Overview
Providing access to medically necessary care while improving cost efficiencies for the overall health care system is critical as we work toward achieving the Triple Aim to improve care experiences, health outcomes and total cost of care for UnitedHealthcare members.

In support of that work, for dates of service on or after May 2, 2016, we will expand site of service-based prior authorization guidelines to include UnitedHealthcare Community Plan Medicaid members in a number of states, excluding Medicare Dual Special Needs Plans (DSNPs) and Medicare Medicaid Plans (MMPs). Additionally, for dates of service on or after May 2, we are also adding some tonsillectomy, adenoidectomy and gynecology codes.

Under these guidelines, prior authorization is required to perform certain surgical procedures in an outpatient hospital setting. However, no prior authorization is necessary if they are performed at an ambulatory surgery center. Coverage determinations take into consideration the availability of a participating network facility, specialty requirements, physician privileges and whether a patient has an individual need for access to more intensive services.

As a reminder, site of service prior authorization reviews are already in place for certain surgical procedures to be performed in an outpatient hospital setting in most states for members of the following UnitedHealthcare Commercial plans, including Exchange plans:

- Golden Rule Insurance Company (group 902667)
- Mid-AtlanticMD Healthplan Individual Practice Association, Inc. (M.D. IPA) or Optimum Choice, Inc. plans
- Neighborhood Health Partnership
- UnitedHealthcare of the River Valley
- UnitedHealthcare Oxford*
- UnitedHealthcare
- UnitedHealthcare Life Insurance Company (group 755870)

*UnitedHealthcare Oxford previously required prior authorization for these procedures when provided in a setting other than a physician’s office. The site of service will now be reviewed for medical necessity as part of that prior authorization review process before these procedures can be performed in an outpatient hospital setting.

We are expanding the site of service prior authorization requirement to apply to Medicaid members enrolled in UnitedHealthcare Community Plan, excluding Medicare Dual Special Needs Plans (DSNPs) and Medicare Medicaid Plans (MMPs), in the following states, effective May 2, 2016, unless otherwise noted:

- Arizona
- New Mexico (effective July 1, 2016)
- New York
- Rhode Island
- Tennessee
- Washington

To align with site of service guidelines that are already in place for many of our commercial plans, these UnitedHealthcare Community Plans will require physicians to submit prior authorization requests to perform the following procedures in an outpatient hospital setting:

Doc#: PCA-2-000413-12102015-01272016
At the same time, these codes will be added to the list of procedures requiring site of service-based prior authorization for all included UnitedHealthcare commercial plans and UnitedHealthcare Community Plans:

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<thead>
<tr>
<th>Procedures</th>
<th>CPT Codes</th>
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<tbody>
<tr>
<td>Abdominal Paracentesis</td>
<td>49083</td>
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<tr>
<td>Carpal Tunnel</td>
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<tr>
<td>Cataract</td>
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<tr>
<td>Hernia Repair</td>
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<td>Liver Biopsy</td>
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<td>Tonsillectomy &amp; Adenoidectomy</td>
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<tr>
<td>Upper &amp; Lower Gastrointestinal Endoscopy</td>
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<td>Urologic</td>
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<tr>
<td>Gynecology</td>
<td>57522, 58555, 58353, 58558, 58563</td>
</tr>
<tr>
<td>Tonsillectomy &amp; adenoidectomy</td>
<td>42820, 42825, 42830</td>
</tr>
</tbody>
</table>

All the codes noted above will require physicians to request prior authorization if they are to be covered in an outpatient hospital setting for all in-scope UnitedHealthcare commercial and UnitedHealthcare Community Plan members for dates of service on or after May 2, 2016, in most states. For UnitedHealthcare commercial plans in Illinois and for UnitedHealthcare Community Plan in New Mexico, the requirement applies for dates of service on or after July 1, 2016.

If prior authorization is not obtained before performing a procedure in an outpatient hospital, claims will be denied, and the member cannot be billed for the service. If prior authorization is denied due to lack of medical necessity, members can be billed for the service to be performed in an outpatient hospital setting if the physician obtains adequate written consent from the member per our protocols and applicable state laws.

For more information, go to the Administrative Guide at UnitedHealthcareOnline.com > Tools & Resources > Policies, Protocols and Guides > Administrative Guides. Medicaid requirements may vary in accordance with applicable state law. For UnitedHealthcare Community Plan, please comply with the plan-specific requirements outlined at UHCCommunityPlan.com > For Health Care Professionals. Select your state from the list to access information about plan-specific requirements.

When making coverage determinations related to site of service, we consider factors such as the availability of a participating facility, specialty requirements, physician privileges and whether a member has an individual need for access to more intensive services. We encourage you to familiarize yourself with network ambulatory surgery centers in your area and obtain privileges to perform procedures in those centers if you do not already have them.

Please reference the following answers to frequently asked questions to learn more.
Q1. Why did UnitedHealthcare choose these particular procedures?
A. We conducted careful clinical reviews to determine which procedures are clinically appropriate to be performed at a network ambulatory surgery center for most members, taking into consideration the Medicaid requirements for our Medicaid members as well as the terms of our members’ benefit plans and significant out-of-pocket costs to UnitedHealthcare commercial members when these procedures are done in a hospital setting.

Q2. What happens if one of these procedures is already scheduled to be performed in an outpatient hospital setting after the effective date?
A. If one of these procedures is scheduled to be performed on or after the effective date, you will need to request prior authorization. In some cases, this may mean you and your patient decide to move a procedure to a participating ambulatory surgery center to align with the coverage determination. Our review process will take into account the terms of the member’s benefit plan, the availability of a participating facility, specialty requirements, physician privileges and whether a patient has an individual need for access to more intensive services. For Medicaid members, our review will take into account applicable Medicaid requirements. We are committed to making this transition as smooth as possible for physicians and their patients who are UnitedHealthcare members.

Q5. How can I find participating ambulatory surgery centers in my area?
For UnitedHealthcare commercial plans, participating ambulatory surgery centers can be found in the UnitedHealthcare Physician Directory at UnitedHealthcareOnline.com > Physician Directory > General Physician Directory:
• When you click on the link, a new tab will open in your browser.
• Select the applicable health plan.
• You will then see a variety of search options. Look for the “Ambulatory Surgicenter” link under “Search by Facility Type.”

For UnitedHealthcare Community Plan, you can locate network ambulatory surgery centers using the “Find a Doctor” tool, available on UHCCommunityPlan.com:
• Go To UHCCommunityPlan.com and enter your zip code or select your state from the drop-down menu on the home page.
• Find the applicable plan, and click the “Doctor Lookup” button in that section. The “Find a Doctor” tool will open in a new tab on your browser. (Care providers in New York may have to navigate through a subsequent page and select the “Find a Doc for NY” link to access the “Find a Doctor” tool.)
• The column on the left offers the option to search for facilities. Under “Type of Facility,” select “All Facilities.”
• For some plans, a drop-down menu will offer the option to choose specialty; if so, choose “ambulatory surgery center.” For plans where there is not a drop-down menu option, you can still narrow your search by typing, “surg” into the facility name search box.
• Click on “Find Facility.” Search results will indicate if a facility is an ambulatory surgery center.

For assistance locating a participating ambulatory surgery center, you can also contact UnitedHealthcare Network Management or the phone number on the back of the member’s UnitedHealthcare member identification card. Additionally, when you submit a request for prior authorization, we will determine whether a network ambulatory surgical center is available within a reasonable service area and provide that information.

Q6. How can I request prior authorization for these procedures to be performed in an outpatient hospital site of service?
A. Prior authorization requests can be submitted in a number of ways:
Many of our plans offer a convenient online option available at UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Notification/Prior Authorizations Submission. The automated process will guide you through a series of questions, and review time may be faster.

For UnitedHealthcare Community Plan, call 866-604-3267 or go to UHCCommunityPlan.com > For Health Care Professionals and select your state to access other plan-specific options.

Call the Provider Services number on the back of your patient’s UnitedHealthcare member identification card.

We are committed to timely reviews and complying with applicable regulatory response timeframes. Coverage determinations reflect only whether or not a service is covered under the provisions of the member’s benefit plan and are not intended to replace treatment decisions made by physicians and their patients.

Q7. What information is considered as part of the prior authorization review?
A. Our prior authorization process, including the site of service reviews conducted as part of that process, is based on the terms of the member’s benefit plan or applicable state Medicaid requirements. It is patient-centered and takes into account various factors in determining whether a procedure can safely and effectively be performed in a more cost-effective setting on an individual basis. Such factors may include availability of a participating facility, specialty requirements, physician privileges and a patient’s need for access to more intensive service. Please submit any information you would like us to consider when requesting prior authorization.

Q8. What happens if the nearest in-network ambulatory surgery center is a long distance for the patient to travel or does not have the equipment or resources for the planned procedure?
A. We realize there may be instances when a UnitedHealthcare member does not have geographic access to a participating ambulatory surgery center that has the necessary resources to provide the care they need. In such cases, the procedure will be authorized at a network outpatient hospital.

Q9. What if a patient has co-morbid medical conditions that may pose increased risks if a procedure is performed at an ambulatory surgery center?
A. We recognize that some patients require more complex care or may not meet facility requirements to receive care in an ambulatory surgery center. Our prior authorization process, including site of service reviews that are conducted as part of that process, is based on the terms of the member’s benefit plan or applicable state Medicaid requirements. It is patient-centered and evaluates which site of service is medically necessary for the patient’s individual needs. We will consider any information that may indicate the immediate need for procedures to be performed at an outpatient hospital setting.

Q10. What if I do not have privileges at a participating ambulatory surgery center?
A. If you do not have privileges at a participating ambulatory surgery center, please provide that information when requesting prior authorization. At this time, we will not deny coverage at an outpatient hospital if you do not have privileges at a network ambulatory surgery center, but as with all requirements, we will continue to evaluate and make adjustments to the requirements, as appropriate. We strongly recommend that you obtain ambulatory surgery center privileges, if you do not already have them.

Q11. How will this review process affect decisions made between a physician and patient?
A. We support informed patient choice and respect that care decisions are always between a patient and their physician. We will work with you to identify the most medically appropriate, cost-effective place of service. We will make coverage determinations based on the language in the member’s benefit plan or applicable state Medicaid requirements and will consider various factors, including the availability of a participating ambulatory surgery center, physician privileges, specialty requirements and whether the
member has a need for more intensive services. Please submit such information to us with your prior authorization request.

**Q12. What effect do these requirements have on a patient’s insurance coverage?**
A. The terms of our member plans and applicable state Medicaid requirements require services and sites of service to be medically necessary and cost-effective. As such, an outpatient hospital site of service determined to be medically necessary and cost-effective is covered. An outpatient hospital site of service determined not to be medically necessary is not covered, and the member cannot be billed for the service if performed in an outpatient hospital setting unless you obtain appropriate written consent from the member in accordance with our protocols. If you do not complete the prior authorization process before performing a procedure at an outpatient hospital setting, claims will be denied, and the member cannot be billed for the service.

**Q13. Can a member opt to have a procedure at an outpatient hospital even if prior authorization for that site of service is denied?**
A. Yes. If the outpatient hospital site of service is denied for lack of medical necessity, the member may consent in writing to having the procedure performed at the outpatient hospital, and the member can be billed for the service. In these cases, you must obtain written consent from the member per our protocols and follow any applicable state Medicaid requirements. You cannot, however, bill the member for claims that are denied due to failure to request and obtain prior authorization.

**Q14. If I have privileges at both a hospital and a participating ambulatory surgery center, will my request for prior authorization at an outpatient hospital site of service be denied?**
A. If after conducting the site of service review as part of the prior authorization process, the outpatient hospital site of service is determined not be medically necessary, the request for the outpatient hospital site of service would be denied.

**Q15. How far in advance of the date of service must prior authorization requests be made?**
A. For UnitedHealthcare commercial plans, advance notification, with supporting clinical documentation, should be submitted at least five business days prior to the planned service date (unless otherwise specified with the Advance Notification List) to allow enough time for coverage review. Expedited reviews are only available in situations in which a delay in treatment could seriously jeopardize the patient’s life, health or ability to regain maximum function, or when, in the opinion of a physician with knowledge of the patient’s medical condition, could cause severe pain. You must explain the clinical urgency when requesting an expedited review.

For Medicaid plans, advanced notice requirements may vary in accordance with applicable state law. For UnitedHealthcare Community Plan, physicians should comply with the plan-specific advance notification requirements outlined at UHCCommunityPlan.com > For Health Care Professionals. Select your state from the list to access information about the applicable plan.

If you have any questions, please contact your local Network Management representative or call the customer service phone number on the back of the member’s health care identification card. Thank you.

Insurance coverage provided by or through UnitedHealthcare Insurance Company, All Savers Insurance Company or its affiliates. Health plan coverage provided by UnitedHealthcare of Arizona, Inc., UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Colorado, Inc., UnitedHealthcare of Texas, Inc. and UnitedHealthcare of Utah, Inc. or other affiliates. Administrative services provided by United HealthCare Services, Inc. OptumRx, OptumHealth Care Solutions, Inc. or its affiliates. Behavioral health products are provided by U.S. Behavioral Health Plan, California (USBHPC), United Behavioral Health (UBH) or its affiliates.