Prior authorization requirements for PT, OT and ST services for UnitedHealthcare Community Plan of Nebraska

Frequently asked questions

Overview

Effective Nov. 1, 2022, prior authorization is required for occupational (OT), physical (PT) and speech therapy (ST) services after the initial evaluation. This applies to UnitedHealthcare Community Plan members in Nebraska.

- Health care professionals should submit an initial prior authorization request for ongoing therapy services (OT, PT or ST) after evaluation
  - You are not required to submit any clinical information at that time
- Based on the initial prior authorization request, each specialty will be given 12 visits per discipline, per episode (48 units for timed services)
- Once the 12th visit per episode (48 timed units) has been exhausted, you're required to submit a new prior authorization request for additional services
- The new prior authorization request must comply with the prior authorization and documentation requirements outlined in the following determination guidelines, resources and frequently asked questions (FAQ) answers

We'll conduct medical necessity reviews for all requests beyond 12 visits per episode (48 units for timed services). To view the documentation requirements, see the **UnitedHealthcare Community Plan Medical & Drug Policies and Coverage Determination Guidelines**.

Additional resources:

- **Occupational, physical and speech coverage determination guidelines**
- UnitedHealthcare Community Plan of Nebraska **prior authorization requirements**

If you have questions, please call UnitedHealthcare at **866-331-2243**. For any contracting and credentialing questions, please call Optum at 800-873-4575.

Frequently asked questions

How do I submit a prior authorization request for PT, OT or ST services?

- **Online:** Use the Prior Authorization and Notification tool on the **UnitedHealthcare Provider Portal**. To sign in to the portal, go to **UHCprovider.com** and select Sign In in the upper-right corner to log in using your One Healthcare ID and password. If you don't have one, visit **UHCprovider.com/access** and link to:
  - **Learn more at UHCprovider.com/priorauth**
- **Phone:** Call Provider Services at **866-331-2243**

When should I submit the prior authorization request?

You can submit your request up to 14 days before the requested service date.

How does this change differ from your previous prior authorization requirements?

Before Nov. 1, 2022, prior authorization was required for PT, OT and ST services. However, clinical review began with the first visit following the initial evaluation. We are now offering up to 12 visits per episode (or 48 timed units) per discipline, per calendar year, prior to conducting a medical necessity-based review.

- We will still require that a prior authorization request be submitted for the initial 12 visits per episode (48 timed units), although these visits will be approved without undergoing clinical medical necessity review
- Once the member has used the initial 12 visits per episode (or 48 timed units), you'll be required to submit complete documentation
- A formal medical necessity review will be performed based on these guidelines

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

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

Key points

- For dates of service on or after Nov. 1, 2022, prior authorization is required for PT, OT and ST services for UnitedHealthcare Community Plan of Nebraska members
- Health care professionals should submit an initial prior authorization request for ongoing PT, OT or ST services after the initial evaluation
- These requirements will apply whether a member is new to therapy or will continue receiving therapy on or after Nov. 1, 2022
- We will deny claims if an approved prior authorization is not on file before the date of service. Members cannot be balance billed.

UnitedHealthcare Community Plan

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

These requirements will not impact members' out-of-pocket costs. If a prior authorization is not on file before performing a procedure, claims for that service will be denied and the member cannot be billed for the service.

If my patient is currently receiving PT, OT or ST services, do I need to do a new evaluation or reevaluation before requesting prior authorization for therapy treatment services?

If the member's plan of care is current (completed within the past 6 months), a new evaluation or reevaluation isn't required. If there is a current authorization on file, care can continue through the end of that authorization. For ongoing care past the current authorization, follow the process outlined below.

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 I submit a prior authorization request?

For members younger than 21:

- Signed and dated physician order, less than 30 days old, specifying the discipline(s) to be evaluated
- Current evaluation/reevaluation report and plan of care (plan of care duration can be for up to 90 days. For care beyond 90 days, a new authorization would need to be submitted with a new plan of care.)
- Current well-child visit or an exam note describing the need for the requested evaluation(s)
- For ST initial evaluation requests for members younger than 6, documentation of a hearing screening performed per the EPSDT Periodicity Schedule. See the **occupational, physical and speech coverage** for additional 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
- Current evaluation/reevaluation report and plan of care (plan of care duration can be for up to 60 days. For care beyond 60 days, a new authorization would need to be submitted with a new plan of care.)
- Exam note describing the need for the requested evaluation(s)

What codes require prior authorization?

Ongoing treatment codes require prior authorization. See the complete list on the UnitedHealthcare Community Plan of Nebraska **prior authorization page**.

Who can submit a prior authorization request for therapy visits?

The treating health care professional can submit the prior authorization requests for subsequent treatment visits.

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 dropdown menu. Do not choose "Outpatient Facility." Home health providers should select the "Home" place of service.

Are submission instructions or training available?

Yes. You can access interactive, self-paced courses on the portal tools, including the Prior Authorization and Notification tool, on our **training page**.

How quickly will you process my request?

We'll process a complete prior authorization request within 14 calendar days from the receipt of request. In most situations, we can review the request within 3 days of receipt as long as the request has complete information.

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 state-specific 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.

How will you notify me of approvals?

If we approve the request, we'll notify the treating therapist by fax. Notifications will also be available on the UnitedHealthcare Provider Portal.

How will you notify me of denials?

If we deny the request, we will notify the treating therapist by phone. We'll also send a letter to the therapist and member.

What are the ages and benefit limits for adult and child therapy?

For members ages 21 and older, Heritage Health – the Nebraska managed care program – covers a combined total of 60 therapy sessions per calendar year. The combined total of 60 therapy sessions per calendar year includes all OT, PT and ST sessions.

For clients ages 20 and younger, Heritage Health covers OT, PT and ST services when the service is:

- An evaluation
- Restorative therapy with a medically appropriate expectation that the client's condition will improve significantly within a reasonable period of time; or
- Recommended in a Department of Health and Human Services (DHHS)-approved department-approved Individual Program Plan (IPP) and the client is receiving services through 1 of the DHHS waiver programs

What is the maximum treatment span duration that may be approved for ongoing services?

The maximum treatment span duration is up to 6 months to support the need for ongoing services. Reevaluations performed more often than once every 6 months should only be completed when the member experiences a significant change in functional level in their condition or functional status.

Can the length of an authorization be extended beyond the initial 12 visits per episode?

We're now offering up to 12 visits per episode (or 48 timed units) annually prior to conducting a medical necessity-based review. Once the member has used the initial 12 visits per episode (or 48 timed units), you're required to submit an authorization for additional services, including complete documentation as outlined in the policies noted above. A formal medical necessity review will be performed based on these guidelines.

Can the length of an authorization be extended beyond the initial time frame?

You'll need to call Provider Services at **866-331-2243** to request an extension. Granting a date extension may depend on the reason those visits were not utilized during the initial date span. Medical necessity would still be a consideration for extending dates. If granted, this would be on a one-time basis for up to 30 days.

Optum therapy providers should call Optum Provider Services at 800-873-4575 if they have questions.

If I treat a member without a prior authorization on file, how many days do I have to send in the request without having to submit an appeal?

A prior authorization should be completed within 5 business days from the initial date of service.

What is the new process for new episodes of care?

Based on the initial prior authorization request, each discipline will be given 12 visits per episode (48 units for timed services) per calendar year. Once the 12th visit (48 timed units) has been exhausted, you will be required to submit a new request for additional services, which includes an authorization for any new episodes of care or condition. The new request must comply with the prior authorization and documentation required in the therapy policy.

Can the patient be seen for 2 PT or OT cases concurrently? What is the authorization process if the patient has 2 different injuries and 2 different doctors?

The initial therapy provider in the same discipline will be given 12 visits per episode (48 units for timed services). Any additional services with a second therapy health care professional in the same discipline will need to submit a prior authorization request for medical necessity review.

Do multiple modalities count as 1 visit, if done on the same day?

Multiple modalities performed by 1 discipline would count as 1 visit. One visit is equal to up to 4 units of time services per day per discipline.

Is authorization required when UnitedHealthcare Community Plan is secondary to UnitedHealthcare Medicare Advantage or commercial plan policies?

Prior Authorization is not required when Medicaid is secondary. However, if at any time UnitedHealthcare Community Plan becomes primary, then an authorization would be required prior to services being rendered.

Does prior authorization apply to members in a skilled level of care or in a long-term care setting?

Prior authorization does not apply to members in skilled or rehabilitation facilities, as those are considered inpatient services and the therapy is the qualifier for the approval of the skilled level of care. Prior authorization applies to all outpatient settings (home health, long-term care, office, hospital outpatient services) and does include residents in custodial/long-term care facilities, as this is their place of residence and the therapies would be considered an outpatient service.

What start date do we need to use when requesting authorization?

Services required on the same date as an evaluation will require prior authorization within 5 business days of the evaluation. If no service is provided on the evaluation date, the date of authorization would be the next scheduled therapy visit.

PCA-1-24-02372-Clinical-FAQ_08202024

United Healthcare® Community Plan

Do we need to send a hard copy of the MD order at the time of the prior authorization request?

Treatment must be ordered by a physician or an advanced practice registered nurse (APRN) and be medically necessary for the member's plan of care. A signed and dated physician or APRN order is not required at the time of requesting prior authorization for the initial 12 visits per episode but is required to be a part of the patient's file for audit purposes.

Do evaluations or reevaluations require prior authorization?

Evaluations and reevaluations do not require prior authorization for in-network providers. Evaluations and reevaluations do require prior authorization for out-of-network providers.

If my prior authorization is denied, who can request a peer review?

Only the primary care provider (PCP) or referring physician can request a peer review.