Prior Authorization Requirements for Certain Therapy Services Effective Sept. 15, 2019

Frequently Asked Questions

Overview

UnitedHealthcare Community Plan of Nebraska aims to improve cost efficiencies for the overall health care system. One way we'll do that is by conducting site of care medical necessity reviews, consistent with the member's benefit plan and applicable state law, for all speech, occupational and physical therapy services. We're also revising our existing prior authorization requirements.

The updated prior authorization requirements outlined in our August 2019 Network Bulletin article will apply and we'll conduct site of service medical necessity reviews for therapy services. You can find the Network Bulletin at UHCprovider.com/news > Network Bulletin > August 2019 Network Bulletin.

Updated Prior Authorization Requirements

For dates of service on or after Sept. 15, 2019, we're changing our prior authorization requirements for speech, occupational and physical therapy services:

- The member's primary care provider (PCP) or referring specialist will be required to submit prior authorization requests for evaluations and re-evaluations.
- Additional documentation is required as part of the prior authorization process for evaluations and re-evaluations.
- After a prior authorization request is approved for an evaluation or re-evaluation, the treating therapy provider can submit the prior authorization requests for subsequent treatment visits.

The documentation requirements are included in the coverage determination guidelines we use to facilitate our medical necessity determinations for these therapy services 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.

You can find the list of services that are subject to prior authorization requirements at UHCprovider.com/NEcommunityplan > Prior Authorization and Notification Resources > Current Prior Authorization Plan Requirements.

If you have questions, please contact Provider Services at 866-331-2243. Thank you.

Key Points

For dates of service starting Sept. 15, 2019, and after, we require prior authorization for outpatient and home health physical, occupational and speech therapy services for all UnitedHealthcare Community Plan of Nebraska members.

These requirements will apply whether a member is new to therapy or will continue receiving therapy on or after Sept. 15, 2019.

Claims will be denied if prior authorization is not on file before the date of service.

UnitedHealthcare Community Plan

Frequently Asked Questions

Prior Authorization Requirement Update

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

In order to support the physician's role in managing member care, starting with dates of service on or after Sept. 15, 2019, the referring care provider (the member's PCP or referring specialist) will be required to submit prior authorization requests for evaluations and re-evaluations. Claims will be denied if prior authorization is not on file before the date of service.

Before this change, these types of prior authorization requests for therapy services were often submitted by therapy providers. For dates of service on or after Sept. 15, 2019, requests for treatment may be submitted by the therapy provider if an authorization for an evaluation or re-evaluation was obtained.

Which members are affected by these new prior authorization requirements?

These prior authorization updates will apply to Nebraska Medicaid benefit plan members.

Will these prior authorization requirements apply for members who have been receiving therapy services before Sept. 15, 2019?

Yes. Prior authorization requirements will apply to members who are new to therapy and those who are currently receiving therapy. You should submit prior authorization requests for members currently receiving treatment, up to 14 days before Sept. 15, 2019, to allow for processing time.

Will these requirements affect claims or a member's out-of-pocket costs?

No. If prior authorization is not on file before performing a procedure, claims for that service will be denied and the member can't be billed for the service.

If my patient who is a UnitedHealthcare Community Plan member currently receives 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 six months), a new evaluation or re-evaluation isn't required. You may submit a prior authorization request for the treatment services. You should 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

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

What documentation is required when the PCP or referring specialist submits a prior authorization request for evaluations and re-evaluation?

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 six, documentation of a hearing screening performed per the member's early periodic screening, diagnostic and treatment (EPSDT) periodicity schedule (See the Speech Language Therapy coverage determination guideline for more 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)

Submitting a Prior Authorization Request

Where can I submit a prior authorization request?

You can submit your prior authorization requests for these services using the Prior Authorization and Notification tool on Link at UHCprovider.com/paan. Go to UHCprovider.com and click on the Link button in the top right corner. Then, select the Prior Authorization and Notification tool on your Link dashboard.

Who can submit a prior authorization request for initial evaluations and re-evaluations?

The member's PCP or referring specialist (MD, DO, physician assistant or nurse practitioner) may submit the prior authorization request for the initial evaluation or re-evaluation.

Who can submit a prior authorization request for therapy visits?

After a prior authorization request is approved for an evaluation or re-evaluation, the treating therapy provider can submit the prior authorization requests for subsequent treatment visits.

Without a completed prior authorization request for evaluation or re-evaluation, the member's PCP will have to send in the request for therapy visits.

How far in advance can I submit my prior authorization request?

You can request prior authorization up to 14 days before the requested service date.

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, please choose the "Office or Outpatient" from the drop-down menu. Do not choose "Outpatient Facility."

Are submission instructions or training available?

Yes. We have reference guides as well as on-demand and live training available at UHCprovider.com/paan > Training.

Which CPT® codes are commonly used for evaluations and re-evaluations?

The following CPT codes are the most commonly used codes for therapy evaluations and re-evaluations.

CPT Code	Therapy Type	Evaluation or Re-Evaluation CPT Code	Code Definition
92521	ST	Evaluation	Evaluation of speech fluency (e.g., stuttering, cluttering)
92522	ST	Evaluation	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)
92523	ST	Evaluation	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); ***with*** evaluation of language comprehension and expression (e.g., receptive and expressive language)
92524	ST	Evaluation	Behavioral and qualitative analysis of voice and resonance
S9152	ST	Re-Evaluation	Speech Therapy, Re-Evaluation
97161	PT	Evaluation	Low Complexity, Evaluation
97162	PT	Evaluation	Moderate Complexity, Evaluation
97163	PT	Evaluation	High Complexity, Evaluation
97164	PT	Re-Evaluation	Re-Evaluation for all levels
97165	OT	Evaluation	Low Complexity, Evaluation
97166	OT	Evaluation	Moderate Complexity, Evaluation
97167	OT	Evaluation	High Complexity, Evaluation
97168	OT	Re-Evaluation	Re-Evaluation for all levels

Prior Authorization Request Review and Notification

How quickly will you process my request?

We'll process a complete prior authorization request within 14 calendar days.

Who will review my prior authorization request?

Licensed medical professionals, including physical therapists, occupational therapists, and speech-language pathologists, will review your prior authorization request using evidenced-based clinical criteria. A licensed physician will review all requests considered for medical necessity.

What criteria does UnitedHealthcare use to review prior authorization requests?

Our medical necessity reviews are consistent with the member's benefit plan and applicable state law for all speech, occupational and physical therapy services. The coverage determination guidelines we use to facilitate our medical necessity determinations for these therapy services will be available 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.

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How will you notify me of the coverage determination for evaluations or re-evaluations?

If we approve the request, we'll notify the requesting care provider and the treating therapist by fax. If we deny the request, we'll send a letter to the requesting care provider, treating therapist and member.

How will you notify me of the coverage determination for treatment services?

If we approve the request, we'll notify the treating therapist by fax. If we deny the request, we'll send a letter to the treating therapist and the member.

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