Prior authorization requirement changes

Medicare Advantage

Physical therapy, occupational therapy and speech therapy services

Arkansas, Georgia, New Jersey and South Carolina

Overview

Beginning Feb. 1, 2022, UnitedHealthcare will require health care providers to obtain prior authorization for physical therapy (PT), occupational therapy (OT) and speech therapy (ST) services delivered at multi-disciplinary offices and outpatient hospital settings. This applies to health care providers in Arkansas, Georgia, New Jersey and South Carolina. These prior authorization requirements apply to patients new to therapy and those who are currently receiving therapy. To confirm that this requirement applies to your patient, please check the Group Number on their member identification card and compare it to the **list of in-scope plans.**

Note: The initial evaluation for your patient does NOT require prior authorization. However, in order to receive reimbursement for the initial evaluation, UnitedHealthcare will also require health care providers to provide the results of the initial PT, OT and ST evaluation by completing our Patient Assessment form. The initial patient evaluation will be used to assist in the request for follow-up treatment, which does require prior authorization.

We will review the prior authorization request for medical necessity and render a determination that may be tracked online using the Portal Eligibility tool on the Provider Portal. Medical necessity reviews are conducted by licensed medical professionals, including physical therapists, occupational therapists and speech-language pathologists. The provider and patient will be notified of our medical necessity determination.

Frequently asked questions

What patients require prior authorization?

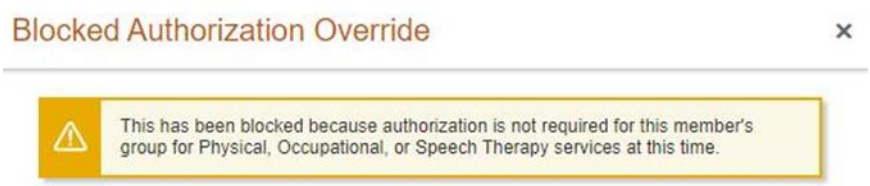
To determine if a patient requires a prior authorization, compare the Group Number to the **list of in-scope plans** that have this requirement. If the Group Number is listed, you will need to complete the submission requirements for prior authorization.

How do I find a Group Number on a patient's insurance card?

The Group Number is listed on the front of the member card.

What if the member doesn't have their card?

If you do not have the patient's Group Number, follow the directions to request a prior authorization described below. If the prior authorization requirements do not apply to the patient, you will be stopped in the process and see the following message. If you see this message, you should follow your normal claims procedure for this patient.



How does this change differ from the current UnitedHealthcare requirements?

Before this change, prior authorization wasn't required for OT, PT or ST. We've expanded the list of therapy codes that require authorization. Please review the **specific therapy codes listed in the November Bulletin.**

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

Yes. Therapy-related revenue codes should be billed with the appropriate CPT® codes. Billing without the appropriate CPT code may impact how a claim is processed.

Which states will be impacted by these new prior authorization requirements?

Providers in New Jersey, Arkansas, South Carolina and Georgia will be impacted.

Which services are excluded from prior authorization requirements?

Inpatient rehabilitation and rehabilitation services performed in the home including, but not limited to, those provided by a home health care agency.

Does the scope include Outpatient Therapy performed in a SNF?

No, therapy delivered in the SNF setting on an outpatient basis does not require PA at this time.

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

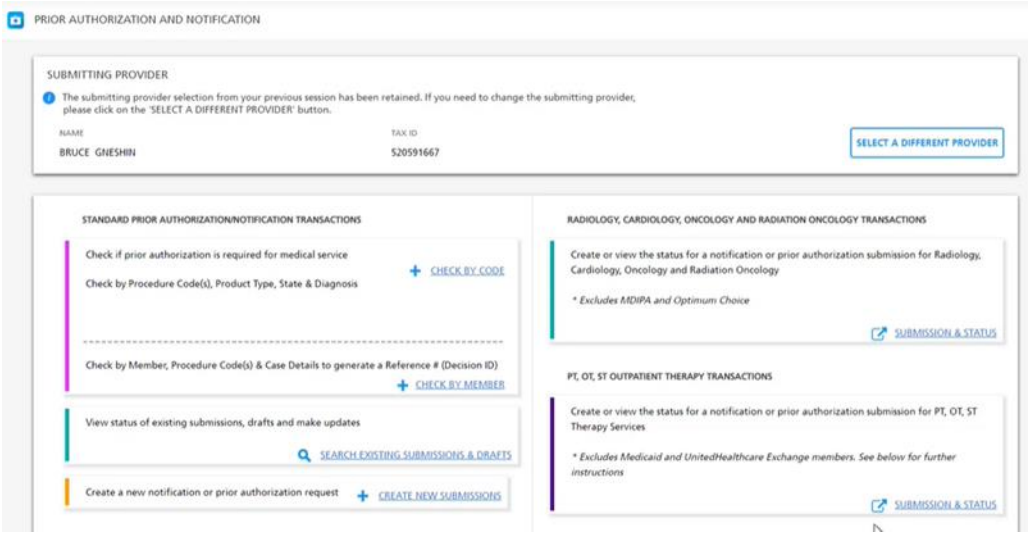
Yes. Prior authorization requirements will apply to members who are new to therapy and those who are currently receiving therapy.

Will these requirements affect claims?

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

How does a care provider request authorization?

For dates of service on or after Feb. 1, 2022, use the **Prior Authorization and Notification** tool, sign in and select the "Submission & Status" hyperlink under "PT, OT, ST Outpatient Therapy Transactions" to submit clinical information and request authorization for your planned PT, OT and ST services. As a reminder, the initial evaluation does not require authorization.



Where can medical necessity guidelines be located?

Review the medical necessity guidelines used to help facilitate the medical necessity determinations for these services.

Outpatient rehabilitation therapy physical therapy, occupational therapy and speech-language pathology services conditions of coverage

Outpatient therapy services are covered in accordance with certain conditions as outlined in the Medicare Benefit Policy Manual, Chapter 15, §220.1 – Conditions of Coverage and Payment for Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services (accessed April 8, 2021).

What are the authorization requirements for patients that are currently in treatment and will continue treatment after Feb. 1, 2022?

For therapy episodes of care that commenced prior to Feb. 1, 2022, authorization of additional visits will be required for visits on or after Feb. 1, 2022.

Who can submit a prior authorization request for therapy visits?
The treating therapy provider can submit the prior authorization requests.

What happens if a request is submitted with incomplete information?
An incomplete request may be denied.

Are submission instructions or training available?
Yes. The **MBMNow User Guide** is available under the “Reference Guides and Additional Resources” section at **UHCprovider.com/paan.**

Who reviews prior authorization requests?
The Optum Utilization Management team will make medical necessity determinations.

What is the contact information if there are questions?
- UnitedHealthcare providers please call Provider Services at **866-416-6594**
- Optum providers please call Provider Services at **800-873-4575**

What if additional visits are required beyond what was submitted in the initial prior authorization?
Authorizations will provide a specific number of visits. Once those are exhausted, a new prior authorization is required for any continued care and a new number of visits will be approved/denied.

A provider is required to see the member first, to complete the Patient Summary form and begin the prior authorization process. Will the initial evaluation be covered?
Yes. At a minimum, the initial evaluation will be covered once the Patient Summary form is submitted and approved. Any additional visits will be approved based on the established clinical guidelines.

Can a claim submission for the initial evaluation ever get denied for no authorization?
Yes, but only if the claim is submitted without having completed the Patient Summary form and submitting the request through the Optum MBMNow portal for authorization. It is recommended to submit the initial evaluation claim after obtaining authorization approval (typically completed within 72 hours upon receipt of submission).

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