# UnitedHealthcare Community Plan of Nebraska

Frequently Asked Questions

## Overview

UnitedHealthcare Community Plan of Nebraska aims to improve cost efficiencies for the overall health care system. One way we'll do that is by conducting site of care medical necessity reviews, consistent with the member's benefit plan and applicable state law, for all speech, occupational and physical therapy services. We're also revising our existing prior authorization requirements.

The updated prior authorization requirements outlined in our August 2019 Network Bulletin article will apply and we'll conduct site of service medical necessity reviews for therapy services. You can find the Network Bulletin at **UHCprovider.com/news** > Network Bulletin > August 2019 Network Bulletin,

### Key Points

For dates of service starting Sept. 15, 2019, and after, we require prior authorization for outpatient and home health physical, occupational and speech therapy services for all UnitedHealthcare Community Plan of Nebraska members.

These requirements apply whether a member is new to therapy or was already receiving therapy prior to Sept. 15, 2019.

Claims will be denied if prior authorization is not on file before the date of service.

### Updated Prior Authorization Requirements

For dates of service on or after Sept. 15, 2019, we now require prior authorization for speech, occupational and physical therapy services:

- The member's primary care provider (PCP) or referring specialist is required to submit prior authorization requests for evaluations and re-evaluations.
- Additional documentation is required as part of the prior authorization process for evaluations and re-evaluations.
- After a prior authorization request is approved for an evaluation or re-evaluation, the treating therapy provider can submit the prior authorization requests for subsequent treatment visits.

The documentation requirements are included in the coverage determination guidelines we use to facilitate our medical necessity determinations for these therapy services at **UHCprovider.com/policies** > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan > Speech Language Pathology Services *or* Outpatient Physical and Occupational Therapy.

You can find the list of services that are subject to prior authorization requirements at **UHCprovider.com/NEcommunityplan** > Prior Authorization and Notification Resources > Current Prior Authorization Plan Requirements.

**If you have questions, please contact Provider Services at 866-331-2243. Thank you.**



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# Frequently Asked Questions

## Prior Authorization Requirement Update

### How does this change differ from UnitedHealthcare's current requirements?

In order to support the physician's role in managing member care, starting with dates of service on or after Sept. 15, 2019, the referring care provider (the member's PCP or referring specialist) will be required to submit prior authorization requests for evaluations and re-evaluations. Claims will be denied if prior authorization is not on file before the date of service.

Before this change, these types of prior authorization requests for therapy services were often submitted by therapy providers. For dates of service on or after Sept. 15, 2019, requests for treatment may be submitted by the therapy provider if an authorization for an evaluation or re-evaluation was obtained.

### Which members are affected by these new prior authorization requirements?

These prior authorization updates will apply to Nebraska Medicaid benefit plan members.

### Will these prior authorization requirements apply for members who have been receiving therapy services before Sept. 15, 2019?

Yes. Prior authorization requirements will apply to members who are new to therapy and those who are currently receiving therapy.

### 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 can't be billed for the service.

### If my patient who is a UnitedHealthcare Community Plan member currently receives therapy services, do I need to do a new evaluation or re-evaluation before requesting prior authorization for therapy treatment services?

For members who were receiving ongoing therapy treatment services prior to Sept. 15, 2019, we will not require a new evaluation or re-evaluation as long as there is a current evaluation or re-evaluation on file. You must submit a prior authorization request for the continuation of treatment services and submit the following documentation:

- Signed physician referral obtained at the time of the evaluation
- Current evaluation or re-evaluation report
- A current plan of care, a current progress report and/or the member's most recent daily treatment notes

Note: We will not accept an evaluation report that is more than 1 year old. We'll review the prior authorization request for medical necessity and will issue an authorization if appropriate.



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### What documentation is required when the PCP or referring specialist submits a prior authorization request for evaluations and re-evaluation?

For members younger than 21:

- Signed and dated physician order, less than 30 days old, specifying the discipline(s) to be evaluated.
- Current well-child visit or an exam note describing the need for the requested evaluation(s).
- For speech therapy initial evaluation requests for members younger than 6, documentation of a hearing screening performed per the member's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) periodicity schedule. (See the Speech Language Therapy coverage determination guideline for more information on hearing screenings.)

For members ages 21 and older:

- Signed and dated physician order, less than 30 days old, specifying the discipline(s) to be evaluated
- Exam note describing the need for the requested evaluation(s)

## Submitting a Prior Authorization Request

### Where can I submit a prior authorization request?

You can submit your prior authorization requests for these services using the Prior Authorization and Notification Tool on Link at UHCprovider.com/paan. Go to UHCprovider.com and click on the Link button in the top right corner. Then, select the Prior Authorization and Notification Tool on your Link dashboard.

### Why should I submit my prior authorization request online?

When you submit a prior authorization request online, we receive the information immediately, which allows us the ability to provide a more timely and efficient response. Please note that prior authorization requests must be submitted by the PCP, referring specialist or therapy provider.

### Who can submit a prior authorization request for initial evaluations and re-evaluations?

The member's PCP or referring specialist (MD, DO, physician assistant or nurse practitioner) may submit the prior authorization request for the initial evaluation or re-evaluation.

### Who can submit a prior authorization request for therapy visits?

After a prior authorization request is approved for an evaluation or re-evaluation, the treating therapy provider can submit the prior authorization requests for subsequent treatment visits.

Without a completed prior authorization request for evaluation or re-evaluation, the member's PCP will have to send in the request for therapy visits.



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## Can a PCP or referring specialist submit a request for evaluation and treatments for immediate physical or occupational therapy care needs?

To support the physician's role in coordinating member care, the member's PCP or referring specialist can submit prior authorization requests for evaluations and treatment. If, at the time of an initial evaluation, the member's referring care provider has identified a need to provide immediate treatment for something such as, but not limited to, post-surgical treatment or splinting, the primary care provider or referring specialist may submit a prior authorization request for an evaluation and up to four treatment visits.

If additional treatment is needed beyond the fourth treatment visit, the therapist must submit a prior authorization request that includes the documentation requirements, as outlined in the therapy clinical determination guidelines, to support that ongoing care is needed.

If a therapy provider completes an evaluation and treatment on the same date of service, we'll require that they maintain all of the following documentation in the medical record:

- Evaluation report
- Plan of care
- Daily treatment note reflecting the skilled intervention provided (i.e. member's progress towards goals established as part of the plan of care, not a summary of the evaluation report)

Note: The PCP will need to request the evaluation and Tx CPT® codes at the time of the prior authorization request.

## How far in advance can I submit my prior authorization request?

You can request prior authorization up to 14 days before the requested service date.

## What happens if I submit my request with incomplete information?

An incomplete request may be denied.

## Which place of service should I choose when submitting my request online?

When choosing "place of service" for outpatient therapy services, please choose the "Office or Outpatient" from the dropdown menu. Do not choose "Outpatient Facility."

## Are submission instructions or training available?

Yes. We have reference guides as well as on-demand and live training available at UHCprovider.com/paan > Training.



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## Which CPT codes are commonly used for evaluations and re-evaluations?

The following CPT codes are the most commonly used codes for therapy evaluations and re-evaluations.

| CPT Code | Therapy Type | Evaluation or Re-Evaluation CPT Code | Code Definition |
|---|---|---|---|
| 92521 | Speech Therapy (ST) | Evaluation | Evaluation of speech fluency (e.g., stuttering, cluttering) |
| 92522 | ST | Evaluation | Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria) |
| 92523 | ST | Evaluation | Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria) ***with*** evaluation of language comprehension and expression (e.g., receptive and expressive language) |
| 92524 | ST | Evaluation | Behavioral and qualitative analysis of voice and resonance |
| S9152 | ST | Re-Evaluation | Speech Therapy, Re-Evaluation |
| 97161 | Physical Therapy (PT) | Evaluation | Low Complexity, Evaluation |
| 97162 | PT | Evaluation | Moderate Complexity, Evaluation |
| 97163 | PT | Evaluation | High Complexity, Evaluation |
| 97164 | PT | Re-Evaluation | Re-Evaluation for all levels |
| 97165 | Occupational Therapy (OT) | Evaluation | Low Complexity, Evaluation |
| 97166 | OT | Evaluation | Moderate Complexity, Evaluation |
| 97167 | OT | Evaluation | High Complexity, Evaluation |
| 97168 | OT | Re-Evaluation | Re-Evaluation for all levels |

# Prior Authorization Request Review and Notification

## How quickly will you process my request?

We'll process a complete prior authorization request within 14 calendar days.

## 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 licensed physician will review all requests considered for medical necessity.

## 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 will be available at UHCprovider.com/policies > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan > Speech Language Pathology Services *or* Outpatient Physical and Occupational Therapy.



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## How will you notify me of the coverage determination?

**For Evaluations/Re-evaluations:**

- We'll fax a letter to the referring care provider and the treating therapist informing them of the approval.
- If we deny the request, we'll fax a letter to the requesting primary care provider/referring specialist and treating therapist and mail a letter to the member.

**For Treatment Visits:**

- We'll fax a letter to the treating therapist informing them of the approval.
- If we deny the request, we'll fax a letter to the requesting therapist and mail a letter to the member.

The approved authorization fax will have the authorization number that the therapist will need when billing the claim for the evaluation. Care providers can also look up current authorizations through UHCprovider.com/Link.

## How can providers with multiple locations and fax numbers know where UnitedHealthcare is sending approvals and denials?

Approvals are faxed to the provider's fax number on file. The provider submitting the request must ensure they are utilizing the provider and their location where services will be rendered. The prior authorization system has all locations that the provider group or facility has submitted for contracting. Each provider has the ability to verify their information is correct and make updates in the provider portal.

## How can I confirm the quantity of services authorized when units and visits are referenced?

When requesting prior authorization for physical and occupational therapy, you should request the total number of visits needed and indicate the number of units requested per CPT code. For speech therapy, you should list the total number of visits needed per procedure code.

## Can prior authorization requests include more than one type of therapy?

No. Requests for physical, occupational and speech therapy must be submitted separately. You must indicate the type of therapy requested.

## How can we look up the status of an authorization request?

Prior authorization requests are updated in the Prior Authorization and Notification Tool in the UnitedHealthcare provider portal to reflect current status. Providers can also contact UnitedHealthcare provider services or follow up with the referring physician if unable to access file in Prior Authorization and Notification.

## Does UnitedHealthcare require a new authorization for a member currently receiving therapy services when an additional diagnosis is identified?

If there's an expectation of payment for services beyond what we've already authorized, you would need to submit a new prior authorization.



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## How do I know when I can start services?

The approved start and end dates of service can be found in the authorization approval letter.

## Does wound care require prior authorization?

Yes, all outpatient physical and occupational therapy services including wound care require prior authorization as indicated in the UnitedHealthcare Coverage Determination Guidelines.

## Do benefit limitations for therapy services still apply now that prior authorization is required?

Yes, benefit limitations for outpatient therapy services will still apply.

## What does a care provider do if they can't access the Individualized Education Plan (IEP) for the member?

Speech, occupational and physical therapists may provide services in both an educational and medical setting, and as the managed care organization (MCO). On behalf of the members we serve, we want to ensure these services are appropriately coordinated across providers. We agree entirely that services provided in the schools are intended to address educational needs, whereas services provided through the Medicaid program are intended to promote increased functional outcomes in the home and community environment; however, services delivered in one setting can impact outcomes in other settings, particularly when providers are using competing interventions.

To promote collaboration and cooperation across services delivery settings, ensure optimal outcomes for our members, and confirm that services are not being duplicated, UnitedHealthcare is requesting supporting documentation as part of our prior authorization process. Therapy services are covered under the Medicaid program when they are medically necessary and meet other coverage criteria specified in the Nebraska Administrative Code. As part of the preauthorization process, we request that the provider submit copies of an IEP if they have it OR provide a description of the goals and objectives from the therapists if an IEP is not available. If neither an IEP nor a description of the goals is available, UnitedHealthcare will also accept a written attestation from the provider stating that the member does not have an IFSP or IEP.

UnitedHealthcare will not deny for lack of an IFSP or IEP. We may deny a request for lack of appropriate documentation to ensure appropriate coordination and non-duplication with educational services.

## Why does UnitedHealthcare require prior authorization when there is a secondary payer?

Our therapy coverage guidelines require prior authorization when UnitedHealthcare Community Plan is a secondary payer. This helps to ensure that any medically necessary care is being provided in the most appropriate setting when Medicaid is a partial payer. Additionally, the requirement protects the therapist by having an authorization in place should the primary payer not cover the services and Medicaid then becomes the primary payer.



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## Are progress reports due every 60 – 90 days?

Intermittent progress reports may be submitted when a therapy provider requests additional therapy visits in between an initial evaluation and a re-evaluation. Intermittent progress reports must demonstrate that the member is making functional progress to reflect that continued services are medically necessary. Progress reports must include all of the elements identified in UnitedHealthcare's Community Plan Speech Language Pathology Services and Outpatient Physical and Occupational Coverage Determination Guidelines. We've included two examples below, one that demonstrates when an intermittent progress report would be needed and a second that demonstrates when a care provider wouldn't need to complete an intermittent progress report.

- ***Example 1***: If a therapy provider is issued an initial authorization for 90 days (3 months), and feels continued care is needed beyond the duration of the initial authorization, they would submit an intermittent progress report to support that additional services are medically necessary. In this instance, services would be considered for up to an additional 90-day period, if medically necessary (6 months total from the date of the initial authorization). If it's anticipated that services are needed beyond this point, a re-evaluation would be needed to determine if ongoing services are medically necessary.
- ***Example 2***: If a therapy provider is issued an initial authorization for 180 days (6 months), the care provider wouldn't be required to submit additional documentation to UnitedHealthcare Community Plan of Nebraska unless they anticipate that additional services are needed beyond the duration of the authorization. The care provider must maintain daily treatment notes in the member's medical record to support all services billed but wouldn't be required to submit intermittent progress reports.

If the therapy provider anticipates that the member has a continued need for therapy visits after the duration of the authorization, the care provider may follow the re-evaluation process to request additional visits.

Re-evaluations must be completed at least once every 6 months to support the need for ongoing services. Re-evaluations performed more often than once every 6 months should only be completed when the member experiences a significant change in functional level (defined as a measurable and substantial increase or decrease in the beneficiary's present functional level compared to the level documented at the beginning of treatment) in their condition or functional status. The documentation must reflect this change. Re-evaluations must include current standardized assessment scores, age equivalents, percentage of functional delay, criterion-referenced scores or other objective information, as appropriate for the member's condition or impairment.

## Who can I contact if I have questions?

If you have questions, please contact Provider Services at **866-331-2243**.



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