Prior authorization for outpatient therapy and chiropractic services

UnitedHealthcare® Medicare Advantage – updated Apr. 1, 2025

Overview

Prior authorization is required for physical therapy (PT), occupational therapy (OT), speech therapy (ST) and chiropractic services delivered in office and outpatient hospital settings, excluding home settings. This currently applies to UnitedHealthcare® Medicare Advantage members.

Reminder

Providers must continue to submit a prior authorization request for the entire plan of care, including the full duration and number of visits requested. For new authorization requests, up to 6 visits of a member's initial plan of care will be covered without conducting a clinical review when the first 6 visits take place within 8 weeks. **A prior authorization request must still be submitted for the initial 6 visits.**

Only plans of care requesting more than 6 visits or exceeding 8 weeks will be assessed for medical necessity. The initial consultation still does not require prior authorization. Authorizations are subject to member eligibility and timely filing policy.

Coverage of the initial consultation and up to 6 visits of a member's requested plan of care within 8 weeks will apply without a clinical review under any of the following circumstances:

- The member is new to your office
- The member presents with a new condition
- The member has had a gap in care of 90 or more days

Once the initial plan of care is complete, additional visits may be requested by submitting a new request for authorization.

For a comprehensive overview of the requirements that began Sept. 1, 2024, see the **Advance Notification and Clinical Submission Requirements**.

Process

Prior authorization is not required for the initial evaluation to be considered for reimbursement. However, a prior authorization is required for the entire plan of care, including the request for up to 6 visits. Health care providers are required to submit the initial evaluation results and the care plan.

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Additional authorization is required for all subsequent visits. Providers should use the **UnitedHealthcare Provider Portal** to request prior authorization.

When performed, medical necessity reviews will use applicable LCDs, **CMS Chapter 15 criteria**, and InterQual® criteria to render a determination. Medical necessity reviews are conducted by licensed medical professionals including chiropractors, physical therapists, occupational therapists and speech-language pathologists. The provider and member will be notified of our medical necessity determination.

Impacted procedure codes

- **Outpatient therapies:** 92507, 92508, 92526, 97012, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97124, 97139, 97140, 97150, 97164, 97168, 97530, 97533, 97535, 97537, 97542, 97545, 97546, 97750, 97755, 97760, 97761, 97799, G0283
- **Chiropractic services (Medicare-covered):** 98940, 98941, 98942 when billed with the AT-modifier

Frequently asked questions

Who will be impacted by these new requirements?

This applies to in-network providers for the following UnitedHealthcare Medicare Advantage benefit plans.

- Medicare Individual (including Chronic SNPs) plans
- Medicare Group Retiree plans
- UHCWest Medicare plans in Nevada, Oregon, Washington and Texas

Which plans are excluded from the new requirement?

- Out-of-Network providers
- UnitedHealthcare® Dual Complete plans including Optum at Home
- UnitedHealthcare Nursing Home and UnitedHealthcare Assisted Living Plans
- UHCWest (specific plans in California and Arizona)
- Erickson Advantage
- Peoples Health Plans
- Preferred Care Network and Preferred Care Partners of Florida
- Rocky Mountain Medicare Advantage Plans

OptumCare and WellMed contracted providers, please refer to the number on member ID card for prior authorization instructions.

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Which services are excluded from the new requirements?

Inpatient therapy and therapy services performed in the home (Place of Service Home) are excluded from this program. Existing prior authorization requirements under Home Health program category will still apply. Please refer to prior authorization requirements found at **Advance Notification and Clinical Submission Requirements | UHCprovider.com**.

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

Yes. All therapy or chiropractic services requires prior authorization for Medicare Advantage members. Providers must continue to submit a prior authorization request for the entire plan of care, including the full duration and number of visits requested.

For new authorization requests, up to the first 6 visits of a member's initial plan of care will be covered without conducting a clinical review when the first 6 visits take place within 8 weeks. **A prior authorization request must still be submitted for the 6 visits.**

Only care plans requesting more than 6 visits or in excess of 8 weeks will be assessed for medical necessity. The initial consultation/evaluation still does not require prior authorization.

What does multidisciplinary practice mean?

Multidisciplinary practices may encompass settings where physical therapy, occupational therapy, speech therapy and chiropractic care are all provided within a single facility or office. Alternatively, they could refer to individual practices, each specializing in a single discipline.

Prior authorization is required for the following place of service/location codes:

Place of Service Code	Place of Service Name
11	Office
19	Off-Campus Outpatient Hospital
22	On-Campus Outpatient Hospital
24	Ambulatory Surgical Center
49	Independent Clinic
62	Comprehensive Outpatient Rehabilitation Facility

Will routine chiropractic services require prior authorization?

No. Routine chiropractic is a supplemental benefit offered on some UnitedHealthcare Medicare Advantage plans that covers chiropractic services that aren't covered under Original Medicare. This benefit allows members to visit chiropractors for pain relief, neuromusculoskeletal disorders and nausea. Routine chiropractic services will not require prior authorization.

However, Medicare-covered chiropractic services (which covers only manual manipulation of the spine to correct subluxation) require prior authorization. Per CMS, Medicare-covered chiropractic services are identified by an AT modifier. Please refer to **CMS.org** for additional information.

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If I only complete an initial evaluation, how will I be reimbursed?

Provider should submit claim with appropriate procedure code. Prior authorization is not required for initial evaluation. The initial evaluation will be covered.

What if the member needs additional therapy visits after the initial set of therapy visits has been approved and provided?

If additional visits are needed, health care providers will need to submit a new prior authorization to get approval for the extension of the care plan.

Will these requirements affect claims?

Yes. If providers do not receive authorization prior to billing one of the in-scope codes, claims for that service will be denied and the member cannot be billed for the service. We recommend submitting claims after receiving the authorization response.

What happens if prior authorization is not requested?

If we don't receive a prior authorization request within 10 business days (14 calendar days) after starting the service, we may deny the claim and providers will not be able to balance bill members.

What happens if an authorization is submitted with incomplete information?

If an authorization request is submitted with incomplete information, we will try to reach out to the submitting provider to obtain the necessary information. If the provider submits the appropriate information within the required time frame, the request will be reviewed according to the UM process. If the submitting provider does not submit the required information, an incomplete request may be denied.

How does a care provider request authorization?

Providers should use the **UnitedHealthcare Provider Portal** to request prior authorization. Sign in and select "Submission & Status" under PT, OT, ST Outpatient Therapy Transactions" to submit clinical information and request authorization for the planned PT, OT, ST or chiropractic services. As a reminder, the initial evaluation does not require prior authorization. The initial consultation/ evaluation still does not require prior authorization. Providers must continue to submit a prior authorization request for the entire plan of care.

When billing a REV code, is an accompanying CPT code required?

Yes, therapy and chiropractic revenue codes should be billed with the appropriate CPT® codes. Billing without the appropriate CPT code may impact how a claim is processed.

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Does a Skilled Nursing Facility need authorization for Part B services?

For skilled nursing facility providers, the bill type defines the place of service, which determines if a prior authorization needs to be submitted. For example, bill type 22X or 24X for a Part B Nursing home would not need to submit prior authorization.

What does "initial request" mean?

An initial request must satisfy 1 of the following 3 criteria:

- The member is new to your office
- The member presents with a new condition
- The member has had a gap in care of 90 or more days

Do I still need to submit authorization if I know my plan of care is less than 6 visits?

Yes, providers will still need to submit timely for authorization for all therapy or chiropractic visits that they intend to provide. Reminder, if we do not receive a prior authorization request within 10 business days (14 calendar days) after starting the service, we may deny the claim and providers will not be able to balance bill members.

What if I requested more than 6 visits of therapy or chiropractic services – can I still start the member's skilled care before authorization is complete?

Yes, UnitedHealthcare will cover up to 6 visits without a clinical review. **Providers will still need to submit timely for authorization for all therapy or chiropractic visits that they intend to provide.**

Clinical examples:

- Provider submits a timely clinical submission for a member that is new to office of 4 visits over 6 weeks:
  - We will identify that this **meets** the criteria to cover up to 6 visits over an 8-week time frame, pending member eligibility
  - Result: 4 visits over 6 weeks will be covered
- Provider submits a timely clinical submission for a member who has a new condition of 12 visits over 24 weeks:
  - We will identify that this meets the criteria to cover up to 6 visits over an 8-week time frame, pending member eligibility
  - Result: 6 visits over an 8-week time frame will be covered without a clinical review, and the remainder of the visits and time frame will be reviewed
- After completion of the approved initial plan of care, provider submits a timely clinical submission for a member who is in ongoing care (established, continuing care) of 12 visits over 24 weeks:
  - This is ongoing care submitted after the initial plan of care. These will be reviewed for medical necessity.
  - The submission will be reviewed clinically in its entirety because this is not the initial plan of care

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Can treatment begin on the same day as the initial evaluation?

Yes, the provider can begin treatment the same day as the initial evaluation. Up to 6 visits will be covered regardless of the status of the authorization request.

How do I receive updates about the status of my authorization request?

Once redirected to the Optum Physical Health web page, you can check the status of your submission under the activity center. Click the 'Check Status' hyperlink under clinical submissions. You will be presented with a list of your submissions over the past 30 days. To view additional details, you can click the hyperlink within the 'status' section of the search results. When the submission is complete, you will receive a summary page with important information regarding your submission. You can also view the determination letter associated with the authorization.

What resources are available?

- **Skilled Nursing Facility, Rehabilitation and Long-Term – Medicare Advantage Coverage Summary**
- **Medicare Chiropractic Services Utilization Management Policy**
- **Prior Authorization and Notification quick start guide**
- **Prior Authorization and Notification: Interactive User Guide**
- Outpatient therapy services are covered in accordance with certain conditions as outlined in the **Medicare Benefit Policy Manual (cms.gov)**

Who can submit an authorization for therapy or chiropractic visits?

The treating therapy or chiropractic provider can submit the authorization request

What happens if an authorization is submitted with incomplete information?

An incomplete request may be denied.

Are submission instructions or training available?

Yes. All submissions/authorizations need to be entered into the **UnitedHealthcare Provider Portal** and will be managed in the Optum systems. Here's a tutorial on **how to submit** a clinical submission.

Who reviews the authorization requests for medical necessity?

Medical necessity reviews are conducted by licensed medical professionals, including chiropractors, physical therapists, occupational therapists and speech-language pathologists.

What happens if a provider wants to appeal a denial?

If there is a clinical denial, appeals documentation will be included in the member and provider Notice of Determination letter.

What is the contact information if providers have questions?

- Providers contracted with UnitedHealthcare: **888-676-7768**
- Providers contracted with Optum: **800-873-4575**

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