Prior authorization changes for outpatient therapy services

UnitedHealthcare Medicare Advantage

Overview

Effective Sept. 1, 2024, UnitedHealthcare will require prior authorization for physical therapy (PT), occupational therapy (OT), speech therapy (ST) and chiropractic services delivered in office and outpatient hospital settings, excluding home settings. This applies to UnitedHealthcare® Medicare Advantage nationally, excluding Dual Complete Special Needs Plans (D-SNP). Current prior authorization requirements in Arkansas, Georgia, South Carolina and New Jersey for outpatient therapies (PT/OT/ST) continues as previously deployed, and will now include Medicare-covered chiropractic services.

Requirements

Following an initial evaluation, outpatient therapy and chiropractic services must be authorized for members new to therapy and those who are currently receiving therapy. For comprehensive requirements starting Sept. 1, 2024, see the **Advance Notification and Clinical Submission Requirements.**

Process

Prior authorization is not required for the initial evaluation to be considered for reimbursement. However, a prior authorization is required for subsequent treatment visits. Health care providers are then required to submit the initial evaluation results and the care plan. For dates of service on or after Sept. 1, 2024, providers should use the **UnitedHealthcare Provider Portal** to request prior authorization.

We'll review the prior authorization request for medical necessity using CMS Chapter 15 criteria, applicable LCDs and InterQual® criteria to render a determination. Medical necessity reviews are conducted by licensed medical professionals including chiropractors, physical therapists, occupational therapists and speech-language pathologists. The provider and member will be notified of our medical necessity determination.

Impacted procedure codes

- **Outpatient therapies:** 92507, 92508, 92526, 97012, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97164, 97168, 97530, 97533, 97535, 97537, 97542, 97545, 97546, 97750, 97755, 97760, 97761, 97799, G0283
- **Chiropractic services (Medicare-covered):** 98940, 98941, 98942 when billed with AT-modifier

Frequently asked questions

How do these changes differ from current UnitedHealthcare requirements?

Beginning Sept. 1, 2024, UnitedHealthcare will expand its prior authorization process nationally, leveraging applicable LCDs as well as CMS Chapter 15 criteria and InterQual criteria, as appropriate, to render a medical necessity determination. Medical necessity reviews are conducted by licensed medical professionals including physical therapists, occupational therapists, speech-language pathologists and chiropractors. Current prior authorization requirements in Arkansas, Georgia, South Carolina and New Jersey for outpatient therapies continue as previously deployed and will now include Medicare-covered chiropractic services.

Who will be impacted by these new requirements?

This applies to in-network providers for the following UnitedHealthcare Medicare Advantage benefit plans. Current prior authorization requirements in Arkansas, Georgia, South Carolina, and New Jersey for outpatient therapies continue as previously deployed and will now include chiropractic services.

- Medicare Individual (including Chronic SNPs)
- Medicare Group Retiree
- UHCWest Medicare plans in Nevada, Oregon, Washington and Texas
- UHCWest Medicare plans in Colorado will begin on Jan. 1, 2025

Which plans are excluded from the new requirement?

- UnitedHealthcare® Dual Complete plans
- UnitedHealthcare® Nursing Home and UnitedHealthcare® Assisted Living Plans
- Erickson Advantage
- Preferred Care Network and Preferred Care Partners of Florida
- UHCWest (California, Arizona)
- OptumCare
- WellMed
- Peoples Health Plan
- Rocky Mountain Medicare Advantage plans

Which services are excluded from the new requirements?

Inpatient therapy and therapy services performed in the home (Place of Service Home) are excluded.

Will these prior authorization requirements apply for members who are already receiving therapy services?

Yes. All care received on or after Sept. 1, 2024, requires prior authorization.

Will routine chiropractic services require prior authorization?

No. Routine chiropractic is a supplemental benefit offered on some UnitedHealthcare Medicare Advantage plans that covers chiropractic services that aren't covered under Original Medicare. This benefit allows members to visit chiropractors for pain relief, neuromusculoskeletal disorders and nausea. Routine chiropractic services will not require prior authorization.

However, only Medicare-covered chiropractic services (which covers only manual manipulation of the spine to correct subluxation) requires prior authorization. Per CMS, Medicare-covered chiropractic services are identified by an AT modifier. Please review to **CMS.org** for additional information.

If I only complete an initial evaluation, how will I be reimbursed?

Provider should submit claim with appropriate procedure code. Prior authorization is not required for initial evaluation. The initial evaluation will be covered.

What if the member needs additional therapy visits after the initial set of therapy visits has been approved and provided?

If additional visits are needed, health care providers will need to submit a new prior authorization to get approval for the extension of the care plan.

Will these requirements affect claims?

Yes. If providers do not receive authorization prior to billing 1 of the in-scope codes, claims for that service will be denied and the member cannot be billed for the service.

What happens if prior authorization is not requested?

If we don't receive a prior authorization request within 10 days after starting the service, we may deny the claim and providers will not be able to balance bill members.

What happens if an authorization is submitted with incomplete information?

If an authorization request is submitted with incomplete information, the Optum Utilization Management (UM) team will try to reach out to the submitting provider to obtain the necessary information. If the provider submits the appropriate information within the required time frame, the request will be reviewed according to the UM process. If the submitting provider does not submit the required information, an incomplete request may be denied.

How does a care provider request authorization?

For dates of service on or after Sept. 1, 2024, providers should use the **UnitedHealthcare Provider Portal** to request prior authorization. Sign in and select "Submission & Status" under "PT, OT, ST Outpatient Therapy Transactions" to submit clinical information and request authorization for the planned PT, OT, ST or chiropractic services. As a reminder, the initial evaluation does not require prior authorization.

When billing a REV code, is an accompanying CPT code required?

Yes, therapy and chiropractic revenue codes should be billed with the appropriate CPT® codes. Billing without the appropriate CPT code may impact how a claim is processed.

What resources are available?

- **Skilled Nursing Facility, Rehabilitation and Long-Term – Medicare Advantage Coverage Summary**
- **Complementary and Alternative Medicine & Chiropractic Services – Medicare Advantage Coverage Summary**
- **Prior Authorization and Notification quick start guide**
- **Prior Authorization and Notification: Interactive User Guide**
- Outpatient therapy services are covered in accordance with certain conditions as outlined in the **Medicare Benefit Policy Manual (cms.gov)**

Who can submit an authorization for therapy or chiropractic visits?

The treating therapy or chiropractic provider can submit the authorization request

What happens if an authorization is submitted with incomplete information?

An incomplete request may be denied.

Are submission instructions or training available?

Yes. All submissions/authorizations need to be entered into the **UnitedHealthcare Provider Portal** and will be managed in the Optum systems.

Who reviews the authorization requests?

The Optum UM team will make medical necessity determinations. Medical necessity reviews are conducted by licensed medical professionals, including chiropractors, physical therapists, occupational therapists and speech-language pathologists.

What happens if a provider wants to appeal a denial?

If there is a clinical denial, appeals documentation will be included in the member and provider Notice of Determination letter.

What is the contact information if providers have questions?

- Providers contracted with UnitedHealthcare: **888-676-7768**
- Providers contracted with Optum: **800-873-4575**

PCA-1-24-02076-Clinical-FAQ_07302024

UnitedHealthcare® Medicare Advantage