Medical Necessity and the member

Member reassurance

- Designed to let members know they are getting quality care at the appropriate place of service
- Designed to reduce variation in care by helping to ensure treatment plans are consistent with evidence-based medicine
- Helps to improve member health outcome limiting exposure to unproven or not medically necessary procedures
- Provides coverage information before services begin
  - Know ahead of time whether or not care is covered
  - Be informed of financial obligation before procedure
- Helps to prevent avoidable hospital re-admissions by managing care transitions

Members' role

- Members only need to request prior authorization if choosing an out-of-network provider*

How does it work?

Prior authorization with Medical Necessity

UnitedHealthcare

Member visits a physician for care and physician recommends a test, procedure or a service that falls within UnitedHealthcare's Prior Authorization "you must call" requirements.

Physician contacts UnitedHealthcare to inform us of the proposed service.

Member is responsible for contacting UnitedHealthcare when they choose out of network services

UnitedHealthcare Clinical Services (UCS) reviews the request to verify the service is medically necessary, and performed at the appropriate place of service.
A determination is rendered.

Physician and member review determination letter and chart out course of care.

Claim is submitted for service rendered.

How is this different from...

UnitedHealthcare's advanced notification process?

Advanced notification determines benefit coverage; Prior authorization also determines whether or not the service is medically necessary.

- Services rendered that were deemed NOT medically necessary during pre-service review are denied, and the provider and member can agree prior to service delivery that the member will pay.