Medicare Advantage: Prior authorization resources for outpatient therapy and chiropractic services

On Sept. 1, 2024, we began requiring prior authorization for physical, occupational, speech therapy and chiropractic services for UnitedHealthcare® Medicare Advantage members. Optum Physical Health has been delegated to review the prior authorization request for medical necessity using CMS Chapter 15 criteria, applicable local coverage determinations (LCDs) and InterQual® criteria to render a determination. Medical necessity reviews are conducted by licensed medical professionals, including physical therapists, occupational therapists and speech-language pathologists.

Reviews are conducted after the member's initial consultation and evaluation and consider the specific circumstances of the individual member to approve a course of treatment supported by the clinical evidence.

Note: Treatment can begin the same day as the member's evaluation if you wish to do so, as authorizations, when issued, will cover dates retroactive to the date of the evaluation. You can submit an authorization up to 10 business days (14 calendar days) after the date of service, and authorizations, when issued, will be retroactive to the date of the evaluation.

Exclusions

The below plans and provider types are not required to submit for authorization:

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

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

Chiropractic care services

Routine (maintenance) chiropractic services will not require prior authorization. Only traditional Medicare-covered chiropractic services (which covers only manual manipulation of the spine to correct subluxation) require prior authorization.

Per CMS, traditional Medicare-covered chiropractic services are identified by an AT modifier. Please refer to cms.gov for additional information. The chiropractor will need to bill with the AT modifier for traditional Medicare services.

Skilled nursing facility 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.

Place-of-service codes

Prior authorization is required for services rendered in the following places of service. If your claim is

submitted indicating procedures were performed at one of these places of service and an authorization has not been obtained, your claim will be denied:

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

Note: Inpatient therapy services and services rendered in the home are excluded from the prior authorization requirement.

This includes services rendered by therapists and chiropractors who operate their own practices or who practice in the same office, such as a physical therapist and an occupational therapist who practice together and services provided in hospital-owned therapy and chiropractic offices.

How to submit a request

You can submit a prior authorization request through the UnitedHealthcare Provider Portal:

- Go to **UHCprovider.com** and click Sign In at the top-right corner
- Enter your One Healthcare ID and password
  - New users who don't have a One Healthcare ID: Visit **UHCprovider.com/access** to get started
- In the menu, select Prior Authorizations
- Scroll down to "Create a new prior authorization submission," click "Select prior authorization type for submission" and then select "Physical Health"
- Next click "Select plan type," select "Medicare" and click "Continue"
- Enter the required information and submit

If we don't receive a prior authorization request within 10 days after starting the service, we may deny the claim, and you won't be able to balance bill members.

Claims submission process

To submit a claim:

- Ensure you have received an authorization prior to submitting the therapy claim to UnitedHealthcare to help avoid denials for lack of an authorization
- The Clinical Submission Number or Service Reference Number (SRN#) is acceptable to submit on the claim form
- If you received an approved authorization after a claim's submission, then you can resubmit the claim for payment

Questions?

If you have questions, please read our Skilled Nursing Facility, Rehabilitation and Long-Term – Medicare Advantage Coverage Summary or visit our Prior Authorization and Notification web page.

For answers to specific questions, contact the clinician at the number that's listed on your authorization letter.

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