Physical, occupational and speech therapy prior authorization requirements

UnitedHealthcare Community Plan of Maryland

Effective May 1, 2022, prior authorization is required for all occupational therapy (OT), physical therapy (PT) and speech therapy (ST) services for UnitedHealthcare Community Plan of Maryland members, ages 21 and older. These prior authorization requirements were announced in **Network News** on Jan. 14, 2022.

For the full list of therapy codes, reference the **list of current prior authorization plan requirements** for Maryland Medicaid.

- These requirements will apply whether a member is new to therapy or will continue receiving therapy
- Prior authorization isn't required for emergency or urgent services
- We'll deny claims if prior authorization is not on file before the date of service, and you won't be able to balance bill the member

Medical necessity review

When you submit a prior authorization request starting May 1, 2022, we'll review your request for medical necessity. We'll provide an authorization, if appropriate, and send that determination to you and the member.

To help ensure members currently under care do not experience disruption of services, providers may initiate a continuity of care request. We'll allow approval for the current episode of care or 90 days, whichever is less, to continue upon receipt of the request and completed plan of care.

Submit prior authorization requests online

You can submit requests for these services with dates of service on or after May 1, 2022, online using the **Prior Authorization and Notification tool.** Providers must submit a completed plan of care to prevent any disruption in services.

Frequently asked questions

What codes require prior authorization?
Ongoing treatment codes requiring prior authorization are online **at UHCprovider.com/MDcommunityplan** > Prior Authorization and Notification > **Current Prior Authorization Plan Requirements.**

What documentation is required when the provider submits a prior authorization request?
Prior authorization is not required for members younger than age 21. For members age 21 and older, the initial authorization for therapy must also include a plan of care.

The plan of care must be:
- Signed and dated by the referring provider (M.D., D.O., P.A. or N.P.) or appropriate specialist
- Less than 30 days old

Providers must develop a member's plan of care based on the results of the evaluation and must include all the following:
- Functional limitations
- Short- and long-term therapeutic goals and objectives
  - Treatment goals should be specific to the member's diagnosed condition or functional or physical impairment
  - Treatment goals must be functional, measurable, attainable and time based
  - Treatment goals must relate to member-specific functional skills
  - Treatment goals written with targets set for achievements specific to standardized testing benchmarks will not be accepted
- Treatment frequency, duration and anticipated length of treatment session(s)
  - Therapeutic methods and monitoring criteria

What happens if I submit my request with incomplete information?
An incomplete request may be denied.

What criteria does UnitedHealthcare use to review prior authorization requests?
Our medical necessity reviews are consistent with the member's benefit plan and applicable state law for all speech, occupational and physical therapy services. The coverage determination guidelines we use to facilitate our medical necessity determinations for these therapy services are available at **UHCprovider.com** > Policies and Protocols > Community Plan Policies > **Community Plan Medical & Drug Policies and Coverage Determination Guidelines** > Outpatient Physical and Occupational Therapy or Speech Language Pathology Services.

Who will review my prior authorization request?
Licensed medical professionals, including physical therapists, occupational therapists and speech-language pathologists, will review your prior authorization request using evidenced-based clinical criteria. A state-specific licensed physician will review all requests considered for medical necessity.

Where can we find the medical necessity guidelines?
The coverage determination guidelines are online at **UHCprovider.com** > Policies and Protocols > Community Plan Policies > **Community Plan Medical & Drug Policies and Coverage Determination Guidelines** > Outpatient Physical and Occupational Therapy or Speech Language Pathology Services.

How quickly will you process my request?
We'll process a complete prior authorization request within 2 business days from receipt of necessary information, not to exceed 14 calendar days from receipt of request.

How will you notify me of approvals?
If we approve the request, we'll notify the treating therapist by fax.

How will you notify me of denials?
If we deny the request, we'll notify the treating therapist by phone. A letter will also be sent to the therapist and member.

Will these prior authorization requirements apply for members who are already receiving therapy services?
Yes. To help ensure members currently under care do not experience disruption of services, providers may initiate a continuity of care request.

We'll allow approval for the current episode of care or 90 days, whichever is less, to continue upon receipt of the request and completed plan of care. Providers must submit a completed plan of care to prevent any disruption in services.

If my patient is currently receiving outpatient therapy services (OT, PT or ST), do I need to do a new evaluation or re-evaluation before requesting prior authorization?
A new evaluation or re-evaluation is **not** required if the member's plan of care is current (completed within the past 6 months).

For members ages 21 and older without a current plan of care, submit the following documentation:
- Current evaluation report and plan of care
- Current progress report or the member's most recent daily treatment notes
- Signed physician referral obtained at the time of the evaluation

We'll review the prior authorization request for medical necessity and issue an authorization if appropriate.

Will these requirements affect claims or a member's out-of-pocket costs?
No. If prior authorization is not on file before performing a procedure, claims for that service will be denied and the member cannot be billed for the service.

How does this change differ from the UnitedHealthcare current requirements?
Previously, prior authorization was not required for PT, OT and ST services.

To view the full list of therapy codes requiring prior authorization, go to **UHCprovider.com/MDcommunityplan** > **Prior Authorization and Notification Resources** > Current Prior Authorization Plan Requirements.

Are submission instructions or training available?
Yes. Training is available at **UHCprovider.com/training** > Digital Solutions > **Interactive Guide for Prior Authorization and Notification.**

Who can I contact if I have questions?
Please call **877-842-3210.**

United Healthcare Community Plan