INSTRUCTIONS FOR USE

This Utilization Review Guideline provides assistance in interpreting UnitedHealthcare benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced. The terms of the federal, state or contractual requirements for benefit plan coverage may differ greatly from the standard benefit plan upon which this Utilization Review Guideline is based. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage supersedes this Utilization Review Guideline. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the contractual requirements for benefit plan coverage prior to use of this Utilization Review Guideline. Other Policies and Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary. This Utilization Review Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The MCG™ Care Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

BENEFIT CONSIDERATIONS

Before using this guideline, please check the federal, state or contractual requirements for benefit coverage.

UTILIZATION MANAGEMENT GUIDING PRINCIPLES

Introduction

In an effort to minimize out-of-pocket costs for UnitedHealthcare members and to improve cost efficiencies for the overall health care system, we are implementing prior authorization guidelines that aim to encourage more cost-effective sites of service for certain outpatient surgical procedures, when medically appropriate.

These prior authorization requirements apply to UnitedHealthcare Medicaid plans that require services to be medically necessary, including being cost-effective.

COVERAGE RATIONALE

With the exception of the qualifying conditions below, certain elective procedures should be performed in an Ambulatory Surgical Center (ASC).

The following will be taken into account to determine whether the elective procedure is being performed in a cost-effective setting:

- State Medicaid contract
- Any federal or state requirements
- Geographic availability of an in network provider
- Ambulatory surgical care (ASC) capability

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Site of Service Guidelines for Certain Outpatient Surgical Procedures

UnitedHealthcare Community Plan Utilization Review Guideline

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• Physician privileging
• Significant member comorbidities (see list of example Qualifying Conditions below)
• American Society of Anesthesiologist (ASA) physical status (PS), classification system

Potential Documentation Requirements
• Physician office notes
• Physician privileging
• ASA score

Elective Procedures List
Prior authorization may be required for the following procedures if performed in an outpatient hospital setting:
• Carpal tunnel surgery
• Cataract surgery and other ophthalmologic procedures
• Cosmetic and reconstructive
• Gynecologic procedures
• Hernia repair
• Liver biopsy
• Tonsillectomy, adenectomy and other ENT procedures
• Upper & lower gastrointestinal endoscopy
• Urologic procedures

Specific procedure codes for services can be found on the UnitedHealthcare Community Plan Prior Authorization List.

Certain Qualifying Conditions
Some patients may require more complex care due to factors such as age or medical conditions. Also, some ASCs may have specific guidelines that prohibit members who are above a certain weight or have certain health conditions from receiving care in those facilities.

Patients with severe systemic disease and some functional limitation (ASA PS classification III or higher) may be appropriate to have the procedure in an outpatient hospital setting (not an all-inclusive list):
• Morbid obesity (>BMI.40)
• Diabetes (Brittle Diabetes)
• Resistant hypertension (Poorly Controlled)
• Chronic Obstructive Pulmonary Disease (COPD) (FEV1 < 50%)
• Advance liver disease (MELD Score > 8)
• Alcohol dependence (at risk for withdrawal syndrome)
• End stage renal disease (Hyperkalemia (above reference range peritoneal or hemodialysis)
• Uncompensated Chronic Heart Failure (CHF) (NYHA class III or IV)
• History of Myocardial Infarction (MI) (recent event (< 3 mo.))
• History of Cerebrovascular Accident (CVA) or Transient Ischemic Attack (TIA) (recent event (< 3 mo.))
• Coronary artery disease (CAD/Peripheral vascular disease (PVD) (ongoing cardiac ischemia requiring medical management recently placed drug eluting stent (within 1 year))
• Sleep Apnea (moderate to severe Obstructive Sleep Apnea (OSA))
• Implanted pacemaker
• Personal history or family history of complication of anesthesia such as malignant hyperthermia
• Pregnancy
• Bleeding disorder requiring replacement factor or blood products or special infusion products to correct a coagulation defect (DDAVP is not blood product and is OK)
• Prolonged surgery (>3 hrs.)
• Anticipated need for transfusion
• Recent history of drug abuse (especially cocaine)
• Patients with Drug Eluting Stents (DES) placed within one year or bare metal stents (BMS) or plain angioplasty within 90 days unless Acetylsalicylic Acid (ASA) and antiplatelet drugs will be continued by agreement of surgeon, cardiologist and anesthesia
• Ongoing evidence of myocardial ischemia
• Poorly controlled asthma (FEV1 < 80% despite medical management)
• Significant valvular heart disease
• Cardiac arrhythmia (symptomatic arrhythmia despite medication)
DEFINITIONS

Please check the definitions within the member benefit plan document that supersede the definitions below.

ASA Physical Status Classification System Risk Scoring Tool: While anesthesia providers use this scale to indicate one's overall physical health or "sickness" preoperatively, it is regarded by hospitals, law firms, accrediting boards and other healthcare groups as a scale to predict risk and thus decide if a patient should have – or should have had – an operation. To predict operative risk, age and obesity, the nature and severity of the operative procedure, selection of anesthetic techniques, the competency of the surgical team (surgeon, anesthesia providers and assisting staff), duration of surgery or anesthesia, availability of equipment, medicine, blood, implants and especially the level of post-operative care etc. are often far more important than multiple ASA classification.

Brittle Diabetes: Diabetes that is difficult to control due to symptoms such as (1) predominant hyperglycemia with recurrent ketoacidosis, (2) predominant hypoglycemia, and (3) mixed hyper- and hypoglycemia.

Obstructive Sleep Apnea (OSA): Severity is defined as:
- Moderate for AHI or RDI ≥ 15 and ≤ 30
- Severe for AHI or RDI > 30/hr

Poorly Controlled: Requiring three or more drugs to control blood pressure.

REFERENCES


ASA Physical Status Classification System.


GUIDELINE HISTORY/REVISION INFORMATION

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