



practice matters

Important information from UnitedHealthcare Community Plan for physicians and other health care professionals and facilities serving Medicaid and Medicare members.

What is Medical Necessity Review

Medical necessity review addresses clinical evidence supporting the use of a health service; its medical appropriateness for a particular patient; and its cost-effectiveness. A treatment is considered medically necessary if it is:

- Performed in accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your condition, disease or its symptoms.
- Not administered mainly for convenience of the member or 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 treatment results.



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In instances where a physician fails to obtain prior authorization approval before administration of the product, the claim will be denied and the member may not be billed for the service, in accordance with Medicaid requirements. UnitedHealthcare's standard appeal process will apply to any denied claims.

We appreciate your participation in the UnitedHealthcare network, and your attention to this new review process. If you have prior authorization questions, please contact your local network manager or call the provider services number on the back of the member's UnitedHealthcare ID card. You may also obtain additional information at UHCommunityPlan.com.

For more information



Call our Provider Service Center
at 888-362-3368



Visit UHCommunityPlan.com

Utilization Review

UnitedHealthcare Community Plan staff performs concurrent review on inpatient stays in acute, rehabilitation and skilled nursing facilities, as well as prior authorization reviews of selected services. A listing of services requiring prior authorization is available in the Provider Manual.

A physician reviews all cases in which the care does not appear to meet guidelines. Decisions regarding coverage are based on the appropriateness of care and service and existence of coverage. The decisions are in no way influenced by financial or incentives of any kind. The treating physician has the right to request a peer-to-peer review with the reviewing physician and to request a copy of the criteria used in the review. The denial letter contains information on how to request materials and how to contact the reviewer. Members, physicians and other health care professionals also have the right to appeal denial decisions.

If you have questions about Utilization Management, call 866-604-3267. Staff is available 24 hours a day, seven days a week. Information on requesting a peer-to-peer review is included in the denial letter

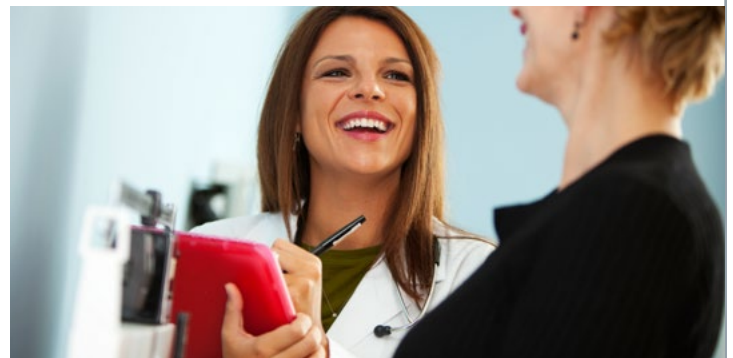
Member Rights and Responsibilities

UnitedHealthcare Community Plan's Member Rights and Responsibilities can be found in the provider manual at UHCCommunityPlan.com. These are distributed to new members upon enrollment and annually.

24-Hour, Seven Day a Week Coverage for PCPs

Federal and state regulations specify that Primary Care Providers (PCP) must be available to members by telephone 24 hours a day, seven days a week, or have arrangements for telephone coverage by another UnitedHealthcare participating PCP. PCPs or their covering practitioner are expected to respond to all after-hours patient calls within 30 minutes.

For questions about 24/7 access, please contact your Provider Advocate. Thank you for the care that you provide to our members.



Clinical Practice Guidelines

Clinical Practice Guidelines are available at UHCCommunityPlan.com. Click on your state and link to the CPGs, or call 866-675-1607 for a copy.



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Practice Matters is a quarterly publication for physicians and other health care professionals and facilities in the UnitedHealthcare network.



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