group health Cooperative of eau claire **KMTSJ, Inc.**	DEPARTMENT:	Utilization Management
	SUBJECT:	Place of Service
	PRODUCT LINE:	All
	POLICY NUMBER:	UM113
	ORIGINAL POLICY EFFECTIVE DATE:	01/02/2022
	LAST REVISED DATE:	07/13/2023
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SCOPE:

To ensure Group Health Cooperative of Eau Claire (the Cooperative) adjudicates benefits for members accurately and consistently according to the contract and to ensure that services are being rendered in the least restrictive place of service.

POLICY:

Services that can be performed in multiple settings require prior authorization to ensure that the service is being done in the least restrictive and most cost-effective setting possible. Place of service is reviewed based on medical necessity criteria including InterQual criteria, CMS place of service code set or medical necessity criteria as outlined below.

Per Wis. Admin. Code DHS 101.03(96m) medically necessary means a medical assistance service that is:
(a) Required to prevent, identify or treat a recipient's illness, injury or disability; **AND**
(b) Meets the following standards:

1. Is consistent with the recipient's symptoms or with prevention, diagnosis or treatment of the recipient's illness, injury or disability;
2. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;
3. Is appropriate with regard to generally accepted standards of medical practice;
4. Is not medically contraindicated with regard to the recipient's diagnoses, the recipient's symptoms or other medically necessary services being provided to the recipient;
5. Is of proven medical value or usefulness and, consistent with s. DHS 107.035, is not experimental in nature;
6. Is not duplicative with respect to other services being provided to the recipient;
7. Is not solely for the convenience of the recipient, the recipient's family or a provider;
8. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the recipient; and
9. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

Home Administered Medications

See Home Infusion Therapy list for which medications can be administered in the home setting. Medications that can be safely administered in the home setting would not be approved in another setting such as clinic, hospital outpatient, hospital observation or inpatient.

Medications that can be safely self-administered by the member at home would not meet medical necessity criteria for administration in another setting such as clinic, hospital outpatient, hospital observation or inpatient.

Office-Based Procedures

Certain elective surgical procedures that are considered office-based would meet medical necessity criteria for performance in an ambulatory surgery center or hospital outpatient setting if any of the following criteria are met:

1. Bleeding disorder that would cause a significant risk of morbidity as determined by the Cooperative advisor reviewer.
2. Failed office-based procedure attempts due to body habitus, abnormal anatomy, or technical difficulties as determined by the Cooperative advisor reviewer.
3. Presence of complications and comorbid disease that would cause office-based procedure to be unsafe or unsuitable as determined by the Cooperative advisor reviewer.

Hospital Outpatient or Ambulatory Surgery Center and Hospital Inpatient Services

InterQual, CMS place of service codes, and Forward Health are used to review services in these settings to determine the appropriate place of service.

1. Video EEGS: The Cooperative would cover as hospital observation when the home or office-based setting is not appropriate. Complications that arise during the observation stay would be reviewed for inpatient coverage on a case-by-case basis.
2. Chemotherapy: Many cancer chemotherapy regimens can be administered safely and effectively in the home or office setting. Coverage in a hospital observation setting would be considered when the chemotherapy cannot be safely administered in the home or office setting. Chemotherapy requests for administration in the hospital setting will be reviewed by a Cooperative physician advisor reviewer and the chemotherapy regimen will be reviewed by the clinical pharmacist. If the request cannot be administered in the office-based setting or hospital outpatient setting, then hospital observation level of care would be approved. If a serious complication, as determined by the Cooperative advisor reviewer, occurs, then an approval for inpatient level of care would be considered. All commercial requests and those from critical access hospitals will be reviewed on a daily basis for coverage.

Telehealth Services

Telehealth services are covered as outlined in the Forward Health Update. For services to be covered by telehealth they must be functionally equivalent to an in-person visit. For commercial plans, the telehealth visit must be between the member and the provider.

Michelle Bauer MD

APPROVED: _____ DATE: 07/13/2023

REVISION HISTORY:

Rev. Date	Revised By/Title	Summary of Revision
01/02/2022	Michele Bauer, MD, CMO	
01/03/2023	Michele Bauer, MD, CMO	Reviewed. No changes.
07/13/2023	Michele Bauer, MD, CMO	Added coverage criteria for chemotherapy administration