Overview

For dates of service on or after March 1, 2019, once prior authorization is requested for certain magnetic resonance imaging (MRI), magnetic resonance angiography (MRA) and computed tomography (CT) imaging procedures in accordance with our Outpatient Radiology Notification/Prior Authorization Protocol, we’ll review the site of care for medical necessity under the terms of the member’s benefit plan. Site of care reviews will be conducted only if the procedure will be performed in an outpatient hospital setting.

We have a utilization review guideline to facilitate our site of care reviews. You can find the latest version of the guideline at UHCprovider.com/policies > Commercial Policies > Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans > [Search for] Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Care – Commercial Utilization Review Guideline.

We’re conducting site of care reviews to help achieve the Triple Aim of improved health care services, health outcomes and overall cost of care.

1 If permitted by state law.

Frequently Asked Questions

What procedure codes are subject to site of care reviews?

Site of care reviews will apply to the following procedure codes, which are currently subject to notification/prior authorization requirements.

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Which UnitedHealthcare plans are affected?
Site of care reviews currently apply to certain commercial benefit plans, including health exchange benefit plans and:
- UnitedHealthcare
- Neighborhood Health Partnership
- UnitedHealthcare of the River Valley

Will site of care reviews take place in all states?
No. Care providers in Alaska, Connecticut, Iowa, Kentucky, Maine, Maryland, Massachusetts, New Hampshire, Texas, Utah, Vermont or Wisconsin are currently not subject to site of care reviews. We will inform you if we expand site of care reviews to these states.

When will site of care reviews begin?
Site of care reviews for certain MR and CT imaging procedures will begin for dates of service on or after March 1, 2019.

What happens if one of these procedures was already scheduled for an outpatient hospital setting after site of care reviews begin?
As long as you obtained prior authorization for the procedure, you don’t need to take any additional action.

Why did we choose these particular procedures?
We conducted careful reviews to determine which procedures are clinically appropriate, equally safe and effective, if performed at locations other than an outpatient hospital setting. We also considered the terms of our members’ benefit plans. The out-of-pocket cost for plan members may be significant, depending on the location where a procedure is performed.
Are we making any changes to the current MR and CT notification/prior authorization process?

No, we’re not making any changes to the current notification/prior authorization process for MR and CT services. The standard prior authorization process still applies to these procedures. You can complete your request online or by phone:

- Online: Use the Prior Authorization and Notification tool on Link. Go to UHCprovider.com and click on the Link button in the top right corner. Then, select the Prior Authorization and Notification tile on your Link dashboard.
- Phone: Call 866-889-8054 from 7 a.m. to 7 p.m. local time, Monday through Friday, or call the Provider Services number on the plan member’s health plan ID card to verify their eligibility and benefit coverage.

We’re committed to doing timely reviews and complying with applicable regulatory response time frames. Coverage determinations reflect only whether or not a service is covered under a member’s benefit plan, and aren’t intended to replace your treatment decisions.

Will there be special considerations for care providers with accountable care organization (ACO) relationships?

Not at this time. We expect participating care providers, including care providers who are part of ACO arrangements, to notify us and request prior authorization in accordance with our protocols.

Will a request be denied if a care provider would like to have the procedure performed in an outpatient hospital setting?

An outpatient hospital site of care will be authorized if the criteria in our utilization review guideline are met. If the criteria are not met, authorization will be denied for the outpatient hospital.

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

We understand some patients need more complex care because of factors like age or medical condition. We review every plan member’s situation to evaluate a site of care according to their needs.

We’re also implementing a utilization review guideline to facilitate our site of care reviews. You can find the latest version of the guideline at UHCprovider.com/policies > Commercial Policies > Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans > [Search for] Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Care – Commercial Utilization Review Guideline.

How can care providers find participating freestanding imaging centers in their area?

Participating freestanding imaging centers are listed in the UnitedHealthcare Physician Directory at UHCprovider.com/findprovider > Search for a Provider.

- When you click the “Search for a Provider” link, a new tab will open in your browser.
• Click on “Medical Directory,” then select the applicable health plan.

• You’ll see a variety of search options. Choose “Places,” “Labs and Imaging” and “Imaging Centers.” To narrow your search, look for the “Freestanding Imaging Facility” link under “Search by Facility Type.”

For help locating a participating freestanding imaging center, you can also contact UnitedHealthcare Network Management or the phone number on the member’s health plan ID card. When you submit a prior authorization request, we’ll also determine whether a participating freestanding imaging center is available within a reasonable distance and give you that information.

What happens if the nearest participating freestanding imaging center is a long distance for the plan member to travel or doesn’t have the equipment or resources for the planned procedure?

We realize there may be instances when a plan member may not be close to a participating freestanding imaging center with the necessary resources for the care they need. In these cases, the procedure will be authorized at a network outpatient hospital.

How will the review process affect decisions between care providers and their patients?

We support informed patient choice and respect care decisions between you and our plan members. Our coverage determinations reflect only whether or not a service is covered under a member’s benefit plan, and aren’t intended to replace your treatment decisions.

Can members be billed if the outpatient hospital site of care is denied for lack of medical necessity?

Plan members can be billed if we determine an outpatient hospital site of care isn’t medically necessary and you get their written consent. The consent must be consistent with our protocols and given before a service is performed.

If you don’t complete the prior authorization process before performing a service, we’ll administratively deny your claim, and the plan member can’t be billed for the service. If a prior authorization request is sent to us saying a procedure will be completed in a freestanding or office location and is actually provided in an outpatient hospital, we’ll consider it a lack of authorization for site of care, and the claim will be administratively denied.