**UnitedHealthcare® Community Plan of Nebraska Prior Authorization Requirements for Physical, Occupational and Speech Therapy Services**

Frequently Asked Questions

# Overview

## Effective November 1, 2022

**Key Points**

* For dates of service starting 11/1/2022, and after, we require prior authorization for outpatient physical, occupational and speech therapy services for all UnitedHealthcare Community Plan of Nebraska members after the initial evaluation, however each member will receive 12 visits of OT, PT or ST services prior to medical necessity review.
* These requirements will apply whether a member is new to therapy or will continue receiving therapy on or after 11/1/2022
* Claims will be denied if prior authorization is not on file before the date of service. Members cannot be balance billed.

Currently we are requiring prior authorization for occupational, physical and speech therapy services after the initial evaluation. We are updating our process as follows:

* Effective November 1, 2022, Providers should create an initial prior authorization request for ongoing therapy services (OT, PT, or ST) after evaluation, however, providers will NOT be required to submit any clinical information at that time.
* Based on the initial prior authorization request, each specialty will be given 12 visits (48 units for timed services). Once the 12th visit (48 timed units) has been exhausted, the provider will be required to submit new request for additional services. The new request must comply with the prior authorization and documentation required outlined in the sections below.

## Updated Prior Authorization Requirements

For dates of service on or after 11/1/2022, the updated prior authorization requirements outlined in our Network Bulletin article will apply and we’ll conduct medical necessity reviews for occupational, physical and speech therapy services for all requests beyond an annual 12 visits (48 units for timed services). You can find the Network Bulletin at UHCprovider.com>Nebraska CommunityPlan > Bulletin and Newsletters[.](https://www.uhcprovider.com/content/dam/provider/docs/public/resources/news/2019/network-bulletin/July-Network-Bulletin-2019.pdf)

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>Nebraska CommunityPlan > Current Policies and Clinical Guidelines > [UnitedHealthcare Community Plan Medical & Drug Policies and Coverage Determination Guidelines](https://www.uhcprovider.com/en/policies-protocols/comm-plan-medicaid-policies/medicaid-community-state-policies.html)

[Speech Language Pathology Services](https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan/ne/speech-language-pathology-services-ne-cs.pdf) *or* [Outpatient Physical and Occupational Therapy.](https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan/ne/outpatient-physical-occupational-therapy-ne-cs.pdf)

You can find the list of services that are subject to prior authorization requirements at <https://www.uhcprovider.com/en/health-plans-by-state/nebraska-health-plans/ne-comm-plan-home/ne-cp-prior-auth.html>

If you have questions, please contact UnitedHealthcare at 1-866-331-2243. For any contracting and credentialing questions, please contact Optum at 1-800-873-4575.



# Frequently Asked Questions

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| **Frequently Asked Questions** | **Question** | **UHC Answer** |
| Question 1 | Where do we submit for prior authorization? | Online Submissions: You can submit your prior authorization requests for these services with dates of service on or after 11/1/2022 up to 14 days before the requested service date, using the Prior Authorization and Notification tool online by visiting UHCprovider.com > Sign In > Prior Authorization and Notification.  Phone: Providers call also request Prior Authorization by calling Provider Services 1-866-331-2243. |
| Question 2 | Where can we find the Medical Necessity Guidelines? | Guidelines Available Online: You’ll find our coverage determination guidelines at UHCprovider.com>Nebraska CommunityPlan > Current Policies and Clinical Guidelines > UnitedHealthcare Community Plan Medical & Drug Policies and Coverage Determination Guidelines > Speech Language Pathology Services or Outpatient Physical and Occupational Therapy. |
| Question 3 | How does this change differ from UnitedHealthcare’s current requirements? | • Before this change, prior authorization was required for physical, occupational, and speech therapy services, however clinical review began with the 1st visit following the initial evaluation. • We are now offering up to 12 visits (or 48 timed units) per discipline annually (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 (48 timed units) although these visits will be approved without undergoing clinical medical necessity review. • Once the member has used the initial 12 visits (or 48 timed units), the provider will be required to submit complete documentation as outlined in the policies noted above. A formal medical necessity review will be performed based on these guidelines.  To view the full list of therapy codes requiring authorization, please reference the current UnitedHealthcare Community Plan Prior Authorization Document by visiting UHCprovider.com>Nebraska CommunityPlan > Prior Authorization and Notification > Current Prior Authorization Plan Requirements. |
| Question 4 | Which members are affected by these new prior authorization requirements? | These prior authorization updates will apply to United HealthCare Community Plan of Nebraska benefit plan members. |
| Question 5 | Will these prior authorization requirements apply for members who are already receiving therapy services? | Yes. Prior authorization requirements will apply to members who are new to therapy and those who are currently receiving therapy. You can submit your prior authorization requests for these services with dates of service on or after 11/01/2022, up to 14 days before the requested service date, using the Prior Authorization and Notification tool online by visiting UHCprovider.com > Sign In > Prior Authorization and Notification. |
| Question 6 | Will these requirements affect claims or a member’s out-of-pocket costs? | It will not impact members out-of-pocket Costs. If 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. |
| Question 7 | If my patient is currently receiving Speech 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. 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 • You can submit your prior authorization requests for these services with dates of service on or after 11/01/2022, up to 14 days before the requested service date, using the Prior Authorization and Notification tool online by visiting UHCprovider.com > Sign In > Prior Authorization and Notification.  • We’ll review the prior authorization request for medical necessity and will issue an authorization if appropriate. |
| Question 8 | If my patient is currently receiving Physical or Occupational 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 will need to submit a prior authorization request for the ongoing treatment services.   • You should submit the following documentation to support the need for ongoing treatment services:  • Signed physician referral obtained at the time of the evaluation • Current evaluation/re-evaluation report and plan of care • Current progress report or the member’s most recent daily treatment notes • You can submit your prior authorization requests for these services with dates of service on or after 11/01/2022 , up to 14 days before the requested service date, using the Prior Authorization and Notification tool online by visiting UHCprovider.com > Sign In > Prior Authorization and Notification.  • We’ll review the prior authorization request for medical necessity and will issue an authorization if appropriate. |
| Question 9 | What documentation is required when the provider submits 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 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 EPSDT Periodicity Schedule (See the Speech Language Therapy coverage determination guideline 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 • Exam note describing the need for the requested evaluation(s) • You can submit your prior authorization requests for these services with dates of service on or after 11/01/2022, up to 14 days before the requested service date, using the Prior Authorization and Notification tool online by visiting UHCprovider.com > Sign In > Prior Authorization and Notification. |
| Question 10 | What codes require prior authorization? | Ongoing treatment codes require prior authorization. See link for Prior Auth:  https://www.uhcprovider.com/en/health-plans-by-state/nebraska-health-plans/ne-comm-plan-home/ne-cp-prior-auth.html |
| Question 11 | Who can submit a prior authorization request for therapy visits? | The treating provider (therapy, chiro, Home Health) can submit the prior authorization requests for subsequent treatment visits. |
| Question 12 | 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. |
| Question 13 | What happens if I submit my request with incomplete information? | An incomplete request may be denied. |
| Question 14 | 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.” For Home Health Providers should select the "Home" place of service. |
| Question 15 | Are submission instructions or training available? | Yes. Training is available at https://www.uhcprovider.com/en/resource-library/training.html?cid=none where there are resources under the Self-Service tools sections (including the interactive self-paced guides and registration for live webinars). This is for all tools, including PAAN. |
| Question 16 | 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 are able to review within 3 days of receipt of a request that contains complete information |
| Question 17 | 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. |
| Question 18 | 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>Nebraska CommunityPlan > Current Policies and Clinical Guidelines > https://www.uhcprovider.com/en/policies-protocols/comm-plan-medicaid-policies/medicaid-community-state-policies.html  Speech Language Pathology Services or Outpatient Physical and Occupational Therapy. |
| Question 19 | 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 website. |
| Question 20 | How will you notify me of denials? | If we deny the request, we will notify the treating therapist by phone. A letter will also be sent to the therapist and member. |
| Question 21 | What are the ages and benefit limits for adult and child therapy? | For clients age 21 and older, Heritage Health covers a combined total of 60 therapy sessions per Calendar year. The combined total of 60 therapy sessions per Calendar year includes all occupational therapy (OT), physical therapy (PT), and speech therapy sessions provided to the client.  For clients age 20 and younger, covered services meet the service criteria below:  SERVICE CRITERIA. Heritage Health covers occupational therapy (OT), physical therapy (PT) and speech therapy services when the following criteria are met. The service must be: (i) An evaluation; (ii) Restorative therapy with a medically appropriate expectation that the client’s condition will improve significantly within a reasonable period of time; or (iii) Recommended in a Department-approved Individual Program Plan (IPP), and the client is receiving services through one of the waiver programs. |
| Question 22 | What is the maximum treatment span duration that may be approved for ongoing services? | The maximum treatment span duration is up to six (6) months to support the need for on-going services. Re-evaluations 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. |
| Question 23 | Is the length of an authorization able to be extended beyond the initial 12? | We are now offering up to 12 visits (or 48 timed units) annually prior to conducting a medical necessity-based review. Once the member has used the initial 12 visits (or 48 timed units), the provider will be required to submit an authorization for additional service including complete documentation as outlined in the policies noted above. A formal medical necessity review will be performed based on these guidelines. |
| Question 24 | Is the length of an authorization able to be extended beyond the initial timeframe? | Providers will need to call into provider services to request an extension. Granting a date extension may depend on the reason why 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. |
| Question 25 | For Optum Therapy Providers, who do I contact for my Provider Service Concerns? | 1. Optum Provider Services Call Center 1-800-873-4575 2. For Contracting & Credentialing questions: If unable to resolve through the call center, providers can reach out to the Nebraska Network providers can reach out to the Nebraska Network Manager, Amber Halford, at 612-428-6474 or amber.halford@optum.com 3. For Claims Questions: If unable to resolve through the call center providers can reach out to the Optum Physical Health Network Program Consultant Bernadine Marquez at 1-602-255-8111 or bernadine\_c\_marquez@optum.com |
| Question 26 | If a pre-authorization request is missed, how many days does a provider have to send in the request without having to do an appeal? | A pre-authorization should be completed within 5 business days from the initial date of service. |
| Question 27 | How does the eval plus 12 visit authorization work for new episodes of care 11/01/2022? | Based on the initial prior authorization request, each discipline will be given 12 visits (48 units for timed services) per calendar year. Once the 12th visit (48 timed units) has been exhausted, the provider will be required to submit 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. |
| Question 28 | Can the patient be seen for two PT or OT cases concurrently? What is the Authorization process if the patient has 2 different injuries, 2 different doctors? | The initial Therapy provider in the same discipline will be given 12 visits (48 unites for timed services). Any additional services with a second Therapy provider in the same discipline will need to submit a Prior Auth for medically necessity review. |
| Question 29 | Do multiple modalities count as one visit, if done on the same day? | Multiple modalities performed by one discipline would count as one visit. One visit is equal for up to 4 unites of times services per day per discipline. |
| Question 30 | Is authorization required when UnitedHealthcare Community Plan is secondary to Medicare or Commercial policies? | Prior Authorization is not required when Medicaid is secondary, however at any time if UnitedHealthcare Community Plan becomes primary then an authorization would be required prior to services being rendered. |
| Question 31 | Does prior authorization apply to members in a skilled level of care or in a long-term care setting? | This does not apply to members in Skilled or Rehab facilities as those are considered IP 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 it 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. |
| Question 32 | 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 next scheduled Therapy visit. |
| Question 33 | Do we need to send a hard copy of the MD order as often we do not receive that until later? | 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 (POC). A signed and dated physician or an APRN order is not required at the time of requesting prior authorization for the initial 12 visits but is required to be a part of the patients file and keep for audit purposes. |
| Question 34 | Do evaluations or reevaluations require prior authorization? | Evaluations or Reevaluations do not require a prior authorization (for a child or adult) for PAR providers. |
| Question 35 | Who can do a Peer Review? | Only the Primary Care physician or referring physician can request a peer review. |