univera HEALTHCARE

CORPORATE MEDICAL POLICY
Introduction

Purpose:

Medical policies can be highly technical and are designed to be used by our participating health care practitioners in assisting them to understand coverage determinations for our members/subscribers. As a result, we recommend patients utilizing this information review the policies with their practitioner(s) so they may fully understand the policies as they relate to their particular situation. Medical policies are not intended to certify coverage or reimbursement availability; they are statements about a particular technology and/or a blend of administrative and medical appropriateness criteria that assist in clarifying coverage of services based on interpretation of member/subscriber contracts.

The medical policies have been reviewed and approved by the Corporate Medical Policy Committee and supersede any other policies issued by other sources except where changed by contract. Medical policies specifically state whether a service is eligible for coverage (e.g., medically necessary or appropriate); requires specific criteria to be met in order to be eligible for coverage; or is investigational. Medical policies are used as a guide. Coverage decisions are made on a case-by-case basis and in accordance with a member's subscriber contract. Always refer to the member's particular benefit plan to determine if a service may be considered for coverage under that plan and if a specific limitation or exception exists. While a service may be medically appropriate, it may be excluded from a member's subscriber benefit plan. For some technologies, the Health Plan uses InterQual® Clinical Decision Support Criteria to assist in the decision-making process, as noted in the medical policy index. Providers may contact the Customer/Provider Service Department to obtain a copy of the InterQual® criteria when appropriate.

Please note:

Although medical policies are effective on the date they are approved by the Corporate Medical Policy Committee, updates to the claims processing systems may not occur for up to 90 days in order to allow provider billing systems to be updated accordingly. When policy criteria change, the Health Plan's requirements related to medical records may also change. Providers should call Customer Care or check the Health Plan web site for the most up-to-date information on medical record requirements.

Services and procedures that have been reviewed and approved by the Corporate Medical Policy Committee are listed under the **Medical Policies** area of the Health Plan's website, Providers section. Secure access to our website (i.e., a username and password) is needed to review and comment on medical policies. If you do not have a username and password, you can create an account by clicking the "review and comment" link as shown below and following the prompts to create an account.

Make a Comment

We invite practitioners to review & comment on our policies

Once your provider account has been created, you can access medical record requirements at Providers -> Claims & Payments -> Submitting Medical Records -> Procedure Codes that Require Medical Record Submission.

Failure to send in the required medical records with the claim submission could delay claim processing and payment.

Intention for Use:

Medical policies do not constitute medical advice. Treating practitioners are solely responsible for medical advice and for the treatment of members/subscribers. The medical policies listed here represent those currently in use by the Health Plan, which includes the following regions: Central New York Region, Central New York Southern Tier Region, Rochester Region, and Utica Region. Additional policies will be added regularly as they are developed. Medical services are constantly evolving, and we reserve the right to periodically review and update our policies. Although we endeavor to maintain up-to-date medical policies and review policies annually, some recent changes may not yet be incorporated herein. The medical policy version in effect at the time of the rendered service shall apply.

Appeals/Application of Policies:

In the event a member/subscriber or his/her practitioner disagrees with a coverage determination, the Health Plan provides the right to appeal the decision. In addition, a member/subscriber may have an opportunity for an independent external review of coverage denials based on lack of medical necessity or experimental/investigational status. For specific questions about the applicability of a medical policy to a member's/subscriber's unique clinical circumstances, practitioners should send the relevant clinical information (including supporting scientific based literature) to the Health Plan using the contact information listed below.

Phone:	Address for all correspondence:
Providers: 1-866-265-5983 Members/Subscribers: Call toll-free number on identification card.	Univera Healthcare PO Box 211256 Eagan, MN 55121

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