UnitedHealthcare Medicare Advantage notification/prior authorization requirements and site of service medical necessity reviews for certain surgical procedures – Effective Jan. 1, 2021

Frequently asked questions

Overview

We've been focused on helping to work toward achieving better health outcomes, improving patient experience and lowering the cost of care. To continue this important work, we're expanding our notification/prior authorization requirements to include the procedures/CPT® codes listed **here**. This will go into effect **for dates of service on or after Jan. 1. 2021**, for most states, and for dates of service on or after **June 1, 2021**, for Arizona, Colorado, Connecticut, Florida, New Jersey, Nevada, New York and Texas. This change affects our **UnitedHealthcare Medicare Advantage plans**. The following states are currently excluded from this requirement: Alaska, Kentucky, Massachusetts, Utah and Wisconsin.

We'll only require notification/prior authorization if these procedures/CPT codes will be performed in an outpatient hospital setting.

Important details

- We conduct medical necessity reviews under the terms of the member's benefit plan, which requires services to be medically necessary, including cost-effective, to be covered
- Consistent with existing prior authorization requirements, if we determine that the requested outpatient hospital setting isn't medically necessary, we will deny the request. You may be able to perform the requested service in an ambulatory surgical center setting. You may need to submit a new prior authorization request if you make a change to the service, and we will require prior authorization for the new service
- We only require notification/prior authorization for planned procedures
- If you don't notify us or complete the notification/prior authorization process before the planned procedure is rendered, we may deny the claims, and you won't be able to bill the member for the service

Key points

- This change, which affects **UnitedHealthcare Medicare Advantage plans**, goes into effect for dates of service on or after **Jan. 1, 2021**, for most states
- This change goes into effect for dates of service on or after **June 1, 2021**, for Arizona, Colorado, Connecticut, Florida, New Jersey, Nevada, New York and Texas
- This change goes into effect for dates of service on or after **June 1, 2021**, for Dual Special Needs Plans (DSNP) in New Jersey

UnitedHealthcare

Frequently asked questions

Why are we making this change?

We're making this change because our newly expanded prior authorization requirement and site of service medical necessity reviews may help to further minimize out-of-pocket costs for our plan members. Additionally, we believe this change will help improve cost efficiencies for the overall health care system, while still providing access to safe, quality health care.

Why did UnitedHealthcare choose these particular procedures?

We conducted careful reviews to determine which procedures can be performed safely and effectively outside of an outpatient hospital setting, while also considering the terms of our members' benefit plans.

Which UnitedHealthcare Medicare Advantage plans are affected/not affected?

The expanded notification/prior authorization requirements and site of service medical necessity reviews will apply to all UnitedHealthcare Medicare Advantage benefit plans, with the exception of the following benefit plans:

- Medicare Advantage Private Fee-for-Service Benefit Plans
- Medicare and Medicaid Enrollee Benefit Plans
- Medicare Advantage Senior Care Options Benefit Plans

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

We support informed patient choices and respect care decisions between physicians and our plan members. Our coverage determinations reflect only whether or not a service or site is covered under a member's benefit plan and aren't intended to replace treatment decisions.

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

To make site of service medical necessity determinations, we'll use the criteria in our **UnitedHealthcare Outpatient Surgical Procedures – Site of Service Utilization Review Guideline**, which we updated to add additional codes. On Jan. 1, 2021, you can find the policy at **UHCprovider.com** > Policies and Protocols > Commercial Policies > Medical & Drug Policies and Coverage Determination Guidelines.

Notification/prior authorization

How do I provide notification or request prior authorization?

The process for completing the notification/prior authorization request and timeframes 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 happens if I don't complete the notification/prior authorization process?

If you don't complete the notification/prior authorization process before the procedure is rendered, 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
- Kentucky
- Massachusetts
- Wisconsin
- Utah

We'll inform care providers if we expand site of service medical necessity reviews to these states.

How can I find participating ambulatory surgical centers in my area?

You can find participating ambulatory surgical centers in the UnitedHealthcare Provider Directory, which is available at **UHCprovider.com** > Find Dr. (in the upper right) > Search for Doctors, Clinics or Facilities by Plan Type > Medical Directory > All UnitedHealthcare Plans > (select the plan you're looking for) > Places > Specialty Centers > Ambulatory Surgical Center.

You can also contact UnitedHealthcare Network Management or call the phone number on the back of a member's health plan ID card. As part of our site of service medical necessity review, we'll also determine whether a participating ambulatory surgical center is available within a reasonable distance.

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

Plan members can be billed if we determine a site of service isn't medically necessary, as long as you get the member's written consent. The consent must be consistent with our protocols and given **before** a service is performed. If you don't get the member's written consent, and we deny the site of service for lack of medical necessity, you can't bill the member.

Additionally, if you send us a prior authorization request saying a procedure will be completed in an ambulatory surgical center and that service is actually provided in an outpatient hospital, we'll consider it a lack of authorization for site of service, and we'll deny the claim. In this case, you can't bill the member.

Can a request be approved 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 done during an inpatient stay.

Example scenarios

What if 1 of these procedures was already scheduled to be performed after the site of service medical necessity reviews begin?

As long as you completed the notification/prior authorization process for the procedure before the effective date, as outlined on page 1, you don't need to take any additional action. If you didn't complete the notification/prior authorization for the procedure, you must complete the notification/prior authorization process.

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

We understand some patients need more complex care because of factors like age or medical conditions. Using the clinical information that you submit, we'll review the plan member's situation to evaluate a site of service according to their needs.

We'll use a utilization review guideline to facilitate our site of service medical necessity reviews. The **UnitedHealthcare Outpatient Surgical Procedures – Site of Service Utilization Review Guideline** includes information on medical conditions that might make an outpatient hospital site medically necessary.

What if the nearest participating ambulatory surgical center is a long distance for the member to travel or doesn't have the equipment or resources for the planned procedure?

We realize there may be times when a plan member isn't within a reasonable distance of a participating ambulatory surgical center with the necessary resources for the care they need. In these cases, we'll authorize the procedure at a network outpatient hospital site, in accordance with the terms of our **UnitedHealthcare Outpatient Surgical Procedures – Site of Service Utilization Review Guideline**.

What if I don't have privileges at a participating ambulatory surgical center?

If you don't have privileges at a network ambulatory surgical center, you should provide that 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 consumers 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 network ambulatory surgical centers in your area and obtain privileges with those centers that best meet your needs and the needs of your patients.

Who can I call if I have questions?

If you have questions, please call Provider Services at **877-842-3210**.

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