UCare

EssentiaCare
Essentia Health + UCare

Understanding Utilization Management for UCare Medicare and EssentiaCare members

Authorization and notification

One of the ways UCare makes sure you get excellent care is by partnering with your doctors to review certain types of services and procedures. We want you to get care that is best for your needs. Your Summary of Benefits notes which types of care or services require notification or authorization. This list may change from time to time. Some examples include spine surgery and home health care.

Notification: Hospitals are required to notify UCare if you are admitted to a hospital, Long Term Care Facility (LTAC), or Skilled Nursing Facility (SNF). UCare's clinical team will coordinate with your doctors to make sure you get the care you need. If needed, UCare may set up post-hospital care.

Authorization: Before some services will be covered, your provider must get approval from UCare. This is true whether the provider participates in a UCare network or is out-of-network. To make a coverage decision, UCare's clinical team evaluates if the service is medically necessary, appropriate and effective for your need.

Pre-authorization, or preservice review, means that before you get the service, your provider must provide information to UCare and request approval. If pre-approval is required for that service, it will only be covered if the approval was granted.

Urgent concurrent and concurrent review often occurs during a LTAC or SNF stay. UCare will review to see if your care might need to continue longer or if different care is needed.

Post-service review is needed if your doctor didn't request pre-service review. Your claim may have already been denied because authorization is required for coverage. After your doctor requests review, UCare will consider your situation and care plan to make sure you get the coverage you are entitled to as a UCare member. If we deny a request made by you or your doctor for medical services or prescription drugs, you or your doctor may appeal our decision. When you file an appeal, you or your doctor may submit additional documentation that is relevant to your appeal. Appeal requests are reviewed against current medical evidence and your benefit plan by physicians. If we deny your appeal, you will be given information on how to file a second level appeal.

Learn more

Go to **ucare.org** and click on "plan resources." You can also look up services in your Evidence of Coverage and Annual Notice of Changes documents. These documents note if notification and authorization is required. The Evidence of Coverage is provided to new members. Every renewal year, members receive an Annual Notice of Changes that explains any changes to their plan benefits.