Overview
Beginning May 2, 2016, certain functional endoscopic sinus surgery procedures will require prior authorization for many UnitedHealthcare commercial plans and UnitedHealthcare Community Plans (Medicaid), excluding Medicare Dual Special Needs Plans (DNSPs) and Medicare Medicaid Plans (MMPs).

This is part of our ongoing responsibility to regularly evaluate our medical policies, clinical programs and health benefits against the latest scientific evidence and specialty society guidance. Using evidence-based medicine to guide coverage decisions supports quality patient care and reflects our shared commitment to the Triple Aim: better care, better health and lower costs.

The prior authorization requirement for these procedures applies to the following UnitedHealthcare plans, including Health Care Exchange plans, for dates of service on and after May 2, 2016, in most states*:

- UnitedHealthcare
- Golden Rule Insurance Company (group 902667)
- Mid-AtlanticMD Healthplan Individual Practice Association, Inc. (M.D. IPA) or Optimum Choice, Inc.
- Neighborhood Health Partnership (These plans already require prior authorization for these procedures.)
- UnitedHealthcare of the River Valley
- UnitedHealthcare Oxford
- UnitedHealthcare Life Insurance Company (group 755870)
- UnitedHealthcare West/Signature Value (not including California members)
- UnitedHealthcare Community Plan (Medicaid)

*For UnitedHealthcare commercial members in Illinois and Iowa, and for UnitedHealthcare Community Plan Medicaid members in Iowa and New Mexico, the requirement applies for dates of service on or after July 1, 2016.

Medical necessity reviews will be required for all UnitedHealthcare Community Plans and commercial members for these procedures in all states. As part of our review, we may evaluate the medical appropriateness of the site of service if the procedure is requested to be performed in an outpatient hospital setting. If a procedure could safely and effectively be performed in a more cost-effective setting, such as a network ambulatory surgery center, we may discuss these options with you.

The following answers to frequently asked questions provide more details.

Q1. When does the prior authorization requirement become effective?
A. The prior authorization requirement is effective in most states for dates of service on or after May 2, 2016. Please note the following exceptions:
   - For UnitedHealthcare commercial members in Illinois and Iowa, the requirement applies for dates of service on or after July 1, 2016.
   - For UnitedHealthcare Community Plan members in Iowa and New Mexico, excluding Medicare dual-enrolled, the requirement applies for dates of service on or after July 1, 2016.
Q2. Which functional endoscopic sinus surgery procedures will require prior authorization?
A. The prior authorization requirement applies to the following procedures:

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Description</th>
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<tbody>
<tr>
<td>31237</td>
<td>Nasal/sinus endoscopy, surgical; with biopsy, polypectomy or debridement</td>
</tr>
<tr>
<td>31239</td>
<td>Nasal/sinus endoscopy, surgical; with dacryocystorhinostomy</td>
</tr>
<tr>
<td>31240</td>
<td>Nasal/sinus endoscopy, surgical; with concha bullosa resection</td>
</tr>
<tr>
<td>31254</td>
<td>Nasal/sinus endoscopy, surgical; with ethmoidectomy, partial (anterior)</td>
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<tr>
<td>31255</td>
<td>Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)</td>
</tr>
<tr>
<td>31256</td>
<td>Nasal/sinus endoscopy, surgical, with maxillary antrostomy;</td>
</tr>
<tr>
<td>31267</td>
<td>Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus</td>
</tr>
<tr>
<td>31276</td>
<td>Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus</td>
</tr>
<tr>
<td>31287</td>
<td>Nasal/sinus endoscopy, surgical, with sphenoidotomy</td>
</tr>
<tr>
<td>31288</td>
<td>Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus</td>
</tr>
</tbody>
</table>

Important clarification: In previous communications about this requirement, CPT code 31238 was included. Prior authorization will not be required for CPT code 31238.

Q3. Why did UnitedHealthcare choose these particular procedures?
A. We regularly evaluate our medical policies, clinical programs and health benefits based on the latest scientific evidence and specialty society guidance, as our member benefit plans require care to be medically appropriate. We take into consideration the terms of our members’ benefit plans, Medicaid requirements and out-of-pocket costs to UnitedHealthcare members, as applicable.

Q4. What impact will this prior authorization requirement have on members’ coverage for functional endoscopic sinus surgery?
A. The coverage review will determine if the functional endoscopic sinus surgery procedure is medically necessary per the terms of the member’s benefit plan or Medicaid requirements. There will be no effect on coverage for procedures that are determined to be medically necessary.

Q5. What information will be considered as part of the prior authorization review?
A. Our prior authorization process is based on the terms of the member’s benefit plan or applicable Medicaid requirements. It is patient-centered and takes into account various factors in determining whether a procedure is medically appropriate. Please submit any information you would like us to consider when requesting prior authorization. If warranted, we will talk with you about the most appropriate evidence-based surgical approach for the specific member and their clinical circumstances.

Q6. How can I submit a prior authorization request?
A. The standard process applies. Prior authorization requests can be submitted in a number of ways:
Many of our plans offer a convenient online option available at UnitedHealthcareOnline.com > Notifications/Prior Authorizations > Notification/Prior Authorizations Submission. The automated process will guide you through a series of questions, and review time may be faster.

For UnitedHealthcare Community Plan, call 866-604-3267 or go to UHCCommunityPlan.com > For Health Care Professionals and select your state to access other plan-specific options.

Call the number on the back of your patient’s UnitedHealthcare member identification card.

Q7. What happens if I do not submit a prior authorization request?
A. If you do not complete the prior authorization process before performing the procedure(s), the claim will be denied, and the member cannot be billed for the service. If prior authorization is denied due to lack of medical necessity, a member can opt to be billed for the service but only with knowledge of our determination and proper written consent per our standard protocols or applicable state law.

Q8. How will I be notified of the outcome of a prior authorization request?
A. The standard process applies. More information is available at UnitedHealthcareOnline.com > Clinician Resources > Advance and Admission Notification Requirements.

Q9. How will prior authorization affect decisions made between a physician and patient?
A. Coverage determinations reflect only whether a service is covered under the provisions of the member’s benefit plan or Medicaid requirements, as applicable, and are not intended to replace treatment decisions made by physicians and their patients. If coverage is denied for lack of medical necessity, the member may consent in writing to have the procedure and be billed for the service. In these cases, the physician must obtain written consent from the member in accordance with our protocols or applicable state law.

Q10. Why are some of my patients with the same conditions denied while others are approved?
A. Our prior authorization process is based on the terms of the member’s benefit plan and is patient-centered, taking into account the information provided by the treating physician. Prior authorization reviews are conducted on a case-by-case basis. Coverage decisions are based on the member’s clinical status and specific benefit plan.

Q11. How far in advance of the service must I submit the prior authorization request?
A. For UnitedHealthcare commercial plans, advance notification, with supporting clinical documentation, should be submitted at least five business days prior to the planned service date (unless otherwise specified with the Advance Notification List) to allow enough time for coverage review. Expedited reviews are only available in situations in which a delay in treatment could seriously jeopardize the patient’s life, health or ability to regain maximum function, or when, in the opinion of a physician with knowledge of the patient’s medical condition, could cause severe pain. You must explain the clinical urgency when requesting an expedited review.

For Medicaid plans, advanced notice requirements may vary in accordance with applicable state law. For UnitedHealthcare Community Plan members, please comply with the plan-specific advance notification requirements outlined at UHCCommunityPlan.com > For Health Care Professionals. Select your state from the list to access information about the applicable plan.

If you have questions, please contact your local Network Management representative or call the phone number on the back of the member’s health care identification card. Thank you.