Outpatient Therapy Prior Authorization Program: UnitedHealthcare Community Plan of Rhode Island

Frequently asked questions

Overview

Effective Nov. 1, 2025, UnitedHealthcare requires prior authorization for physical therapy (PT), occupational therapy (OT) and speech therapy (ST) for UnitedHealthcare Community Plan members in Rhode Island. These prior authorization requirements apply to patients new to therapy and those who are currently receiving therapy. **A prior authorization request must be submitted to ensure claims are paid**.

Prior authorization is not required for the initial evaluation to be considered for reimbursement. The first 6 visits over a period of up to 8 weeks are not subject to clinical review. However, a timely prior authorization is required for the entire plan of care, including the initial 6 visits. **Prior authorization requests for visits beyond the sixth visit will be subject to medical necessity review**. A new authorization is required for any care requested beyond the approved visits/timeframe.

Process

Effective Nov. 1, 2025, prior authorization is required for the entire plan of care, including the full duration and number of visits requested, for all outpatient therapy services (PT, OT, ST) excluding the initial evaluation. Please note the following important requirements:

- 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 of the first date of service. A prior authorization request must still be submitted for the first 6 visits.
- Only care plans requesting more than 6 visits or care plans exceeding 8 weeks will be assessed for medical necessity.
- Authorization requests may be submitted up to 2 business days after the first date of service. When issued, authorizations will be retroactive to the date of the request.

Providers should use the **UnitedHealthcare Provider Portal** to request prior authorization.

Medical necessity reviews will use the UnitedHealthcare Community Plan Medical Policy: Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) to render a determination. Medical necessity reviews are conducted by licensed medical professionals including physical therapists, occupational therapists and speech-language pathologists. The provider 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, 97530, 97533, 97535, 97537, 97542, 97545, 97546, 97750, 97755, 97760, 97761, 97799

Frequently asked questions

Who will be impacted by these new requirements?

This applies to both in-network and out-of-network providers.

What are the exclusions from this new requirement?

- UnitedHealthcare® Dual Complete plans
- Plan members under three years of age

Which services are excluded from the new requirements?

Inpatient therapy is excluded from this program. Existing prior authorization requirements under the Home Health program category still apply. Please refer to prior authorization requirements found at **Advance Notification and Clinical Submission Requirements | UHCprovider.com**

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

Yes. All care received on or after Nov. 1, 2025, requires prior authorization. For patients currently receiving care, the provider must submit treatment plans for dates of service on or after Nov. 1, 2025, for medical necessity review. A prior authorization request must be submitted to ensure claims are paid.

Does this prior authorization requirement apply to any specific place of service?

Prior authorization is required for the following place of service/location codes when billing the impacted procedure codes:

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

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 codes. If billing treatment codes on same day as initial evaluation, prior authorization requirements apply.

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, a new prior authorization request is required and will be reviewed for medical necessity.

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. It is recommended that claims are submitted after receiving the authorization response.

What happens if prior authorization is not requested?

If we don't receive a prior authorization request within 2 business days of the initial requested date of service, we may deny the claim.

What happens if an authorization is submitted with incomplete information?

If an authorization request is submitted with incomplete information, the Optum Utilization Management (UM) team will attempt to reach out to the submitting provider to obtain the necessary information. If the provider submits the appropriate information within the required timeframe, 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?

For dates of service on or after Nov. 1, 2025, providers should use the **UnitedHealthcare Provider Portal** to request prior authorization for all treatment.
From any page on UHCprovider.com, select Sign In at the top-right corner

- Enter your One Healthcare ID
  - New users who don't have a One Healthcare ID: Visit UHCprovider.com/access to get started
- From the left-hand tabs, select Prior Authorizations & Notifications. Then, click "Create a new request."
- Select the "Physical Health (physical therapy, occupational therapy, or speech therapy)" from the dropdown
- Select the "Plan Type" Medicaid
- Enter the required information and click Continue

For training, view our **Prior Authorization and Notification: Interactive User Guide**

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

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

What does “initial request” mean?

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

- The member is new to your office.
- The member presents with a new condition; or
- 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 authorization for all therapy visits for the above impacted procedure codes.

If I requested more than 6 visits of therapy services, can I start the member’s skilled care before authorization is complete?

Yes, UnitedHealthcare will cover up to 6 visits over a period of up to 8 weeks without a clinical review when the above “initial request” criteria is met. Providers will still need to submit timely authorization for all therapy visits for the above impacted procedure codes.

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

Yes, the provider may begin treatment on the same day as the initial evaluation, provided prior authorization is submitted for that date of service.

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

Providers can view the status of their requests within the **UnitedHealthcare Provider Portal**.

Who reviews the authorization requests?

Medical necessity reviews are conducted by licensed medical professionals, including 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 Adverse Determination letter.

What is the contact information if providers have questions?

For chat options and contact information, visit **UHCprovider.com/contactus** or call **855-766-0344**.

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