

Cardiology prior authorization program

Frequently asked questions

Overview

Prior authorization is required for select cardiology procedures provided to certain UnitedHealthcare Community Plan members. The cardiology procedures that are subject to prior authorization requirements are referred to as “cardiac procedures” in these frequently asked questions.

We use the prior authorization process to help support compliance with evidence-based guidelines and help reduce medical risk. It may help improve care experiences, outcomes and total cost of care for UnitedHealthcare Community Plan members.

We’ve worked with external physician advisory groups to develop and update the cardiology prior authorization program in order to apply more consistent current scientific clinical evidence and professional society guidance to diagnostic and interventional cardiology procedures.

We review the clinical guidelines annually to align with current best practices. They reflect guidance from our external Cardiac Scientific Advisory Board, which is comprised of leading clinical and academic board-certified cardiologists. The clinical guidelines along with other related resources are available on UHCprovider.com/cardiology.

Please use these frequently asked questions as a resource about the requirements of the cardiology prior authorization program.

General information and plan exclusions

Is prior authorization required if UnitedHealthcare Community Plan is the secondary payer?

No. Prior authorization isn’t required when UnitedHealthcare Community Plan is secondary to any other payer, including Medicare.

Who is responsible for requesting prior authorization for a cardiac procedure?

The ordering care provider’s office is responsible for requesting a prior authorization number before scheduling the cardiac procedure. Since cardiac procedures aren’t always performed by the same ordering and rendering care provider, the ordering care provider must request prior authorization and communicate it to the rendering care provider.

If the rendering care provider determines there is no prior authorization on file and the ordering care provider doesn’t participate in the UnitedHealthcare network, the rendering care provider is required to complete the prior authorization process and verify that a prior authorization has been issued in accordance with the program.



Key points

- The cardiology prior authorization program applies to certain of the following diagnostic and interventional cardiology procedures:
 - Diagnostic catheterizations
 - Electrophysiology implant procedures
 - Echocardiograms
 - Stress echocardiograms
- Prior authorization requirements apply to outpatient and office settings
- Provider demographic information and other details on what’s required to initiate and include with a prior authorization request are outlined
- The process for urgent requests and retrospective authorization is explained

How can I obtain and verify a prior authorization number?

You can initiate the prior authorization process online or by phone:

- **Online:** Use the Prior Authorization and Notification tool at UHCprovider.com/paan
- **Phone:** Call **866-889-8054** from 7 a.m.–7 p.m. local time, Monday–Friday

Which cardiac procedures require prior authorization?

Prior authorization is required for the following cardiac procedures and corresponding CPT® codes:

- **Diagnostic Catheterization**
 - CPT codes: 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461
- **Electrophysiology Implants**
 - Pacemaker Implant CPT codes: 33206, 33207, 33208, 33212, 33213, 33214, 33227, 33228
 - CRT (Cardiac Resynchronization Therapy) CPT device codes: 33221, 33224, 33229, 33231, 33264, CPT Lead code 33225
 - Defibrillator (AICD) Implant CPT codes: 33230, 33240, 33249, 33262, 33263, 33270
 - Echocardiogram CPT codes: 93303, 93304, 93306, 93307, 93308
 - Stress Echocardiogram CPT codes: 93350, 93351

If you don't request prior authorization or verify that one has been obtained before rendering cardiac procedures, it may result in administrative claim denial. You cannot balance bill members for the services.

Does receipt of a prior authorization number guarantee that UnitedHealthcare will pay the claim?

No. Receipt of a prior authorization number does not guarantee or authorize payment. Payment for covered services is contingent upon various factors, including coverage within the member's benefit plan and your Participation Agreement with UnitedHealthcare Community Plan.

Who is responsible for confirming that the prior authorization process has been completed?

Rendering care providers are responsible for confirming that the prior authorization process has been completed and a prior authorization number has been issued before rendering the cardiac procedure. If the rendering care provider determines there is no prior authorization on file, the rendering care provider is required to complete the prior authorization process and verify that a prior authorization has been issued, in accordance with the program.

If the ordering care provider doesn't participate in the UnitedHealthcare network, the rendering care provider is required to complete the prior authorization process and verify that a prior authorization has been issued, in accordance with the program.

Prior authorization requirements

Which places of service are subject to the cardiology prior authorization requirements?

The following chart outlines the places of service that are subject to prior authorization requirements:

Cardiac procedure	Outpatient	Office	Inpatient
Diagnostic catheterization	Required	Required	Not required
Electrophysiology implant	Required	Required	Not required
Echocardiogram	Required	Required	Not required
Stress echocardiogram	Required	Required	Not required



Which places of service are not subject to prior authorization requirements?

Cardiac procedures performed in, and appropriately billed with, the following places of service are not subject to prior authorization requirements:

- Emergency rooms
- Urgent care centers
- Hospital observation units
- Inpatient settings

Who reviews prior authorization requests?

- Board-certified cardiologists will review prior authorization requests. Ordering or rendering care providers may request a physician-to-physician discussion with the reviewing cardiologist.
- Call **866-889-8054**. Then, select option 3 and provide the 10-digit case number. If there is no case number or it is invalid, press *.

What information may be requested for a prior authorization request to be reviewed?

The following information may be requested:

- Member's name, address, phone number and date of birth, member identification (ID) and group number
- Ordering care provider's name, tax ID number (TIN)/national provider identifier (NPI) number
- Ordering care provider's mailing address, phone and fax number, and email address
- The cardiac procedure(s) being requested, with the CPT code(s)
- The working diagnosis with the appropriate ICD code(s)
- The member's clinical condition, including any symptoms, listed in detail, with severity and duration
- Treatments that have been received, including dosage and duration for drugs; and dates for other therapies
- Dates of prior imaging studies performed
- Any other information that will help in evaluating whether the service ordered meets current evidence-based clinical guidelines, including but not limited to, prior diagnostic tests and consultation reports

To help ensure proper payment, the ordering care provider must communicate the authorization number to the rendering care provider.

Does the prior authorization process have to be completed for each cardiac procedure ordered?

Yes. The prior authorization process must be completed for each individual CPT code. Each authorization number is CPT code-specific. Authorization numbers are not required on the claim form.

Will any professional component(s) claims be affected if the prior authorization process isn't completed?

For stress echocardiograms, the professional component (modifier 26) will not be subject to administrative denial if the prior authorization process isn't completed.

For cardiac catheterization and electrophysiology implants, the full claim, including the professional component modifier 26, will be subject to administrative denial if the prior authorization process isn't completed.

For all cardiac procedures, if a clinical denial is received and the procedure is still performed, the global, technical and professional components will be subject to denial for lack of medical necessity, including professional claims billed with modifier 26.

Urgent requests and retrospective authorization

Can the ordering care provider request a prior authorization number on an urgent basis, during UnitedHealthcare normal business hours?

Yes. The ordering care provider may request a prior authorization number on an urgent basis if rendering the service urgently is medically required. Urgent requests must be requested by phone at **866-889-8054**. You must state that the case is “clinically urgent” and explain the clinical urgency. UnitedHealthcare will respond to urgent requests within 3 hours of our receipt of all required information.

Can an ordering care provider request a prior authorization number on an urgent basis, outside of UnitedHealthcare normal business hours?

Yes. If a procedure is medically required on an urgent basis, outside of UnitedHealthcare normal business hours, a prior authorization number must be requested retrospectively.

- The retrospective review request must be made by calling **866-889-8054**
- Retrospective review requests for electrophysiology implants and diagnostic catheterizations must be requested within 15 calendar days after the date of service. This retrospective review process does not apply to the facility’s separate inpatient admission notification requirement. For echocardiogram and stress echocardiogram procedures, retrospective review requests must be made within 2 business days after the date of service.
- Documentation must include an explanation of why the procedure was required on an urgent basis and why a prior authorization number could not have been requested during UnitedHealthcare normal business hours, or that it was performed during the course of an inpatient stay. Retrospective review is not available for outpatient elective procedures.

CPT codes and modifications

When can the rendering care provider modify the CPT code for the cardiac procedure being performed without contacting UnitedHealthcare?

The rendering care provider will not be required to contact UnitedHealthcare to modify the existing prior authorization record for CPT code combinations listed in the Cardiology Prior Authorization CPT Code List and Crosswalk Table.

A complete listing of codes and the CPT Code Crosswalk Table are available at [UHCprovider.com](https://www.uhcprovider.com) > Prior Authorization and Notification Resources > Cardiology. Click on Community Plan under Specific Cardiology Programs.

If a CPT code combination is not listed on the CPT Code Crosswalk Table, the Cardiology Prior Authorization program for additional cardiac procedures still applies and a modification to the authorized procedure would need to occur.

How does the CPT Code Crosswalk Table work?

The Crosswalk Table reads from left to right. If the ordering care provider obtains a prior authorization for a CPT code listed in the left column, and the procedure is later changed to the corresponding CPT code in the right column, no further action is required. In this case, the rendering care provider does not need to update the original prior authorization number request.

If the ordering care provider obtains a prior authorization for a CPT code listed in the left column, and the procedure is later changed to a CPT code not listed in the right column, either the ordering or rendering care provider must modify the original prior authorization number request. The modification must occur online or by calling us within 2 business days after the procedure is rendered.

Case numbers and prior authorization numbers

What is a case number, and when is a case number assigned?

A case number is assigned upon initiating the prior authorization process. If a prior authorization number request can’t be completed after the initiation of the request by either phone or online, the case number is used as a reference for providing missing clinical information.

- The case number format is a 10-digit number (e.g., 1041401245)
- Case numbers are **not valid** for claim payment



When will a prior authorization number be issued, and what makes the prior authorization number different from a case number?

When the prior authorization process has been completed, a prior authorization number is issued. Unlike case numbers, prior authorization numbers are alphanumeric.

How long is a prior authorization number valid?

The prior authorization number is valid for 45 calendar days. It is specific to the procedure requested, to be performed 1 time, for 1 date of service within the 45-day period.

UnitedHealthcare will use the date the prior authorization number was issued as the starting point for the 45-day period in which the cardiac procedure must be completed.

If a procedure is not completed within 45 days, a new prior authorization number must be requested.

How is the ordering care provider notified that the prior authorization process has been completed?

Once the prior authorization process has been completed, the ordering care provider will receive a letter by fax. If you elected to receive correspondence by email, you'll be notified by email when the letter is available online.

If we determine during the prior authorization process that the service does not meet medical necessity criteria, a clinical denial is issued. We issue the member and ordering care provider a denial notice with the appeal process outlined.

Is the information requested during the online submission process the same as the information requested by telephone?

Yes. The information requested online and over the telephone is the same.

What happens if the wrong insurance information is presented to the ordering care provider and the authorization request is not initiated as required?

If a claim is denied for not completing the prior authorization process because the wrong insurance information was presented to the care provider, the rendering care provider may submit an appeal by contacting UnitedHealthcare. For more information, please refer to the claims reconsideration and appeals process outlined in the UnitedHealthcare provider administrative guide available at UHCprovider.com/guides.

Is there an appeal process if the prior authorization request is not approved?

Yes. The ordering care provider and the member will be informed in writing of the reason for the prior authorization denial, including the clinical rationale, as well as how to initiate an appeal. All appeals will be managed by UnitedHealthcare. An authorized representative, including a care provider, acting on behalf of his/her patient, with the member's written consent, may file an appeal on behalf of their patient.



We're here to help

If you have questions, please contact your provider advocate or UnitedHealthcare network representative. Thank you.

