Therapy Prior Authorization Process and Documentation Requirements for UnitedHealthcare Community Plan in Texas – Effective Nov. 1, 2019

Frequently Asked Questions

Overview

Effective **Nov. 1, 2019**, we'll implement prior authorization updates and documentation requirements for outpatient and home health therapy services for Children's Health Insurance Plan (CHIP), STAR, STAR Kids, STAR+PLUS, UnitedHealthcare Connected® (Medicare-Medicaid Plan). These changes will impact specialty therapies (physical therapy, occupational therapy and speech therapy) in the following ways:

- Prior authorization will be required for all initial evaluations and we'll continue to require prior authorization for all re-evaluations and therapy visits for outpatient and home health therapy specialty services (physical, occupational and speech therapy services).
- We'll implement revised prior authorization requirements, including documentation requirements, for therapy services.

We're making this change to help support quality patient care for our members. As part of our commitment to the Triple Aim of improved quality, better health outcomes and better cost for our members, we regularly evaluate our policies using objective, evidence-based criteria to guide coverage decisions and support patient care.

We may deny claims for specialty therapy services (physical, occupational and speech therapy) rendered without an approved prior authorization.

These requirements are subject to change depending on regulatory requirements from the Texas Health and Human Services Commission (HHSC) or updates to UnitedHealthcare Community Plan policies and procedures.

Key Points

As of Nov. 1, 2019, we will require prior authorization for initial evaluations for outpatient and home health therapy services. We'll also require updated documentation requirements with each prior authorization submission. These updates will apply to CHIP, STAR, STAR Kids, STAR+PLUS and UnitedHealthcare Connected (Medicare-Medicaid Plan) members.

You can continue to request prior authorization online and fax through the Optum Physical Health Portal.

We may deny claims for therapy services rendered without an approved prior authorization.

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UnitedHealthcare® Community Plan

Frequently Asked Questions

Prior Authorization Process and Requirements

Which therapy-related evaluation/re-evaluation procedure codes require prior authorization?

- **Speech Therapy Evaluations CPT® Codes**
  Evaluations: 92521, 92522, 92523, 92524, 92610, 96105, 92626,92627
  Re-evaluations: S9152
- **Physical Therapy Evaluations CPT Codes**
  Evaluations: 97161, 97162, 97163
  Re-evaluations: 97164
- **Occupational Therapy Evaluations CPT Codes**
  Evaluations: 97165, 97166, 97167
  Re-evaluations: 97168

Note: To see a list of **all** therapy codes that require prior authorization, please check the prior authorization code list at **UHCProvider.com** > Health Plans by State > Texas > Medicaid > Prior Authorization and Notification.

How do I request prior authorization for therapy services?

You can continue to submit authorization requests in the following ways:

- Online at myoptumhealthphysicalhealth.com
- Fax 877-470-7613

To download the necessary form(s) to request prior authorization or find instructions, sign in to myoptumhealthphysicalhealth.com > Resource Library > Clinical Submission Forms or Tools and Resources.

Note: To comply with Health Insurance Portability and Accountability Act (HIPPA) requirements, please send one fax request per member – each having its own cover sheet. We're unable to process requests received with multiple members per fax.

Is a new authorization needed for a member who is already receiving therapy services?

Members who already have a current authorization for therapy services can continue with their current authorization. If additional therapy services are needed at the end of that authorization, all continuing care requests for prior authorization requests will be required to follow the updated documentation requirements per the UnitedHealthcare's prior authorization process. Go to **UHCprovider.com** > Health Plans by State > Texas > Current News, Alerts and Messages from Texas > Medicaid (Community Plan) > Prior Authorization Policy Change for Speech, Occupational and Physical Therapy Services.

Prior authorization will be required for each initial evaluation, re-evaluation and therapy visit prior authorization is currently required for, but you will now need to send in a separate prior authorization request for each re-evaluation and all therapy visits.

PCA-1-19-01464-C&S-EM_11112019

When can I submit a prior authorization for the re-evaluation?

Re-evaluations will require their own separate prior authorization. Requests for re-evaluation should be submitted no more than 60 days prior to the expiration of the existing treatment authorization. Requests submitted more frequently will be reviewed on a case-by-case basis.

Will there be any changes to prior authorization for Early Childhood Intervention (ECI) services?

There will be no changes to the prior authorization process for ECI services.

Who can request prior authorization for therapy services?

The treating physical/occupational therapist or the speech-language pathologist is responsible for requesting prior authorization for therapy.

How will I know if you received my prior authorization request?

You'll receive a reference number when you submit a request using the Prior Authorization and Notification tool on the Optum Physical Health Portal.

Who will review my prior authorization request?

Licensed medical professionals, including speech-language pathologists, and physical and occupational therapists, will review your request using evidenced-based clinical criteria. This helps ensure your request meets administrative and medical necessity guidelines. A Texas-licensed physician will review all requests considered for denial.

How quickly will you process my request?

We'll process a **complete** prior authorization request within 3 business days.

How will I be notified of the coverage determination?

Approvals are posted on the Optum Physical Health Portal. You can check the status of your submission and access your decision letter online at myoptumhealthphysicalhealth.com. If the request is denied, in whole or in part, we'll fax a letter to you as the requesting therapist and mail a letter to the member.

What happens if I don't have a prior authorization approved before I deliver services?

When we process your claim, we'll validate that a prior authorization has been approved. If the authorization has not been approved, we'll deny the claim with an explanation that the service had not been prior authorized. Prior authorization isn't a guarantee of payment and services rendered are subject to benefit limitations.

Will you backdate requests for prior authorization?

We will not backdate requests for prior authorization because doing so bypasses case management and medical necessity reviews.

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What documents are required for prior authorization requests?

All submissions need to include:

- The Optum Physical Health PSF-750 Authorization form.
- The Texas Medicaid Pediatric Supplement to the PSF-750

Please refer to UnitedHealthcare's prior authorization process for clinical documentation requirements. Go to **UHCprovider.com** > Health Plans by State > Texas > Current News, Alerts and Messages from Texas > Medicaid (Community Plan) > Prior Authorization Policy Change for Speech, Occupational and Physical Therapy Services.

What are the requirements for completing standardized assessments?

Please refer to UnitedHealthcare's prior authorization policy by going to **UHCprovider.com** > Health Plans by State > Texas > Current News, Alerts and Messages from Texas > Medicaid (Community Plan) > Prior Authorization Policy Change for Speech, Occupational and Physical Therapy Services.

Does UnitedHealthcare require prior authorization when there is a secondary payer?

Our therapy coverage guidelines require prior authorization when UnitedHealthcare Community Plan is a secondary payer and commercial insurance is the primary payer. This requirement makes sure that any medically necessary care is being provided in the most appropriate setting when Medicaid is a partial payer. Additionally, the requirement protects the therapist by having an authorization in place should the primary payer not cover the services, then making Medicaid the primary payer.

How can I learn more about these updated prior authorization requirements?

To watch a recorded training on UHC On Air go to **UHCprovider.com**, sign in to Link and select the UHC On Air tile on your Link dashboard.

How can I get help with the online submission process through the Optum Physical Health Portal?

For assistance with prior authorization submissions on the Optum Physical Health Portal, please call Optum Provider Services at **800-873-4575**.

Who should I contact if I have questions?

If you have questions, please call Provider Services at:

- UnitedHealthcare Network Provider
  888-887-9003
- Optum Providers
  800-873-4575

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