Notice of Utilization Review & Benefit Determination Procedures – West Virginia

As required by the state of West Virginia, this notice is to help you understand how decisions are made regarding whether or not certain services are covered under your benefit plan. Your plan benefits are limited to the Covered Health Services outlined in your benefit plan documents, such as the Certificate of Coverage (COC), Schedule of Benefits, and any Riders and/or amendments. Benefit coverage is subject to the terms, conditions, exclusions and limitations of the policy, as agreed upon between UnitedHealthcare and the Enrolling Group (such as your employer) offering you your benefit plan.

Before receiving care, you should check your COC to see if the service is covered under your plan. Some services may require you to get approval from UnitedHealthcare before you receive the service. To confirm whether or not a service is covered, call the phone number listed in your plan documents or on your health plan ID card. UnitedHealthcare has several procedures in place for determining benefit coverage as outlined below.

Benefit Determinations

Benefit determinations—decisions as to whether your benefit plan will pay for any portion of the cost of a health care service you intend to receive or have received—are made according to the coverage terms, benefits, limitations and exclusions as provided in your benefit plan documents.

How much UnitedHealthcare pays toward Covered Health Services is determined by the benefit level as described in the Schedule of Benefits and subject to the terms, conditions, exclusions and limitations as explained in your benefit plan documents. This means we only pay our portion of the cost of Covered Health Services. You are responsible for paying for any remaining costs. You are responsible for paying all of the costs for non-covered (excluded) services.

Administration decisions are for payment purposes only. We do not make decisions about the kind of care you should or should not receive. You and your providers must make those treatment decisions.

Utilization Review

Some services may require a formal review to determine if benefit coverage meets the requirements of the benefit plan offering. In addition, some services may require you to notify UnitedHealthcare, or get approval from UnitedHealthcare, before receiving the service in order to receive benefit coverage.

Clinical Reviews (applies to medical plans only)

Clinical Coverage Review

Clinical Coverage Review (CCR) is a review of clinical and medical records to determine if a particular service should be covered according to benefit plan documents, state insurance laws, and state and federal mandates, as required. Evidence-based medical policy, standardized Coverage Determination Guidelines (CDGs), Utilization Review Guidelines (URGs), UnitedHealthcare Medical Technology Assessments, and nationally recognized clinical guidelines and criteria are used for clinical reviews by CCR staff. CCR Medical Directors talk with ordering physicians as needed to gather clinical information, or whenever requested by ordering physicians. All clinical non-coverage determinations are made by physicians. Notice of all review outcomes is communicated in accordance with applicable state, federal or accreditation requirements.

UnitedHealthcare®

Clinical Reviews (applies to medical plans only) – continued

Clinical coverage reviews are components of the following processes:

Prospective/Pre-service Review

Prospective or pre-service review is an administrative or clinical review that is done before an inpatient admission, stay, other service or course of treatment including outpatient procedures and services. Pre-service reviews include eligibility verification and benefit plan interpretation, and may include review of medical necessity and appropriateness of care.

Prior Authorization/Pre-Certification

Some plans may require you to get approval from UnitedHealthcare before receiving certain services in order to be covered under plan benefits. If you do not get Prior Authorization before receiving such services, you may be responsible for paying for the entire cost of the service. Coverage for these services may only be provided if the service is deemed medically necessary or meets specific requirements, as described in the benefit plan documents. Pre-certification is when a covered person is pre-approved to receive a particular medical service or prescription drug after an assessment to determine if the proposed services meet the clinical requirements for medical necessity, appropriateness, level of care, or effectiveness under the provisions of the applicable benefit plan.

Inpatient Care Management/Concurrent Review/Discharge Planning

The Inpatient Care Management (ICM) and Skilled Nursing Facility (SNF) Specialist activities focus on helping patients in facilities, such as hospitals and nursing homes, access care at the appropriate time. Specialist nurses perform onsite or telephonic review using evidence-based national guidelines. Medical necessity determinations may be made if required by the benefit plan. The ICM consults with the hospital/SNF review team and/or attending physician to discuss any potential issues according to appropriate guidelines. Along with the ICM Medical Director, they review cases and discuss treatment plans with the treating physician to collaboratively facilitate access to care or alternate care settings.

If you have questions about a notification (coverage approval) or your use of medical services, or if you disagree with either a pre-service request for benefits determination or post-service claim determination, call the member phone number on your health plan ID card and ask to be connected to a representative in our Clinical Services unit.

UnitedHealthcare®