# Prior authorization requirements for certain therapy services, effective October 1, 2021

Frequently asked questions

## Overview

Effective October 1, 2021, we'll require prior authorization for occupational therapy (OT), physical therapy (PT) and speech therapy (ST) services for UnitedHealthcare Community Plan of New Jersey members.

Additionally, we'll conduct medical necessity reviews for PT/OT/ST services.

For a full list of the therapy codes that require prior authorization, go to **UHCprovider.com** > Health Plan by State > State > Medicaid (Community Plan) > Prior Authorization and Notification Resources > Current Prior Authorization Plan Requirements.

### Key points

- This change affects UnitedHealthcare Community Plan of New Jersey members
- These requirements will apply, whether a member is new to therapy or will continue receiving therapy
- 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

## Frequently asked questions

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

- Before this change, prior authorization wasn't required for occupational and physical therapy services
- We've expanded the list of speech therapy CPT® codes that require authorization

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

- These prior authorization updates will apply to the following benefit plan members:
  [New Jersey FamilyCare]
  [New Jersey Managed Long Term Services and Supports (MLTSS)]

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

- Yes. Prior authorization requirements will apply to members who are new to therapy and those who are currently receiving therapy.
- You can request an authorization review 30 days prior to the program's effective date using the Prior Authorization and Notification solution at **UHCprovider.com/paan**

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## Will these requirements affect claims?

Yes. If prior authorization isn't on file before performing a procedure, claims for that service will be denied, and the member cannot be billed for the service.

## Where do I submit a prior authorization request?

**Online Submissions:** You can submit your prior authorization requests up to 30 days before the requested service, using the Prior Authorization and Notification solution at **UHCprovider.com/paan** .

## Reviewing your requests before the effective date

We'd like to help you get ready by offering a review for your patients who are or will start receiving therapy services before the prior authorization requirement effective date. Starting 30 days before the effective date, you can submit the patient information using the Prior Authorization and Notification tool at UHCprovider.com/paan . We'll let you know if your request meets the coverage determination guidelines 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.

- If the review shows that the request meets the coverage determination guidelines, we'll give you an authorization number at that time. With an authorization number, you won't have to resubmit a request for that initial prior authorization.
- If the review shows that the request wouldn't be approved under the coverage determination guidelines, we'll give you more information about our decision. You may resubmit for review with more information.

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

## Where can I find the Medical Necessity Guidelines?

You can find our coverage determination guidelines 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.

## If my patient is currently receiving speech therapy services, do I need to do a new evaluation or re-evaluation before requesting prior authorization for therapy treatment services?

If the member's plan of care is current (completed within the past 6 months), a new evaluation or re-evaluation isn't required. If there is a current authorization on file, care can continue through the end of that authorization. For ongoing care past the current authorization, please submit the following documentation to support the need for treatment services:

- Signed physician referral obtained at the time of the evaluation
- Current evaluation report and plan of care
- Current progress report or the member's most recent daily treatment notes
- You can request an authorization review 30 days prior to the program's effective date using the Prior Authorization and Notification solution at **UHCprovider.com/paan**

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## If my patient is currently receiving Physical or Occupational therapy services, do I need to do a new evaluation or re-evaluation before requesting prior authorization for therapy treatment services?

If the member's plan of care is current (completed within the past 6 months), a new evaluation or re-evaluation isn't required. You'll need to submit a prior authorization request for the ongoing treatment services. Please include the following documentation to support the need for ongoing treatment services:

- Signed physician referral obtained at the time of the evaluation
- Current evaluation/re-evaluation report and plan of care
- Current progress report or the member's most recent daily treatment notes
- You can request an authorization review 30 days prior to the program's effective date using the Prior Authorization and Notification solution at **UHCprovider.com/paan**

## What documentation is required when I submit a prior authorization request?

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 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Periodicity Schedule. (See the speech language therapy coverage determination guideline for additional 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)

You can submit your prior authorization requests for these services with dates of service on or after October 1, 2021, up to 30 days before the requested service, using the Prior Authorization and Notification solution at **UHCprovider.com/paan.**

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

The treating therapy provider can submit the prior authorization requests for subsequent treatment visits.

## 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, hospitals, MD offices and free-standing facilities should choose "Office" or "Outpatient" from the dropdown menu, not "Outpatient Facility." Skilled Nursing Facilities (SNF) should choose "Outpatient" from the dropdown menu, not "Outpatient Facility."

## Are submission instructions or training available?

Yes. Training is available at **UHCprovider.com/training** , where there are resources under the Self-Service tools sections (including the interactive self-paced guides and registration for live webinars). This is for all tools, including Prior Authorization and Notification.

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## How quickly will you process my request?

We'll process a complete prior authorization request within state-mandated turnaround times.

## Who will review my prior authorization request?

Licensed medical professionals, including physical, occupational 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.

## How will you notify me of approvals or denials?

If we approve the request, we'll notify the treating therapist by fax. If we deny the request, we'll notify the treating therapist by phone. If unable to make verbal contact, a fax will be sent. A letter will also be sent to the member.

## Who do I contact if I have questions?

If you have questions about this process, please contact UnitedHealthcare at **866-362-3368**. For any Optum contracting and credentialing questions, please contact Optum at **800-873-4575**.