Prior Authorization Requirement for Certain Surgical Procedures

Overview
As we continue to work toward the Triple Aim of better care, better health and lower costs for UnitedHealthcare members, we are expanding our prior authorization requirement for certain surgical procedures to be covered in an outpatient hospital setting to include the following procedures, effective for dates of service on or after Oct. 1, 2016 in most states. In Illinois, the effective date is Dec. 1, 2016.

<table>
<thead>
<tr>
<th>Cardiovascular</th>
<th>36561</th>
<th>36590</th>
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<tbody>
<tr>
<td>Cosmetic and Reconstructive</td>
<td>13101</td>
<td>13132</td>
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<td>14301</td>
<td>21552</td>
</tr>
<tr>
<td>Ear, Nose and Throat</td>
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<td>30140</td>
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<td>69631</td>
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<tr>
<td>Hernia</td>
<td>49505</td>
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<tr>
<td>Miscellaneous</td>
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<td>Ophthalmology</td>
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<td>65730</td>
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<tr>
<td>Urology</td>
<td>54161</td>
<td>55040</td>
</tr>
</tbody>
</table>

Important clarification: In previous communications about this requirement, CPT code 66180 was included. Prior authorization will not be required for CPT code 66180.

Effective Oct. 1, 2016, we are also expanding this requirement to UnitedHealthcare Community Plan Medicaid members in Delaware, to include the full list of codes already in scope for this prior authorization requirement as well as these additional procedures.

When you request prior authorization for these procedures, we will work with care providers based on the terms of the member’s benefit plan to determine whether the site of service is medically necessary or if the procedure may safely and effectively be performed in a more cost-effective setting, such as an ambulatory surgery center. Coverage determinations take into account the availability of a participating facility, specialty requirements, physician privileges and whether a member has individual needs that require more intensive services.

You do not need to request prior authorization to perform these procedures in a network ambulatory surgery center unless the patient is a member of a health plan that already requires it to evaluate the medical necessity of the procedure in any setting.

As a reminder, many UnitedHealthcare plans already require physicians to request prior authorization to perform certain surgical procedures in an outpatient hospital setting in most states. The requirement applies to 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)

*Neighborhood Health Partnership, UnitedHealthcare Oxford and UnitedHealthcare of the River Valley plans require prior authorization requests to evaluate medical necessity for procedures provided in any setting other than a physician’s office. Site of service will now be reviewed as part the existing prior authorization review process for these procedures to be performed in an outpatient hospital setting.
The requirement also applies to Medicaid members enrolled in UnitedHealthcare Community Plan, excluding Medicare Dual Special Needs Plans (DSNPs) and Medicare Medicaid Plans (MMPs), in the following states:

- Arizona
- Maryland
- New Mexico
- New York
- Pennsylvania
- Rhode Island
- Tennessee
- Washington

Effective Oct. 1, 2016, we will also implement this requirement for UnitedHealthcare Community Plan in Delaware to include the full list of codes that currently in scope for this requirement, as outlined below, as well as the procedure codes being added at this time.

The following procedures already require site of service medical necessity reviews to be performed in an outpatient hospital setting:

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal Paracentesis</td>
<td>49083</td>
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<tr>
<td>Carpal Tunnel</td>
<td>64721</td>
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<tr>
<td>Cataract</td>
<td>66821, 66982, 66984</td>
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<tr>
<td>Gynecology</td>
<td>57522, 58353, 58558, 58563</td>
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<td>Hernia Repair</td>
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<td>Liver Biopsy</td>
<td>47000</td>
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<tr>
<td>Tonsillectomy &amp; Adenoidectomy</td>
<td>42820, 42821, 42825, 42830, 42826</td>
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<tr>
<td>Upper &amp; Lower Gastrointestinal Endoscopy</td>
<td>43235, 43239, 43249, 45380, 45384, 45385, 45378</td>
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<tr>
<td>Urology</td>
<td>50590, 52000, 52005, 52204, 52224, 52234, 52235, 52260, 52281, 52310, 52332, 52351, 52352, 52353, 52356, 57288</td>
</tr>
</tbody>
</table>

Site of service medical necessity reviews are part of our prior authorization process that supports member benefit plans and state Medicaid guidelines requiring care to be medically necessary as well as cost-effective. Ambulatory surgery centers frequently offer significant cost savings compared with a hospital setting, which can help many of our members save on out-of-pocket costs. Ambulatory surgery centers may provide more convenient care experiences for patients, as well.

As health care continues to evolve and consumers increasingly demand a wider range of quality, cost effective options for their health care services, we anticipate a continued focus on place of service. We encourage you to review network ambulatory surgery centers in your area and obtain privileges with those centers that best meet your needs and your patients’ needs.

Standard prior authorization processes and protocols apply. If you do not notify us or complete the prior authorization process before performing a service that is subject to notification/prior authorization requirements, 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.

Please reference the following answers to frequently asked questions to learn more about these requirements.
Frequently Asked Questions

Q1. Why did UnitedHealthcare choose these procedures for site of service reviews?
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. We took into consideration the terms of our members’ benefit plans, and any applicable state Medicaid guidelines, that require care to be medically necessary, including cost-effective. We also considered the patient care experience and significant out-of-pocket costs to UnitedHealthcare commercial members when these procedures are done in a hospital setting.

Q2. What information is considered as part of the site of service medical necessity review?
A. Clinical reviews evaluate the availability of a participating facility, specialty requirements, physician privileges and whether a member has individual needs that require more intensive services. Please provide any information you would like for us to consider at the time you submit your prior authorization request.

Q3. What happens if one of these procedures is already scheduled to be performed in an outpatient hospital setting after the effective date?
A. We are committed to working with physicians to make this transition smooth for their practice and their patients who are UnitedHealthcare members. 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.

Q4. How can I find participating ambulatory surgery centers in my area?
A. 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:
   • Go to UnitedHealthcareOnline.com > Physician Directory > Medicaid and other State Programs Physician Directory.
   • The “Find a Doctor” tool will open in a new window on your browser. 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.

You can also contact UnitedHealthcare Network Management or the phone number on the back of the patient’s UnitedHealthcare member identification card for assistance. 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.
Q5. 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.

Q6. 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 medical necessity review process is patient-centered and evaluates individual patient needs in conjunction with their benefit plans and applicable, state Medicaid guidelines. Our reviews consider and encourage your submission of any information that may indicate a need for procedures to be performed at an outpatient hospital setting.

Q7. What if I do not have privileges at a participating ambulatory surgery center?
A. If you do not have privileges at a network 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. As with all requirements, we will continue to evaluate and make adjustments as appropriate. We strongly recommend that you obtain ambulatory surgery center privileges if you do not already have them. As health care continues to evolve and members increasingly ask for a wider range of options for their health care services, we anticipate a continued focus on place of service as part of our clinical review process.

Q8. What effect do these requirements have on a patient’s insurance coverage and payments?
A. Site of service medical necessity review requirements align with our member benefit plan requirements and applicable state Medicaid guidelines related to medically appropriate and cost-effective care. If an outpatient hospital site of service is determined to be medically necessary and cost-effective, it will be covered. If coverage is denied based on our review, the member cannot be billed for the service 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.

Q9. 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. Coverage determinations are patient-centered and take into account any information you submit that might indicate a patient has a clinical need for services in an outpatient hospital setting. If, based on the information provided, it is determined that the outpatient hospital site of service is not medically necessary, the request for the procedure to be covered in that setting would be denied.

Q10. Do these requirements apply to colonoscopy procedures that are preventive?
A. You are not required to request prior authorization for preventive colonoscopies. This includes preventive colonoscopy services that turn into diagnostic procedures upon performing the surgery.

If you have additional 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.