

# Outpatient Radiology Notification/Prior Authorization Protocol for Commercial and Exchange Plans

## Frequently Asked Questions

### Overview

Notification/prior authorization is required for select advanced outpatient imaging procedures provided to certain UnitedHealthcare commercial and Exchange plan members. The advanced outpatient imaging procedures that are subject to notification/prior authorization requirements are referred to as “advanced outpatient imaging procedures” in these frequently asked questions.

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

We worked with external physician advisory groups to develop and update the Outpatient Radiology Notification/Prior Authorization Protocol to apply more consistent current scientific clinical evidence and professional society guidance to advanced outpatient imaging procedures.

We review the evidence-based clinical guidelines annually to align with current best practices. They are based on guidance from nationally and internationally recognized medical societies, supplemented by material from peer-reviewed literature, to reflect the most current evidence-based guidelines for imaging. The clinical guidelines, along with other related resources, are available on [UHCprovider.com/radiology](https://UHCprovider.com/radiology).

Please use these frequently asked questions as a resource about the requirements of the Outpatient Radiology Notification/Prior Authorization Protocol.

### Frequently Asked Questions

#### Does the Outpatient Radiology Notification/Prior Authorization Protocol apply to all UnitedHealthcare commercial and Exchange plans?

No. The protocol does not apply to all UnitedHealthcare commercial and 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

### Key Points

The Outpatient Radiology Notification/Prior Authorization Protocol applies to certain instances of the following advanced outpatient imaging procedures:

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron-emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology

Notification/prior authorization requirements apply to outpatient and office-based settings.

Certain UnitedHealthcare commercial and Exchange plans are excluded from the protocol.

Provider demographic information and other specific details for what's required to initiate and include with a notification/prior authorization request are outlined below.

The process for urgent requests and retrospective authorization is explained below.

members are not responsible for providing notification or requesting prior authorization).

- **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**
- **Sierra**
- **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.
- 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 notification/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 an advanced outpatient imaging procedure?**

The ordering care provider's office is responsible for notifying UnitedHealthcare before scheduling the advanced outpatient imaging procedure. In some situations, however, the rendering care provider is responsible for notifying us. Question 9 has additional information about the rendering care provider's responsibilities.

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

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

- Sign in to Link by clicking on the Link button in the top right corner of **UHCprovider.com**. Then select the Prior Authorization and Notification tool.
- Call **866-889-8054**, 7 a.m. to 7 p.m., local time, Monday through Friday.

### **Which advanced outpatient imaging procedures require notification/prior authorization?**

Notification/prior authorization is required for certain instances of the following advanced outpatient imaging procedures:

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron-emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology

For the most current listing of CPT® codes for which notification/prior authorization is required pursuant to the protocol, refer to **UHCprovider.com/radiology**.

If you don't request notification/prior authorization or verify that one has been obtained before rendering an advanced outpatient imaging procedure, it may result in an administrative claim denial. **You cannot bill members for the services.**

## **Does receipt of a notification/authorization number guarantee that UnitedHealthcare will pay the claim?**

No. Receipt of a notification/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. 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 an advanced outpatient imaging procedure, in order for coverage to be provided, the service must be medically necessary. 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 in order to be covered, and if the service doesn't 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.

## **If a primary care provider refers a member to a specialist, and the specialist determines the need for an advanced outpatient imaging procedure, who is responsible for notifying UnitedHealthcare?**

The care provider who orders the advanced outpatient imaging procedure is responsible for notifying UnitedHealthcare before scheduling the procedure. In this situation, the specialist is responsible for notifying UnitedHealthcare.

## **What is the rendering care provider's responsibility when the ordering care provider does not participate in UnitedHealthcare's 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, he or she 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 Exchange members.

If the Outpatient Radiology Notification/Prior Authorization Protocol is not followed by the rendering care provider, administrative claim denials may result. You cannot bill members for claims that are administratively denied.

## **Who is responsible for confirming that the notification/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 prior to rendering the advanced outpatient imaging procedure. If the rendering care provider determines the notification/prior authorization process has not been completed and a coverage determination has not been issued, if required, and the ordering care provider participates in UnitedHealthcare's 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's 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.

# Notification/prior authorization requirements

## Which places of service are subject to the notification/prior authorization requirements?

Notification/prior authorization is required for services performed in outpatient and office-based settings.

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

Advanced outpatient imaging 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 notification/prior authorization requests?

Physicians in various specialties, including radiology, review prior authorization requests. Ordering or rendering care providers may request a physician-to-physician discussion with the reviewing provider.

- Call **866-889-8054** and select option 3. Then, provide the 10-digit case number. If there is no case number or it is invalid, press \*.

## What information may be requested for a notification/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 imaging 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.
- 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 notification/prior authorization process have to be completed for each advanced outpatient imaging procedure ordered?

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

## If a free-standing clinic is attached to a hospital, and members are sent from the hospital to the clinic for an advanced outpatient imaging procedure, is notification/prior authorization still required?

Yes. Notification/prior authorization is required if an advanced outpatient imaging procedure is requested from an inpatient, emergency room, observation unit or urgent care center but the procedure will be billed with an outpatient place of service.

However, notification/prior authorization is not required for advanced outpatient imaging procedures rendered in, and appropriately billed with, an emergency room, observation unit or urgent care center, or during an inpatient stay.

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

If the notification/prior authorization process is not completed, the professional component (modifier 26) will not be subject to administrative denial if the notification/prior authorization process isn't completed.

If a clinical denial is received and the procedure is still performed, the professional component of the claim will be subject to denial for lack of medical necessity.

## **Urgent requests and retrospective notification/authorization**

### **Can the ordering care provider request a notification/prior authorization number on an urgent basis during UnitedHealthcare's 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**. You must state that the case is "clinically urgent" and explain the clinical urgency. UnitedHealthcare will respond to urgent requests within three hours of our receipt of all required information.

### **Can an ordering care provider request a notification/prior authorization number on an urgent basis outside of UnitedHealthcare's normal business hours?**

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

- You must submit the request for notification/prior authorization retrospectively within two business days after the date of service.
- Documentation must include an explanation as to why the procedure was required on an urgent basis and why a notification/prior authorization number couldn't have been requested during UnitedHealthcare's normal business hours.

## **CPT codes and modifications**

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

The rendering care provider is not required to contact UnitedHealthcare to modify the existing notification/prior authorization record for CPT code combinations listed in the Radiology Notification/Prior Authorization Crosswalk Table. A complete listing of codes and the CPT Code Crosswalk Table is available at [UHCprovider.com](http://UHCprovider.com) > Prior Authorization and Notification Resources > Radiology.

### **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 does not 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 two business days after the procedure is rendered.

## When must I contact UnitedHealthcare to modify the CPT code for the imaging procedure being performed?

You're required to contact UnitedHealthcare when the CPT code combination is **not listed** in the Radiology Notification/Prior Authorization Crosswalk Table. Please follow these steps to modify the existing notification/prior authorization number request:

- If the procedure being performed is for a contiguous body part, either the ordering or rendering care provider must modify the original notification/prior authorization number request. The request must be modified within two business days after the procedure is rendered either online or by phone.
- To access the Prior Authorization and Notification tool, sign in to Link by going to **UHCprovider.com** and clicking on the Link button in the top right corner.
- Call **866-889-8054**.
- If the procedure being performed **is not** for a contiguous body part, the ordering care provider must obtain a new notification/prior authorization number.
- UnitedHealthcare must issue a coverage decision prior to the procedure being performed.
- A procedure for a different, noncontiguous body part will be considered a new request for a notification/ prior authorization number.

## Case numbers and notification/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 notification/prior authorization number be issued, and what makes the notification/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 notification/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 one time, for one 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 notification/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 UnitedHealthcare's 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 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 notification/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 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 Provider Administrative Guide available at [UHCprovider.com/guides](https://www.uhcprovider.com/guides). (Choose the UnitedHealthcare Administrative Guide for Commercial and Medicare Advantage Including UnitedHealthcare West Fee-for-Service.)

## We're here to help.

If you have questions, please contact your Provider Advocate or UnitedHealthcare Network Representative. Thank you.



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