Notice of Utilization Review & Benefit Determination Procedures

We are providing this notice in accordance with state regulatory requirements. Your right to medical benefits is 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 offering you your benefit plan. UnitedHealthcare has several procedures in place for determining benefit coverage as outlined below.

Benefit Determinations

Benefit determinations—administrative 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.

Covered Health Services are paid according to the benefit level as described in the Schedule of Benefits, subject to the terms, conditions, exclusions and limitations as provided in your benefit plan documents. This means we only pay our portion of the cost of Covered Health Services. It also means that not all of the health care services you receive may be paid for (in full or in part) by your benefit plan.

Our 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 is in accordance with the benefit plan offering. In addition, some services may require you to notify UnitedHealthcare, or get approval from UnitedHealthcare, prior to receiving the service, in order to receive benefit coverage.

Clinical Coverage Review

Clinical Coverage Review (CCR) is a review of clinical records to determine benefit coverage for requested services in accordance with applicable 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. Clinical coverage reviews are components of the following processes:

Prospective/Pre-service Review

Prospective or pre-service review is an administrative or clinical review conducted prior to an inpatient admission, stay, other service or course of treatment including outpatient procedures and services. Pre-service review includes eligibility verification and benefit plan interpretation, and may include review of medical necessity and appropriateness of care for making benefit plan determinations regarding inpatient and outpatient services.
**Prior Authorization/Pre-Certification**

Some plans may require you to get approval from UnitedHealthcare prior to receiving certain services. Coverage for these services may only be provided if the service is deemed medically necessary or meets specific requirements as provided in the benefit plan documents. Pre-Certification is a prior assessment that, based on the information provided, 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 promoting delivery of care for facility-based patients 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. They consult with the ICM Medical Director to 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.