Medicare Advantage: Prior authorization and site of service expansion for surgical procedures

Overview

We're expanding the surgical procedures requiring prior authorization and site of service medical necessity reviews for UnitedHealthcare® Medicare Advantage plans. The changes will be effective for dates of service on or after May 1, 2022.

You can access the full list of expanded Current Procedural Terminology (CPT®) codes at **Medicare and DSNP: Prior authorization and site of service expansion.** The requirement doesn't apply to the following states: Alaska, Hawaii, Kentucky, Massachusetts, Utah and Wisconsin.

Most procedures only require prior authorization or notification if performed in an outpatient hospital setting. For procedures that are already subject to notification or prior authorization requirements, we'll continue to review them to determine medical necessity of the service and site.

Key points

- This change affects members with UnitedHealthcare Medicare Advantage plans and goes into effect for dates of service on or after May 1, 2022
- The information can be accessed at the **Medicare and DSNP: Prior authorization and site of service expansion**

Frequently asked questions

Why are you making these changes?

Our newly expanded prior authorization requirement and site of service medical necessity reviews help minimize out-of-pocket costs for our members. We believe these changes will help improve cost efficiencies and access to safe, quality care.

How did you choose these surgical procedures?

We conducted careful reviews to determine which procedures are safe and effective when not performed in outpatient hospital settings. We also considered the terms of our members' plans.

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Which Medicare Advantage plans are affected, and which are not affected?

The expanded prior authorization and notification requirements and site of service medical necessity reviews will apply to all our Medicare Advantage plans, except for the following:

- Medicare Advantage Private Fee-for-Service (PFFS) plans
- Medicare Advantage Senior Care Options (SCO) plans

How will the review process affect decisions between a physician and their patients?

We support informed patient choices and respect the care decisions made between health care professionals and our members. Our determinations reflect whether a service is medically necessary under a member's plan and don't replace treatment decisions.

What criteria will you use for site of service medical necessity reviews?

To make these determinations, we'll use the criteria in our **Hospital Services (Inpatient and Outpatient) – Medicare Advantage Coverage Summary.** In the Table of Contents, select **Outpatient Surgical Procedures – Site of Service.** For coverage summaries, visit **UnitedHealthcare Medicare Advantage Coverage Summaries.**

Prior authorization and notification

How do I provide notification or request prior authorization?

The process for completing the notification/prior authorization request and time frames remains the same. You can complete the prior authorization and notification process or confirm a coverage decision as follows:

- **Online:** Go to **UHCprovider.com/paan**
- **Phone:** Call **877–842–3210** from 7 a.m.–7 p.m. local time, Monday–Friday

What if I don't complete the prior authorization or notification process before the procedure is rendered?

In this case, we may deny the claims and you can't bill the member for the service.

Site of service medical necessity reviews

Will site of service medical necessity reviews take place in all states?

No. Site of service medical necessity reviews will not take place in the following states at this time: Alaska, Hawaii, Kentucky, Massachusetts, Utah and Wisconsin. We'll inform you if we expand site of service medical necessity reviews to these states.

How can I find in-network ambulatory surgical centers in my area?

- Visit our **Provider Directory**
- Visit our **Contact information for providers** page to see each state's Network Management contact information
- Call the phone number on the back of a member's ID card

As part of our site of service medical necessity review, we'll also determine whether an in-network ambulatory surgical center is available within a reasonable distance.

Can I bill a member if the site of service is denied for lack of medical necessity?

You can bill the member if we determine that a site of service isn't medically necessary and the member gives their written consent. Their consent must be consistent with our protocols and given before a service is performed.

We're unable to approve a claim if we receive a prior authorization request for a procedure to take place in an ambulatory surgical center, but the procedure is actually performed in an outpatient hospital. We consider this a lack of authorization for site of service and you can't bill the member.

Will you approve my request if I don't use an ambulatory surgical center?

We'll only approve the outpatient hospital site of service if it satisfies the utilization review guidelines for an outpatient hospital site. If it doesn't, we won't provide the authorization for coverage for the outpatient hospital location. You aren't required to complete the prior authorization process for any surgical procedures performed in an emergency room, urgent care center or observation unit, or during an inpatient stay.

Example scenarios

What if a procedure was already scheduled after the start of the site of service medical necessity reviews?

You don't need to take additional action if you complete the prior authorization or notification process for the procedure before the effective date.

What if a patient has medical conditions requiring the use of an outpatient hospital site?

We understand some patients need more complex care due to factors such as age or medical conditions. We'll review site of service medical necessity using the member's clinical information you submit.

We'll use a utilization review guideline to facilitate our site of service medical necessity reviews. The **Hospital Services (Inpatient and Outpatient) – Medicare Advantage Coverage Summary** includes information on medical conditions that might make an outpatient hospital site medically necessary.

What if the nearest in-network ambulatory surgical center is far from where the member lives or doesn't have the equipment or resources for the planned procedure?

In these cases, we'll authorize the procedure at an in-network outpatient hospital site in accordance with the terms of our **Hospital Services (Inpatient and Outpatient) – Medicare Advantage Coverage Summary.**

What if I don't have privileges at an in-network ambulatory surgical center?

You should provide this information during the prior authorization process. At this time, we won't deny coverage at an outpatient hospital if you don't have privileges at a network ambulatory surgical center. As with all requirements, we'll continue to evaluate and make adjustments as appropriate.

As health care continues to evolve and members have an increasing need for a wider range of quality, cost-effective options for their health care services, we anticipate a continued focus on site of service. We encourage you to review in-network ambulatory surgical centers in your area and obtain privileges with those centers that best meet your needs and the needs of your patients.

Questions?

Please call Provider Services at **877-842-3210**

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