Cardiology prior authorization program

Frequently asked questions

UnitedHealthcare Individual Exchange and commercial plans overview

Prior authorization is required for select cardiology procedures provided to certain UnitedHealthcare commercial and Individual Exchange 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 commercial and Individual Exchange 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 at **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

Does the cardiology prior authorization program apply to all UnitedHealthcare commercial and Individual Exchange plans?

No. Prior authorization doesn’t apply to all UnitedHealthcare commercial and Individual Exchange plans. The following benefit plans are excluded:

- UnitedHealthcare Options PPO: Care providers aren’t required to follow this protocol for Options PPO benefit plans because members enrolled in these benefit plans are responsible for providing notification/requesting prior authorization
  Exception: Care providers are required to follow this protocol for Options PPO benefit plans for members in Colorado. These members are not responsible for providing notification or requesting prior authorization.

Key points

- The cardiology prior authorization program applies to certain instances 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
- Certain UnitedHealthcare commercial and Individual Exchange plans are excluded from the protocol
- 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

PCA-2-21-04434-VC-WEB_12152021

United Healthcare

- UnitedHealthOne – Golden Rule Insurance Company, group number 705214 only
- M.D. IPA, Optimum Choice, Inc. or OneNet PPO
- Oxford Health Plans
- UnitedHealthcare Indemnity/Managed Indemnity
- Benefit plans sponsored or issued by certain self-funded employer groups
- Medicare Advantage, Medicaid or CHIP plans. Members of these plans are subject to the administrative guide, member manual or supplement of that affiliate.
- Individual Exchange plans offered in Nevada and Colorado are subject to the administrative guide, member manual or supplement of that affiliate

Any existing requirements about notification, authorization and/or precertification for the above listed excluded entities remain in place.

Is prior authorization required if UnitedHealthcare is the secondary payer?

No. Notification/prior authorization isn't required when UnitedHealthcare is secondary to any other payer, including Medicare.

Who is responsible for providing notification/requesting prior authorization for a cardiac procedure?

The ordering care provider's office is responsible for notifying UnitedHealthcare before scheduling the cardiac procedure. In some situations, however, the rendering care provider is responsible for notifying us.

How can I initiate the prior authorization process or confirm that a coverage decision has been made?

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

- **Online:** Use the Prior Authorization and Notification tool at **UHCprovider.com/paan**
- **Phone:** Call **866-889-8054,** 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 notification/prior authorization number doesn't 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. Payment is also subject to applicable state regulations.

How will I know if a clinical coverage review is required to determine if the service is medically necessary?

When we receive notification of a cardiac procedure, and if the member's benefit plan requires services to be medically necessary in order to be covered, we will conduct a clinical coverage review to determine whether the service is medically necessary pursuant to the prior authorization process. You don't need to determine whether prior authorization is required in a given case or for a given member, because once you notify UnitedHealthcare of a planned service, we will confirm whether a clinical coverage review is required.

If the member's benefit document doesn't require that services be medically necessary to be covered, and if the service does not meet evidence-based clinical guidelines or if additional information is necessary, UnitedHealthcare will confirm whether the ordering care provider must engage in a physician-to-physician discussion.

What is the rendering care provider's responsibility when the ordering care provider doesn't participate in UnitedHealthcare network?

If a non-participating ordering care provider is unwilling to complete the notification/prior authorization process, the rendering care provider is required to complete the process. If a non-participating care provider is registered to use our secure applications, they can still initiate the notification/prior authorization process on **UHCprovider.com,** or by calling **866-889-8054** and selecting the option for UnitedHealthcare commercial and Individual Exchange members.

If the cardiology notification/prior authorization protocol isn't followed by the rendering care provider, administrative claim denials may result. You cannot bill members for claims that are administratively denied.

If an administrative denial is appealed by the rendering care provider, UnitedHealthcare will uphold the denial on the basis that the ordering care provider doesn't participate in UnitedHealthcare network and the rendering care provider didn't complete the notification/prior authorization process as required.

Who is responsible for confirming that the prior authorization process has been completed and a coverage decision has been issued?

Rendering care providers are responsible for confirming that the notification/prior authorization process has been completed and a coverage decision has been issued before performing the cardiac procedure. If the rendering care provider determines the notification/prior authorization process hasn't been completed and a coverage determination has not been issued, if required, and the ordering care provider participates in UnitedHealthcare network, we will use reasonable efforts to work with the rendering care provider to urge the ordering care provider to complete the process and, if applicable, obtain a coverage decision prior to rendering the procedure.

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

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 notification/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 notification/prior authorization requirements:

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

Who reviews prior authorization requests?

Board-certified cardiologists review notification/prior authorization requests. Ordering or rendering care providers may request a physician-to-physician discussion with the reviewing cardiologist. To initiate a physician-to physician discussion:

- Call **866-889-8054** and select option 3. Be sure to 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
- Rendering care provider's name, mailing address, phone number and TIN/NPI number (if different than the ordering provider)
- 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 notification/authorization number to the rendering care provider.

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

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

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

- For echocardiograms and stress echocardiograms, the professional component (modifier 26) will not be subject to administrative denial if the notification/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 notification/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 notification/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.** The ordering care provider 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 the ordering care provider request a prior authorization number on an urgent basis outside of UnitedHealthcare normal business hours or request a prior authorization number on a retrospective basis?

Yes. If a procedure is medically required on an urgent basis, outside of UnitedHealthcare normal business hours, a notification/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 notification/prior authorization number couldn't 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 notification/prior authorization record for CPT code combinations listed in the Cardiology Notification/Prior Authorization CPT Code List and Crosswalk Table
- A complete listing of codes and the CPT Code Crosswalk Table are available at **UHCprovider.com** > Prior Authorization and Notification Resources > Cardiology

How does the CPT Code Crosswalk Table work?

The Crosswalk Table reads from left to right. If the ordering care provider obtains a notification/prior authorization number 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 doesn't need to update the original notification/prior authorization number request

If the ordering care provider obtains a notification/prior authorization number 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 notification/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 notification/prior authorization process. If a notification/prior authorization number request can't be completed after the request is initiated by phone or online, the case number is used to access case details during a physician-to-physician discussion or 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 notification/prior authorization process has been completed, a notification/prior authorization number is issued. Unlike case numbers, notification/prior authorization numbers are alpha/numeric.

How long is a prior authorization number valid?

- The notification/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 notification/prior authorization number was issued as the starting point for the 45-day period in which the procedure must be completed
- If the procedure is not completed within 45 days, a new notification/prior authorization number must be requested

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

Once the notification/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 clinical coverage review 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.

What is a physician-to-physician discussion, and when is one required?

The physician-to-physician discussion is an opportunity for the ordering care provider to review the notification/prior authorization request with a reviewing physician from UnitedHealthcare (or the UnitedHealthcare designee) to provide additional clinical information and/or discuss alternative approaches to the requested procedure. The discussion can be performed by the ordering care provider, a nurse practitioner or a licensed physician's assistant. If a request does not meet evidence-based clinical guidelines or if additional information is necessary and:

- The member's benefit plan doesn't require services to be medically necessary in order to be covered, a physician-to-physician discussion will be required for the process to be completed
- The member's benefit plan does require services to be medically necessary in order to be covered, while a physician-to-physician discussion is not required, it is available as an option to the ordering care provider. A physician-to-physician discussion can also be performed after a clinical denial has been issued. Subject to certain state regulations, this discussion may be considered an informal reconsideration.

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

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

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

- If a claim is denied for not completing the notification/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** > UnitedHealthcare Care Provider Administrative Guide

We're here to help

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