Mental Health Parity and Addiction Equity Act
Non-Quantitative Treatment Limitations – Answers to Key Questions

UnitedHealthcare Options Preferred Provider Organization (PPO)
(third party MH/SUD vendor)
Medical Necessity Model

This summary is applicable to fully insured and self-funded UnitedHealthcare Options Preferred Provider Organization (PPO) plans using the Medical Necessity Model and that carve out their behavioral health services to a third party vendor (i.e. they do NOT use United Behavioral Health (“Optum”) as their behavioral health vendor). If the customer has a UnitedHealthcare Options PPO plan and uses Optum as their behavioral health vendor, then the UnitedHealthcare Options PPO (with Optum) grid should be used. If a grid is needed for another UnitedHealth Group entity or plan type (including a Care Coordination Model), please refer to the appropriate grid for that other entity or plan type.

The information provided below is based, where applicable, on standard UnitedHealthcare Certificates of Coverage (COCs) and standard UnitedHealthcare-drafted Summary Plan Descriptions (SPDs). Self-funded (ASO) customers will need to verify that the information below is consistent with their plan’s specific SPD and the services the customer has purchased from UnitedHealthcare, and make modifications accordingly.

Date: September 12, 2014

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### Exclusion for Failure to Complete Treatment

Exclusion for Failure to Complete Treatment

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### Fail First Requirements

Fail First Requirements

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### Formulary Design for Prescription Drugs

Formulary Design for Prescription Drugs

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### Restrictions Based on Geographic Location

Restrictions Based on Geographic Location

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**APPLICABLE TO INPATIENT CLASSIFICATION:**

- Notification
- Prior Authorization
- Concurrent Review
- Retrospective Review

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**APPLICABLE TO OUTPATIENT CLASSIFICATION:**

- Prior Authorization
- Outlier Management & Concurrent Review
- Retrospective Review
### Non-Quantitative Treatment Limitations

#### General Medical/Surgical

**Are services subject to a medical necessity standard?**

Yes, services received from both Network and non-Network providers must meet the following definition of medical necessity:

Health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance use disorder, condition, disease or its symptoms, which are all of the following as determined by UnitedHealthcare or our designee, within our sole discretion.

- In accordance with *Generally Accepted Standards of Medical Practice*
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the member's sickness, injury, mental illness, substance use disorder, disease or its symptoms
- Not mainly for the member’s convenience or that of the member's doctor or other health care provider
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's sickness, injury, disease or symptoms.

*Generally Accepted Standards of Medical Practice* are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. UnitedHealthcare reserves the right to consult expert opinions in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within our sole discretion.

UnitedHealthcare develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting our determinations regarding specific services.

These clinical policies (as developed by us and revised from time to time), are available to Covered Persons on UnitedHealthcare’s member website or by calling the telephone number on the Covered Person’s ID card. They are available to Physicians and other health care professionals on UnitedHealthcare’s provider website or by calling the telephone number on the Covered Person’s ID card.

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### Non-Quantitative Treatment Limitations

<table>
<thead>
<tr>
<th>General Medical/Surgical</th>
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</thead>
<tbody>
<tr>
<td><strong>In Network &amp; Out of Network</strong></td>
</tr>
<tr>
<td>The plan utilizes a comprehensive program for the detection, investigation and remediation of potential fraud, waste and abuse. The processes utilized are claims algorithms and a reporting hotline for detection, pre-payment and post-payment review for investigation and recovery is conducted via claims offsets and invoicing for collection of overpaid amounts.</td>
</tr>
</tbody>
</table>

The Fraud, Waste and Abuse processes that investigate and identify fraud though pre-payment and post-payment reviews are non-quantitative limits that may impact the scope or duration of treatment by affecting the payment of benefits to a provider or member. This limitation may occur through the denial of claims (pre-payment review) and recovery of overpaid claims (post-payment review).

Pre-payment review may be applied to the claims or a provider or member for whom there is a basis to suggest irregular or inappropriate services based on the claims submitted, referral tips from the fraud hotline or other means. A pre-payment review entails review of each claim, requests for additional information to support and/or validate the claim and, if necessary, may result in denial of the claim if not substantiated. This process may be applied to any provider or member’s claims without regard to the payer, the amount of claim, type of service etc.

Post-payment review is conducted when an algorithm, routine claims audit, referral tips from the fraud hotline or other information suggests the need for review of a provider’s billing practices and patterns after claims have previously been processed and paid. A post-payment review will involve an audit for a period that may span from six months to six years using a sampling and extrapolation methodology and may involve any amount of claims with no specified minimum amount involved or potential recovery probability. The audit and investigation will involve review of contemporaneous treatment records as well as member and provider interviews.

### Is there Exclusions for Experimental, Investigational and Unproven Services?

Yes, services received from both Network and non-Network providers are subject to the following exclusions:

**Experimental or investigational services** are medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time a determination regarding coverage in a particular case is made, are determined to be any of the following:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use.
- Subject to review and approval by any institutional review board for the proposed use. (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational.)
### Non-Quantitative Treatment Limitations

#### General Medical/Surgical

- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

*Unproven services* are services, including medications, which are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials. (Two or more treatments are compared to each other, and the patient is not allowed to choose which treatment is received.)
- Well-conducted cohort studies. (Patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.)

Experimental or Investigational and Unproven Services and all services related to Experimental or Investigational and Unproven Services are excluded. The fact that an Experimental or Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental or Investigational or Unproven in the treatment of that particular condition.

### Network Admission Criteria

#### In Network

Providers must meet all credentialing criteria outlined in the UnitedHealthcare Credentialing Plan to remain eligible for network participation. The Credentialing Plan is available online at [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com). Go to Quick Links > Policies, Protocols and Administrative Guides.

Participation criteria for practitioners include:

1. **Education**
   - M.D.s and O.D.s: graduation from allopathic or osteopathic medical school and successful completion of either a residency program or other clinical training and experience for their specialty and scope of practice.
   - Chiropractors: graduation from chiropractic college
   - Dentists: graduation from dental school
   - Podiatrists: graduation from podiatry school and successful completion of a hospital residency program
   - Mid-level practitioners: graduation from an accredited professional school and successful completion of a training program.
   - Any board certification claimed by an applicant shall be verified by the credentialing committee.

2. **Licensing**
### Summary of Various Non-Quantitative Treatment Limitations

#### Mental Health Parity and Addiction Equity Act

**UnitedHealthcare Options Preferred Provider Organization (PPO)**

(with Medical Necessity)

<table>
<thead>
<tr>
<th>Non-Quantitative Treatment Limitations</th>
<th>General Medical/Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicants must maintain current, valid licensure or certification, without material restrictions, conditions or other disciplinary actions in all states where the applicant practices.</td>
<td></td>
</tr>
</tbody>
</table>

3. Admitting privileges

Must have full hospital admitting privileges without material restrictions, conditions or other disciplinary actions with at least one network hospital or arrangements with a network physician to admit and provide hospital coverage to members at a network hospital.

4. Valid DEA or Controlled Substance Certificate or acceptable substitute in each state where the Applicant practices (unless such Certificate is not required for the Applicant's practice).

5. Medicare/Medicaid Program Participation Eligibility

Must not be ineligible, excluded or debarred from participation in Medicare, Medicaid or other related state and federal programs, or terminated for cause from same, and must be without any sanctions levied by the Office of the Inspector General or General Services Administration or other disciplinary action by any federal or state entities identified by CMS.

6. Work History

Must provide a 5 year employment history. Gaps longer than 6 months must be explained by the applicant and found acceptable by the credentialing committee.

7. Insurance or state approved alternative

Must maintain malpractice insurance coverage or show similar financial commitments made through an appropriate State-approved alternative in the required amounts, and provide a 5 year professional liability claims history showing any settlements or judgments paid by or on behalf of the Applicant and a history of liability insurance coverage, including any refusals or denials to cover the Applicant or cancellations of coverage.

8. Site visit

If required by the credentialing committee must agree to a site visit and obtain a passing score.

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<th>Non-Quantitative Treatment Limitations</th>
<th>General Medical/Surgical</th>
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</thead>
</table>

9. Network participation

At the credentialing committee's discretion, Applicant must not have been denied initial network participation or had prior network participation terminated (for reasons other than network need) within the preceding 24 months.

Participation criteria for facilities includes:

1. Current required licenses

2. Must maintain general/comprehensive liability coverage and malpractice insurance for at least the "per occurrence" and aggregate limits required by UnitedHealthcare, or show similar financial commitments made through an appropriate state approved alternative.

3. Medicare/Medicaid Program Participation Eligibility

Must not be ineligible, excluded or debarred from participation in Medicare, Medicaid or other related state and federal programs, or terminated for cause from same, and must be without any sanctions levied by the Office of the Inspector General or General Services Administration or other disciplinary action by any federal or state entities identified by CMS.

4. Appropriate accreditation or satisfactory alternative by a recognized accreditation entity (e.g. JC, AOA, CARF, AFAP, etc.) and must provide copy of the accreditation report.

5. Compliance with participation agreement (for re-credentialing)

Providers and facilities are re-credentialed every 36 months, unless earlier re-credentialing is required under an applicable state or federal law/regulation.

The information provided to the Credentialing Committee is forwarded without reference to clinician's race, gender, age, sexual orientation or the types of procedures so decisions are made in a nondiscriminatory manner.

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## Non-Quantitative Treatment Limitations

### General Medical/Surgical

#### Accessibility Standards

The health plan maintains standards for the numeric and geographic availability of participating medical/surgical practitioners and providers based on the following strategies, processes, evidentiary standards and other factors:

1. Geographic factors
2. Provider/facility availability
3. Supply/demand factors

Based on these strategies, processes, evidentiary standards and other factors the plan analyzes the network against the following established standards at least annually:

#### Standards for the Geographic Distribution of Participating Practitioners and Providers

<table>
<thead>
<tr>
<th>Practitioner/Provider Type</th>
<th>Large Metro Miles</th>
<th>Metro Miles</th>
<th>Micro Miles</th>
<th>Rural Miles</th>
<th>CEAC Miles</th>
<th>Goal All Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care</strong> 1 within</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Practice</td>
<td>5</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>60</td>
<td>90%</td>
</tr>
<tr>
<td>General Practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Medicine</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Gerontology</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pediatrics</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>OB/GYN (in states where applicable)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Specialty Care Physician</strong> 1 within</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td>10</td>
<td>20</td>
<td>35</td>
<td>60</td>
<td>85</td>
<td>90%</td>
</tr>
<tr>
<td>General Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Orthopedics</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td>10</td>
<td>30</td>
<td>45</td>
<td>60</td>
<td>100</td>
<td>90%</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Non-Quantitative Treatment Limitations

#### General Medical/Surgical

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<thead>
<tr>
<th>Practitioner/Provider Type</th>
<th>Large Metro</th>
<th>Metro</th>
<th>Micro</th>
<th>Rural</th>
<th>CEAC</th>
<th>Goal-All Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital 1 within</td>
<td>10</td>
<td>30</td>
<td>60</td>
<td>60</td>
<td>100</td>
<td>90%</td>
</tr>
<tr>
<td>Ancillary Providers 1 within</td>
<td>Laboratory Services</td>
<td>5</td>
<td>10</td>
<td>60</td>
<td>60</td>
<td>100</td>
</tr>
<tr>
<td>Ambulatory Surgical Facilities</td>
<td>10</td>
<td>30</td>
<td>60</td>
<td>60</td>
<td>100</td>
<td>90%</td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Home Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>10</td>
<td>30</td>
<td>60</td>
<td>60</td>
<td>85</td>
<td>90%</td>
</tr>
<tr>
<td>Outpatient Dialysis</td>
<td>10</td>
<td>30</td>
<td>50</td>
<td>50</td>
<td>90</td>
<td>90%</td>
</tr>
</tbody>
</table>

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## Summary of Various Non-Quantitative Treatment Limitations

**Mental Health Parity and Addiction Equity Act**

UnitedHealthcare Options Preferred Provider Organization (PPO)
(with Medical Necessity)

<table>
<thead>
<tr>
<th>Non-Quantitative Treatment Limitations</th>
<th>General Medical/Surgical</th>
</tr>
</thead>
</table>
| **What is the Basis for Provider Reimbursement?** | In Network  
Medical/Surgical providers are reimbursed based on negotiated contract rates. Several factors being taken into consideration in the rate-setting process, including CMS benchmarks, as well as regional market dynamics and current business needs.  
Depending on provider type, contract rates may be based on a MS-DRG, Per Diem, Per Case, Per Visit, Per Unit, Fee Schedule, etc.  
Inpatient and outpatient contract rates are negotiated on a facility by facility basis. Contract rates are typically negotiated for a 2-3 year term with agreed upon escalators for each year.  
**Out of Network**  
Fees are established using a percentage of the CMS fee amounts for the same or similar service within the applicable geographic market based on provider type, or by using an outside vendor network that uses contractual methodologies. Certain services are reimbursed using a reduced percentage of CMS rates – such as laboratory services and durable medical equipment. If there is no CMS rate then a default rate of 50% of billed charges is used. |
| **Does the Plan Have Exclusions for Failure to Complete a Course of Treatment?** | In Network & Out of Network  
The medical/surgical benefit does not include exclusions based on a failure to complete a course of treatment. |
| **Does the Plan Include Fail First Requirements (also known as step therapy protocols)?** | In Network & Out of Network  
Application of a “fail first” or “step therapy” requirement is based on use of nationally recognized clinical standards, which may be incorporated into the plan’s review guidelines.  
Based on, and consistent with, these nationally recognized clinical standards, some of the plan's medical/surgical review guidelines have what may be considered to be “fail first” or “step therapy” protocols. |

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<table>
<thead>
<tr>
<th>Non-Quantitative Treatment Limitations</th>
<th>General Medical/Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The full list of the guidelines (Medical &amp; Drug Policies and Coverage Determination Guidelines) is available at <a href="http://www.unitedhealthcareonline.com">www.unitedhealthcareonline.com</a>. Go to Quick Links &gt; Policies, Protocols and Administrative Guides.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Formulary Design for Prescription Drugs</th>
<th>In Network &amp; Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The plan’s Prescription Drug List (PDL) is created utilizing all medications approved by the FDA as a starting point. Certain drugs may then be excluded from the PDL coverage based on a variety of clinical, pharmacoeconomic and financial factors. These factors are also utilized to determine inclusion and tier placement on the PDL. For example, the plan excludes coverage of prescription drugs for which a therapeutic equivalent over-the-counter drug is available.</td>
</tr>
</tbody>
</table>

This process is conducted by a national Pharmacy & Therapeutics Committee which reviews and evaluates all clinical and therapeutic factors. The committee meets no less than quarterly and assesses the medication’s place in therapy, and its relative safety and efficacy. The committee reviews decisions consistent with published evidence relative to these factors developed by a pharmacoeconomic work group which extensively reviews medical and outcomes literature and financial models which assess the impact of cost versus potential offsets from the use of a prescription drug such as decreases in hospital stays, or reduction in lab tests or medical utilization due to side effects etc. 

The committee and work group do not utilize any factors which take into account the prescription drug's primary indication as a mental health or substance use disorder prescription drug. Such drugs are assessed under the process above without regard to their primary indication being related to mental health or substance use disorder. |

<table>
<thead>
<tr>
<th>Are There Restrictions Based on Geographic Location?</th>
<th>In Network &amp; Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The medical/surgical benefit does not include restrictions based on geographic location.</td>
</tr>
</tbody>
</table>
# Non-Quantitative Treatment Limitations Compliance Summary

## Mental Health Parity and Addiction Equity Act

### UnitedHealthcare Options

**Preferred Provider Organization (PPO)**

*(with Medical Necessity)*

**Applicable to Inpatient Classification**

<table>
<thead>
<tr>
<th>Non-Quantitative Treatment Limitations</th>
<th>General Medical/Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Does the Plan Require Notification for Inpatient Admissions?</strong></td>
<td><strong>In Network</strong></td>
</tr>
<tr>
<td>Requirement:</td>
<td>Requirement:</td>
</tr>
<tr>
<td>Yes. The member must notify the plan for all inpatient admissions. Failure to notify results in reduced benefits or no benefits (in Colorado, the treating physician and/or facility is required to give notification).</td>
<td>Yes. The member must notify the plan for all inpatient admissions. Failure to notify results in reduced benefits or no benefits (in Colorado, the treating physician and/or facility is required to give notification).</td>
</tr>
<tr>
<td></td>
<td>Benefit reductions are applied to members who fail to provide timely notification. Members are allowed to delegate their responsibility to provide notification to the facility.</td>
</tr>
<tr>
<td><strong>Out of Network</strong></td>
<td><strong>Out of Network</strong></td>
</tr>
<tr>
<td>All inpatient services require notification. When these services are provided out of network, the member is responsible for providing the notification and relevant information. Members should provide notice of notify admissions within 24 hours or as soon as reasonably possible given the circumstances.</td>
<td>All inpatient services require notification. When these services are provided out of network, the member is responsible for providing the notification and relevant information. Members should provide notice of notify admissions within 24 hours or as soon as reasonably possible given the circumstances.</td>
</tr>
<tr>
<td></td>
<td>Members are allowed to delegate their responsibility to provide notification to the non-network facility.</td>
</tr>
<tr>
<td></td>
<td>Initial notification results in a medical necessity review based on plan requirements and may result in an adverse benefit determination.</td>
</tr>
<tr>
<td></td>
<td>If admission notification is not obtained by the member within the required timeframe, a benefit reduction is applied to the member. The reduction percentage will vary by plan.</td>
</tr>
<tr>
<td><strong>Does the Plan Require Prior Authorization for Inpatient Services?</strong></td>
<td><strong>In Network</strong></td>
</tr>
<tr>
<td>Yes, members are required to obtain prior authorization for several services/procedures. A current listing of these services can be found at</td>
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## Non-Quantitative Treatment Limitations

### General Medical/Surgical


These services/procedures were selected based on the following strategies, processes, evidentiary standards and other factors:

1. Practice Variation/variability by
   - a) Level of care
   - b) Geographic region
   - c) Diagnosis
   - d) Provider/facility
2. Significant drivers of cost trend
3. Outlier performance against established benchmarks
4. Disproportionate Utilization
5. Preference/System driven care
   - a) Preference driven
   - b) Supply/demand factors
6. Gaps in Care that negatively impact cost, quality and/or utilization
7. Outcome yield from the UM activity/Administrative cost analysis

Members are allowed to delegate their responsibility to provide prior authorization to the facility.

Upon request, even when prior authorization is not required for a particular service or procedure, the member/facility/provider can request that the medical plan provide a medical necessity review of a proposed service prior to the provision of such service. This enables the member/facility/provider to avoid retrospective medical necessity or other coverage review, which can result in full or partial denial of claims.

### Out of Network

Members are responsible for obtaining prior authorization for all inpatient services to non-network facilities. Members are required to obtain the prior authorization within certain timeframes, depending on the member's specific plan requirements. Clinical information necessary to perform reviews is required.

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## Non-Quantitative Treatment Limitations Compliance Summary

**Mental Health Parity and Addiction Equity Act**

**UnitedHealthcare Options Preferred Provider Organization (PPO) (with Medical Necessity)**

**Applicable to Inpatient Classification**

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</thead>
<tbody>
<tr>
<td>Some inpatient services require prior authorization “as soon as possible” before the services/treatment are received. Examples of these benefits include, but are not limited to, transplants.</td>
<td></td>
</tr>
<tr>
<td>Other inpatient services require prior authorization 5 days before receiving the benefit. Examples of services requiring prior authorization 5 business days before admission include, but are not limited to, planned inpatient admissions, scheduled maternity admissions, reconstructive procedures, rehabilitation/habilitative services, and SNF admissions.</td>
<td></td>
</tr>
<tr>
<td>Members should provide notice of emergent admissions within 24 hours of admission or as soon as reasonably possible given the circumstances.</td>
<td></td>
</tr>
<tr>
<td>Members are allowed to delegate their responsibility to obtain prior authorization to the non-network provider.</td>
<td></td>
</tr>
<tr>
<td>A prior authorization review involves a medical necessity review based on plan requirements and may result in an adverse benefit determination.</td>
<td></td>
</tr>
<tr>
<td>If prior authorization is not obtained by the member within the required timeframe, a benefit reduction is applied to the member. The reduction percentage will vary by plan.</td>
<td></td>
</tr>
</tbody>
</table>

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### Non-Quantitative Treatment Limitations Compliance Summary

#### Mental Health Parity and Addiction Equity Act

#### UnitedHealthcare Options Preferred Provider Organization (PPO) (with Medical Necessity) 

**Applicable to Inpatient Classification**

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<table>
<thead>
<tr>
<th>Non-Quantitative Treatment Limitations</th>
<th>General Medical/Surgical</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Does the Plan Conduct Concurrent Reviews for Inpatient Services?</strong></td>
<td>In Network</td>
</tr>
<tr>
<td>Inpatient review is a component of the medical plan's utilization management activities. The Medical Director and other clinical staff review hospitalizations to detect and better manage over- and under-utilization and to determine whether the admission and continued stay are consistent with the member's coverage, medically appropriate and consistent with evidence-based guidelines.</td>
<td></td>
</tr>
<tr>
<td>Inpatient review also gives the plan the opportunity to contribute to decisions about discharge planning and case management. In addition, the plan may identify opportunities for quality improvement and cases that are appropriate for referral to one of our disease management programs.</td>
<td></td>
</tr>
<tr>
<td>Reviews usually begin on the first business day following admission. If a nurse reviewer believes that an admission or continued stay is not an appropriate use of benefit coverage, the facility will be asked for more information concerning the treatment and case management plan. The nurse may also refer the case to our Medical Director for a peer-to-peer discussion. If the plan Medical Director determines that an admission or continued stay at the facility, being managed by a participating physician, is not medically necessary, the facility and the physician will be notified.</td>
<td></td>
</tr>
<tr>
<td>Non-reimbursable charges are not billable to the member. The facility and the attending physician have sole authority and responsibility for the medical care of patients. The plan’s medical management decisions do not override those obligations. We do not ever direct an attending physician to discharge a patient. We simply inform the member of our determination.</td>
<td></td>
</tr>
<tr>
<td>• Participating facilities are required to cooperate with all medical plan requests for information, documents or discussions for purposes of concurrent review and discharge planning including, but not limited to: primary and secondary diagnosis, clinical information, treatment plan, patient status, discharge planning needs, barriers to discharge and discharge date.</td>
<td></td>
</tr>
<tr>
<td>• Initial and concurrent review can be conducted by telephone, on-site and when available, facilities can provide clinical information via access to Electronic Medical Records (EMR).</td>
<td></td>
</tr>
<tr>
<td>• Participating facilities must cooperate with all medical plan requests from the inpatient care management team and/or medical director to engage our members directly face-to-face or telephonically.</td>
<td></td>
</tr>
<tr>
<td>• The medical plan uses MCG™ Care Guidelines, or other guidelines, which are nationally recognized clinical guidelines, to assist clinicians in making informed decisions in many health care settings. This includes acute and sub-acute medical, rehabilitation, skilled nursing facilities, home health care and ambulatory facilities. The medical plan clinical criteria can be requested from the Case Reviewer. Criteria other than MCG™ Care Guidelines may be used in situations when published peer-reviewed literature or guidelines are available from national specialty organizations that address the admission or continued stay. When the guidelines are not met, the Medical Director considers community resources and the availability of alternative care settings, such as skilled facilities, sub-acute facilities or home care and the ability of the facilities to provide all necessary services within the estimated length of stay.</td>
<td></td>
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### Non-Quantitative Treatment Limitations

#### General Medical/Surgical

- Medical and Drug Policies and Coverage Determination Guidelines are available online at [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com)

**Out of Network**

All inpatient care is reviewed concurrently for appropriate use of benefit coverage. Concurrent clinical information is required, and is used to develop a discharge plan and ensure appropriate use of the benefit, based on medical necessity.

A concurrent review can result in a modification of the services requested. The facility and the attending physician have sole authority and responsibility for the medical care of patients. The plan’s medical management decisions do not override those obligations. We do not ever direct an attending physician to discharge a patient. We simply inform the member of our determination.

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#### Does the Plan Conduct Retrospective Reviews for Inpatient Services?

**In Network & Out of Network**

Yes, post-service, pre-claim reviews are conducted on inpatient services. Network providers should follow the same process as is applied for a standard Prior Authorization request. A clinical coverage review will be done to determine whether the service is medically necessary and payment may be withheld if the services are determined not to have been medically necessary.

Urgent services rendered without a required Prior Authorization number will also be subject to retrospective review for medical necessity, and payment may be withheld if the services are determined not to have been medically necessary.

Network providers/facilities may not balance bill the member for any denied charges under these circumstances.
### Non-Quantitative Treatment Limitations Compliance Summary

#### Mental Health Parity and Addiction Equity Act

**UnitedHealthcare Options Preferred Provider Organization (PPO)**

**(Medical Necessity Model)**

**Applicable to Outpatient Classification**

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<tr>
<td><strong>Does the Plan Require Prior Authorization for Outpatient Services?</strong></td>
<td><strong>In Network</strong></td>
</tr>
<tr>
<td><strong>In Network</strong></td>
<td>Upon request, even when prior authorization is not required, the facility/provider can request that the medical plan provide a medical necessity or coverage determination review of a proposed service prior to the provision of such service. This enables the facility/provider to avoid retrospective medical necessity review, which can result in full or partial denial of claims.</td>
</tr>
</tbody>
</table>

The medical plan determines when prior authorization and other management interventions may be required by evaluating the potential administrative cost of these interventions when compared to their potential benefit. The following strategies, processes, evidentiary standards and other factors are used as part of this analysis:

1. Practice Variation/variability by
   a. Level of care
   b. Geographic region
   c. Diagnosis
   d. Provider/facility
2. Significant drivers of cost trend
3. Outlier performance against established benchmarks
4. Disproportionate Utilization
5. Preference/System driven care
   a. Preference driven
   b. Supply/demand factors
6. Gaps in Care that negatively impact cost, quality and/or utilization
7. Outcome yield from the UM activity/Administrative cost analysis

Based on these strategies, processes, evidentiary standards and other factors the medical/surgical plan requires prior authorization for a range of planned medical/surgical services that are covered under the outpatient benefit. A current listing of these services can be found at [www.unitedhealthcareonline.com](http://www.unitedhealthcareonline.com). Go to Quick Links > Policies, Protocols and Administrative Guides.

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### Non-Quantitative Treatment Limitations

#### General Medical/Surgical

A benefit reduction may be imposed for failure to obtain a prior authorization. The amount of reduction depends on the benefit plan. Grace periods are not applicable. The member cannot be balance billed for any denied charges under these circumstances.

**Out of Network**

When the services on the prior authorization list are obtained from a non-network provider, the member is responsible for obtaining the prior authorization. Clinical information necessary to perform reviews is required. The member can delegate this responsibility to the non-network provider.

A prior authorization review involves a medical necessity review based on plan requirements and can result in a medical necessity denial.

Members should notify the plan of emergent admissions within 24 hours or as soon as reasonably possible given the circumstances.

If prior authorization is not obtained by the member within the required timeframe, a benefit reduction is applied to the member. The reduction percentage will vary by plan.

### Does the Plan Conduct Outlier Management & Concurrent Review for Outpatient Services?

#### In Network & Out of Network

Outlier management algorithms are applied to outpatient services based on the following criteria:

- Treatment plans ranging from 1-24+ visits, with the likelihood for treatment being medically unnecessary increasing with higher number of visits
- Treatment durations ranging from 1-365+ days, with the likelihood for treatment being medically unnecessary increasing with longer treatment durations
- Visits including multiple units of services, with the likelihood for treatment being medically unnecessary increasing with higher number of services per visit
- Potential to bill for the same service using multiple levels of coding
- Relatively low/modest cost per service

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Non-Quantitative Treatment Limitations Compliance Summary
Mental Health Parity and Addiction Equity Act

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<tr>
<td>• Variable rates of patient progress during a treatment plan</td>
<td></td>
</tr>
<tr>
<td>• Variable approaches to patient care among providers</td>
<td></td>
</tr>
<tr>
<td>• Coverage up to and including the point of maximum therapeutic benefit being attained, after which additional improvement is no longer expected, and coverage for the same services may no longer exist</td>
<td></td>
</tr>
<tr>
<td>• A portion of patients never having complete resolution of their condition resulting in ongoing management for a chronic condition</td>
<td></td>
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</tbody>
</table>

Based on the above criteria, the medical/surgical plan has identified the following services in the outpatient classification:

- Chiropractic
- Occupational Therapy
- Physical Therapy

Outpatient medical/surgical services rendered using E/M codes are not included in this outlier program.

In order to ensure members have access to services available to them through their COC/SPD and the sponsor does not pay for non-covered services a utilization review program is then applied to the identified medical/surgical services. This utilization review program has the following attributes:

- Differentiated UR process based on historical provider performance
- Business rules identify attributes of cases with a high likelihood for medically unnecessary services currently or in the relatively near future
- Identified cases are clinically reviewed
- In cases with apparent medically unnecessary services, peer to peer telephonic contact is initiated to make sure complete information is available
- In cases where ongoing services have been determined to be unnecessary an adverse benefit determination is made and member/provider communication, compliant with all state and federal regulatory requirements, is issued
- Appeals process is available for adverse determination

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<td>Network providers and facilities may not balance bill the member for any denied charges</td>
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<td>under these circumstances.</td>
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