Overview

With care experiences and out-of-pocket costs for UnitedHealthcare members in mind, we require notification/prior authorization for certain procedures to be covered in settings other than a physician’s office. These requirements are already in place for UnitedHealthcare commercial plan members in most states. **Starting April 1, 2018, care providers in Indiana and New Jersey are also subject to these requirements.**

While notification/prior authorization isn’t required for these procedures to be covered in a physician’s office, notification must be provided if the procedure is performed in a physician’s office and there is an accompanying facility charge.

In many cases, a physician’s office is medically appropriate and may offer more convenient care experiences as well as savings on out-of-pocket costs compared with other sites of service.

If you bill for a site of service without completing the notification/prior authorization process, claims will be denied. Members can’t be billed for services that are denied due to failure to comply with notification/prior authorization requirements.

Site of service medical necessity reviews are part of our prior authorization process that supports member benefit plans requiring care to be medically necessary, including cost-effective.

Key Points

For many UnitedHealthcare commercial plan members, we require notification/prior authorization for certain procedures to be covered in settings other than a physician’s office.

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Frequently Asked Questions

What procedure codes require notification/prior authorization to be covered in settings other than a physician’s office?

The following procedure codes require notification/prior authorization to be covered in a setting other than a physician’s office.

<table>
<thead>
<tr>
<th>Category</th>
<th>CPT Code</th>
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<tbody>
<tr>
<td>Dermatologic</td>
<td>11402, 11403, 11406, 11422, 11426</td>
</tr>
<tr>
<td>General Surgery</td>
<td>19000</td>
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<tr>
<td>Muscular/Skeletal</td>
<td>27096, 64479, 64483, 64490, 64493</td>
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<tr>
<td>Neurologic</td>
<td>62270, 62321, 62323, 64633, 64635</td>
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<tr>
<td>Obstetrics/Gynecology</td>
<td>57460</td>
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<tr>
<td>Respiratory</td>
<td>31579</td>
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Which UnitedHealthcare plans are included in this requirement?

The requirement applies to the following UnitedHealthcare Commercial plans in states where we conduct site of service medical necessity reviews:

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

*UnitedHealthcare Oxford plans already require prior authorization requests for certain procedures to evaluate whether it’s medically necessary for the procedure to be provided in a setting other than a physician’s office. Site of service will now be reviewed as part the existing process for these procedures.

Why did UnitedHealthcare choose these procedures for this requirement?

We conducted careful clinical reviews to determine which procedures are medically appropriate to be performed at a physician’s office for most patients. We took into consideration the terms of our members’ benefit plans and out-of-pocket costs to our members when these procedures are done in a hospital or ambulatory surgery center.
How will the notification/prior authorization process work for these procedures?
The standard process applies. When we receive notification, we'll determine if the member’s benefit plan requires covered services to be medically necessary. If so, we’ll evaluate the medical necessity of the sites of service as part of our prior authorization process. Coverage determinations will take into account whether the patient has a need for more intensive services and whether the office has the equipment necessary to deliver the service.

What should care providers in Indiana or New Jersey do if one of these procedures has already been scheduled for an outpatient hospital or ambulatory surgery setting after the effective date of the requirement?
If one of these procedures is already scheduled to be performed on or after the effective date of the requirement, you'll need to complete the notification/prior authorization process. In some cases, this may mean you and your patient decide to move procedures to the physician’s office to align with the coverage determination.

What information will be considered as part of the prior authorization review?
Reviews will take into account various factors, including the terms of the member’s benefit plan, whether the patient has a need for access to more intensive services, and whether the site of service is equipped to deliver the service. Please submit any information you would like us to consider.

What if a patient has medical conditions that may increase risks if a procedure is performed at a physician’s office?
We recognize some patients require more complex care due to factors such as age or medical conditions, and that some physicians’ offices may not be equipped to manage risks for patients who are above a certain weight or have certain health conditions. We'll consider any information you submit that may indicate the patient has a need for access to more intensive services.

How will this review process affect decisions made between a physician and patient?
We support informed patient choice and respect that care decisions are always between a patient and their physician. Coverage determinations reflect only whether a service is covered under the provisions of the benefit plan and aren’t intended to replace treatment decisions made by physicians and their patients.

What effect will these requirements have on my patient’s benefit coverage?
If a site of service is determined not to be medically necessary, the procedure won’t be covered in that site of service. The member can’t be billed for the service without appropriate written consent prior to the procedure, in accordance with our protocols. If you do not follow the notification/prior authorization process, claims will be denied, and the member cannot be billed for the service.
Can a member opt to have a procedure at an outpatient hospital or ambulatory surgery center even if prior authorization for that site of service is denied?

Yes. If prior authorization is denied because the site of service isn’t medically necessary, the member may consent in writing to be billed for the procedure at that site of service. In these cases, you must obtain written consent from the patient prior to rendering the service, in accordance with our protocols. Members can’t be billed for claims that are denied due to failure to complete the notification/prior authorization process.

Who do I contact if I have questions?

Please contact your local Network Management representative or call the phone number on the back of the member’s health plan ID card with questions.