extent and duration of services must be appropriate for the individual member.
  - **Cost effectiveness** - Services must not be more costly than alternative services that are at least as likely to produce equivalent therapeutic and diagnostic results.
Why Medical Necessity?

The marketplace is asking for increased health care effectiveness and affordability

- Current health care inflationary trend is unsustainable, while gaps continue between health care quality and delivery
- Employers are demanding that health care dollars spent have meaningful impact on quality and stretch further
- Employers are expressing interest in plan designs that guide member choices and access

Meeting the opportunities and challenges of health care advancements

- Rapid advancements in the availability of health care data and innovations require an additional focus on services that are clinically appropriate, clinically effective and cost effective.
- Pre-service clinical review of highly variable services allows for evidence-based coverage determinations

Health Care Reform impacts

- Health care reform calls for increased focus on addressing high costs and high variation in care while preparing for the influx of additional consumers into insured markets
Components of our Model

**Evidence-Based Medicine**
- Clinical Appropriateness
- Clinical Effectiveness
- Cost Effectiveness

**Prior Authorization**
Pre-service benefit coverage decision for a service, procedure or test
- Requires migration to the 2011 COC or SPD that supports medical necessity as a requisite for benefit coverage
- Medical necessity determination applied to a service
- All services on our Prior Authorization list are subject to the appropriate evidence-based review

**Inpatient Care Management**
Concurrent or retrospective reimbursement decision for inpatient bed days
- Based on our facility contracts
- Bed days or levels of care determined to be not medically necessary are facility liability; member is held harmless
- Member must be on a COC/SPD that supports such review

**Radiology and Cardiology Prior Authorization**
Future component slated for 2013
How does it work?
Prior Authorization

- **How is it different from UnitedHealthcare’s existing process?**
  - Coverage determinations will be based upon clinical reviews that utilize medical necessity criteria.
  - Services rendered that are deemed NOT medically necessary during pre-service review will not be covered. Member may choose to move forward with service which will result in member liability.
## Prior Authorization: Member Experience

<table>
<thead>
<tr>
<th>Key Processes</th>
<th>Current Process</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of services that require member to obtain Prior Authorization</td>
<td>Member Notification requirements are listed in member’s benefit plan document</td>
<td>Member Prior Authorization requirements are available in member’s benefit plan document. For a listing of standard member requirements, please reference UnitedHealthcare standard Member Prior Authorization list.</td>
</tr>
<tr>
<td>Responsibility for Notification/Prior Authorization</td>
<td>Generally, network provider is responsible for obtaining approval. Member is responsible for notifying if non-network provider accessed or member is in a plan accessing the Options PPO network</td>
<td>No Change</td>
</tr>
<tr>
<td>Clinical Review Performed</td>
<td>Coverage review is performed according to member’s benefit plan</td>
<td>Coverage Review is performed according to member’s benefit plan, which includes use of medical necessity criteria</td>
</tr>
<tr>
<td>Notification of Coverage Determination</td>
<td>Determination letter is mailed to member with cc to physician</td>
<td>No Change</td>
</tr>
<tr>
<td>Liability if Notification/ Prior Authorization is not obtained</td>
<td>Person/entity responsible for notifying UnitedHealthcare.</td>
<td>No Change</td>
</tr>
<tr>
<td>Liability if services are deemed not covered</td>
<td>Generally, the member is liable. For members in provider-driven plans, the member will be liable only if an adverse determination was rendered prior to service being performed and provider obtains attestation that member will pay (New Feature)</td>
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<tr>
<td>Appeals Process</td>
<td>Member and provider are able to appeal coverage or claim decision in accordance with applicable state and/or federal law</td>
<td>No Change</td>
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</table>
Provider Prior Authorization Requirements*

- Accidental Dental Services***
- Ambulance Transportation (non urgent)
- Bariatric Surgery
- Behavioral Health Services
- BRCA Genetic Testing Program
- Cancer Treatment Initiation
- Cardiology Services**
- Capsule Endoscopy
- Chiropractic Services
- Cochlear Implants and other auditory implants
- Congenital Heart Disease
- Durable Medical Equipment (DME – greater than $1000)
- End State Renal Disease/ Dialysis Services
- Home Health Care***
- Hospice (inpatient)***
- Hyperbaric Oxygen Treatment (outpatient)
- Intensity Modulated Radiation Therapy (IMRT)
- Joint Replacement
- MR-guided Focused Ultrasound (MRGFUS) to treat Uterine Fibroid
- Physical Therapy / Occupational Therapy (PT/OT)
- Pregnancy, Healthy Pregnancy**
- Radiology /Advanced Imaging**
- Reconstructive / Potentially Cosmetic Procedures
- Referral for Out-of-Network Services
- Specific Medications as indicated on the PDL
- Sleep Apnea Procedures and Surgeries
- Spine Surgeries (inpatient & outpatient)
- Transplant of tissue or organs

Expected Additions - Proposed Effective Date 4/1/13****
- Bone Growth Stimulator
- Septoplasty / Rhinoplasty
- Breast Reconstruction, non Mastectomy
- Clinical Trials
- Home Health Care, Nutritional
- Infertility
- Injectable Medications
- Muscle Flap Procedure
- Orthognathic Surgery
- Orthotics – greater than $1000
- Potentially Unproven Services
- Proton Beam Therapy
- Speech Therapy
- Sleep Studies, facility-based
- Spinal Stimulator for Pain Management
- Vagnus Nerve Stimulation
- Vein Procedures

* Applies to in network services for members in Managed Care products [e.g. Choice, Choice Plus, Navigate]
** Notification only
*** Requirement currently in effect, but will be retired effective 4/1/2013
**** Expected additions, however Provider Administrative Guide will govern
Member Prior Authorization Requirements* – Standard

- BRCA testing (breast cancer susceptibility)
- Non-emergent ambulance
- Clinical Trials
- CHD Surgeries
- Accidental Dental
- Durable Medical Equipment (DME) – greater than $1000), including insulin pumps
- Home Health Care
- Hospice – inpatient
- Hospital – inpatient
- MH/SU – inpatient & outpatient
- Pregnancy – Healthy Pregnancy Notification Program**
- Maternity - IP stays that exceed normal 48 for vaginal delivery or >96 hours for cesarean
- Reconstructive Procedures
- Rehab Services (outpatient) – chiropractic
- SNF/Acute Rehab
- Surgery (outpatient) – diagnostic catheterization, electrophysiology implant**, sleep apnea surgeries
- Therapeutics (outpatient) – dialysis, intensity modulated radiation therapy, MR-guided focused ultrasound
- Transplant Services

* Generally applies to out-of-network services for all plans and in-network and out-of-network services for PPO plans

** Notification only
How does it work?
Inpatient Care Management

- How is it different from UnitedHealthcare's current inpatient utilization management process?
  - Inpatient Care Management uses a medical necessity standard in concurrent or retrospective bed day reviews;
  - Denial of bed days where length of stay or level of care is not medically appropriate and where unnecessary delays in service impact the length of stay;
  - Denial of bed days will occur in facilities that have agreed to support this feature and the members COC/SPD supports this type of review
  - Bed days or levels of care determined to be not medically necessary are facility liability; member is held harmless.

Member schedules service at a participating inpatient facility. (If planned service)
Member is admitted and participating inpatient facility provides Admission Notification (lets us know the member has arrived at the facility).
UnitedHealthcare nurse clinically reviews each member’s care while in the hospital (Concurrent Review) to help verify member is getting the appropriate care according to the evidence-based guidelines.
Nurse provides input and support for discharge planning and transitional care placement (if needed). Patient is discharged.
Healthcare providers submit claims for services rendered. UnitedHealthcare processes the claim.
# Inpatient Care Management: Member Experience

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| **Inpatient Utilization Management Model Overview** | **Objective:** Promote appropriate delivery of care for facility-based members  
**High Level Process:**  
• UHC specialist nurses perform onsite or telephonic review using evidence-based national guidelines.  
• UHC nurses and medical directors review cases and consult with the hospital/SNF review team and/or attending physician to address any potential issues according to appropriate guidelines.  
• UHC Medical Director discuss treatment plans with the treating physician to collaboratively facilitate access to care or alternate care settings. | Current Process objective and high level process remain in tact. Key change includes the ability to deny payment of inpatient care that is not medically necessary in in-network facilities that participate in this program and where the benefit plan supports denial of care that is not medically appropriate. |
| **Responsibility for providing notification of Admission** | In-network facilities are responsible for providing Admission Notification. If member is admitted into an out-of-network facility, the member is responsible for providing notification of admission. | No change |
| **Clinical Review Performed** | Evidence-based clinical review by a specialist nurse and/or medical director.  
Inpatient days deemed ‘custodial’ result in a bed day denial | Same as current process, with the following:  
Inpatient days and level of care that are determined to be not medically necessary may result in denial of payment to the facility |
| **Liability if inpatient day is denied** | Custodial day denials are a non-covered service according to the members benefit document, and therefore will be member liability. | Length of Stay, Delay in Service and Level of Care denials will result in facility liability. The member is held harmless.  
Custodial bed day denials will continue to be member liability. |
| **Liability if Admission Notification is not provided** | Person/entity responsible for providing Admission Notification UnitedHealthcare. | No Change |
| **Appeals Process** | Member and provider have the right to appeal clinical decision or claim decision in accordance with applicable state and/or federal law | No Change |
Questions?