

Outpatient radiology prior authorization protocol

Frequently asked questions

Overview

We require prior authorization for certain advanced outpatient imaging procedures for most UnitedHealthcare commercial and Individual Exchange plans, also referred to as UnitedHealthcare Individual & Family ACA Marketplace plans.

We review the evidence-based clinical guidelines at least annually to align with current best practices. These guidelines are available at UHCprovider.com/radiology.

General

Does this protocol apply to all commercial and Individual Exchange plans?

No. The following plans are excluded from this protocol:

- Individual Exchange plans offered in Nevada and Colorado
- UnitedHealthcare Options PPO plans
 - We don't require you to follow this protocol for Options PPO plans. Members enrolled in these benefit plans are responsible for requesting prior authorization.
 - Exception: We require you to follow this protocol for Options PPO benefit plans for members in Colorado. These members aren't responsible for requesting prior authorization.
- UnitedHealthOne – Golden Rule Insurance Company, group number 705214 only
- M.D.IPA, Optimum Choice, Inc. or OneNet PPO
- Oxford Network plans
- UnitedHealthcare Indemnity/Managed Indemnity plans
- Sierra plans/Health Plan of Nevada
- Health plans sponsored or issued by certain self-funded employer groups



Key points

The outpatient radiology prior authorization protocol applies to:

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron-emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology
- Outpatient and office-based settings

Some commercial and Individual Exchange plans are excluded from the protocol

Which advanced outpatient imaging procedures require prior authorization?

We require prior authorization for the following advanced outpatient imaging procedures:

- Computerized tomography (CT)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron-emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology

For the most current listing of radiology CPT® codes that require prior authorization, visit UHCprovider.com/radiology.

If you don't request prior authorization before rendering an advanced outpatient imaging procedure, it may result in an administrative claim denial. You cannot bill members for the services.

How can I initiate the prior authorization process or confirm that a coverage decision has been made?

You can initiate the prior authorization process by:

- Visiting UHCprovider.com and signing in in the top-right corner using your One Healthcare ID and password. If you don't have one, go to UHCprovider.com/access.
- Calling **866-889-8054** from **7 a.m.–7 p.m. local time, Monday–Friday**

Does receipt of an authorization number guarantee that you'll pay the claim?

No. Receipt of an authorization number doesn't guarantee or authorize payment. Payment for covered services is contingent upon various factors, including coverage within the member's benefit plan and your Participation Agreement with us. Payment is also subject to applicable state regulations.

How do I know if you require a clinical coverage review to determine if the service is medically necessary?

The service must be medically necessary for us to cover it. When you notify us of a planned service, we'll confirm if we require a clinical coverage review. You don't need to determine this.

We'll confirm whether the ordering health care professional must engage in a physician-to-physician discussion. For example, we'll let you know if the service doesn't meet evidence-based clinical guidelines or the member's benefit document doesn't require that services be medically necessary for us to cover them. We'll also let you know if additional information is necessary.

Responsibilities

Who's responsible for requesting prior authorization for an advanced outpatient imaging procedure?

The ordering health care professional's office is responsible for notifying us before scheduling the advanced outpatient imaging procedure. However, in some situations the rendering health care professional is responsible for notifying us. See below for additional information about the rendering health care professional's responsibilities.

If a primary health care professional refers a member to a specialist and the specialist determines the need for an advanced outpatient imaging procedure, who's responsible for notifying UnitedHealthcare?

The health care professional who orders the advanced outpatient imaging procedure is responsible for notifying us before scheduling the procedure. In this situation, the specialist is responsible for notifying us.

What's the rendering health care professional's responsibility when the ordering health care professional doesn't participate in your network?

If a non-participating ordering health care professional is unwilling to complete the prior authorization process, we require that the rendering health care professional completes the process. The non-participating health care professional can register to use our secure applications and initiate the prior authorization process by:

- Visiting UHCprovider.com and signing in in the top-right corner using your One Healthcare ID and password. If you don't have one, go to UHCprovider.com/access.
- Calling **866-889-8054** and selecting the option for commercial and Individual Exchange plan members

If the outpatient radiology prior authorization protocol isn't followed by the rendering health care professional, it may result in an administrative claim denial. You cannot bill members for administratively denied claims.

Who's responsible for confirming the completion of the prior authorization process and coverage decision?

If the ordering health care professional participates in our network and we haven't completed the prior authorization process or issued a coverage determination, we'll use reasonable efforts to work with the rendering health care professional to urge the ordering health care professional to complete the process. If applicable, we'll provide a coverage decision prior to the procedure.

If the ordering health care professional doesn't participate in our network, the rendering health care professional should complete the prior authorization process and verify that the coverage decision is in accordance with the protocol.

Prior authorization requirements

Do you require prior authorization if you're the secondary payer?

No, we don't require prior authorization if we're secondary to a payer, including Medicare.

Which places of service are subject to the prior authorization requirements?

We require prior authorization services performed in outpatient and office-based settings.

Which places of service aren't subject to prior authorization requirements?

Advanced outpatient imaging procedures performed in, and appropriately billed with, the following places of service aren't subject to prior authorization requirements:

- Emergency rooms
- Urgent care centers
- Hospital observation units
- Inpatient settings

Who reviews prior authorization requests?

Health care professionals of various specialties, including radiology, review prior authorization requests. The ordering or rendering health care professional may request a physician-to-physician discussion with the reviewing health care professional by following these steps:

- Call **866-889-8054**
- Select option 3
- Provide the 10-digit case number
 - If you don't have a case number or it's invalid, press*



How do I submit a prior authorization request?

1. Visit **UHCprovider.com** and sign in
 2. Select **Radiology, Cardiology, Oncology and Radiation Oncology Transactions**
 3. Select **Radiology**
 4. Select the product type of Commercial or Exchanges
- Or, call **866-889-8054** from 7 a.m.–7 p.m. local time, Monday–Friday.

How can I change an existing prior authorization request?

If the existing prior authorization request is pending review or has been completed, call **866-889-8054** to request a change.

What information do you need when I submit a prior authorization request?

We may request that you provide us with the:

- Member's name, address, phone number, date of birth, member identification (ID) and group number
- Ordering health care professional's name, tax (ID) number (TIN) or National Provider Identifier (NPI) number
- Ordering health care professional's mailing address, phone, fax number and email address
- Rendering health care professional's name, mailing address, phone number and TIN/NPI number (if different than the ordering health care professional)
- The requested imaging procedure(s) and CPT code(s)
- The working diagnosis and appropriate ICD code(s)
- The member's clinical condition, including any symptoms, with severity and duration listed in detail
- Received treatments, including dosage and duration of medications, and dates of other therapies
- Any other information that will help us evaluate whether the ordered service meets current evidence-based clinical guidelines, including, but not limited to, prior diagnostic tests and consultation reports

To help ensure proper payment, the ordering health care professional must communicate the authorization number to the rendering health care professional.

Do I have to complete the prior authorization process for each advanced outpatient imaging procedure?

Yes. Please complete the prior authorization process for each individual CPT code. Each authorization number is specific to the CPT code. We don't require authorization numbers on the claim form.

If a hospital has a freestanding clinic and members are sent from the hospital to the clinic for an advanced outpatient imaging procedure, is prior authorization still required?

Yes. We require prior authorization if an advanced outpatient imaging procedure is requested from an inpatient, emergency room, observation unit or urgent care center but the procedure will be billed with an outpatient place of service.

However, we don't require prior authorization for advanced outpatient imaging procedures rendered in, and appropriately billed with emergency rooms, inpatient stays, observation units or urgent care centers.

Will any professional component(s) claims be affected if I don't complete the prior authorization process?

If you don't complete the prior authorization process, the professional component (modifier 26) isn't subject to administrative denial.

If you receive a clinical denial and perform the procedure, the professional component of the claim is subject to denial for lack of medical necessity.

Can the ordering health care professional make an urgent request for a prior authorization?

Yes. The ordering health care professional may request a prior authorization number on an urgent basis if it's medically required to render the service urgently.

- **During business hours:** Please call **866-889-8054** and explain the clinical urgency. We'll respond to urgent requests within 3 hours of receipt of all required information.
- **Outside business hours:** You must submit the request within 2 business days after the date of service. Please include an explanation of the urgent nature of the service and why it wasn't possible to request a prior authorization number during our normal business hours.



CPT codes and modifications

Can the rendering health care professional modify the CPT code for the imaging procedure without contacting UnitedHealthcare?

The rendering health care professional isn't required to contact us to modify the existing prior authorization record for CPT code combinations listed in the Radiology Prior Authorization Crosswalk Table. A complete listing of codes and the CPT Code Crosswalk Table is available at UHCprovider.com > Prior Authorization > Radiology > Specific Radiology Programs > Commercial Plans > **UnitedHealthcare Radiology Prior Authorization Crosswalk Table**.

How does the CPT Code Crosswalk Table work?

The Crosswalk Table reads from left to right.

Two example scenarios:

- If the ordering health care professional obtains a prior authorization number for a CPT code listed in the left column and the procedure is later changed to the corresponding CPT code in the right column, we require no further action. In this case, the rendering health care professional doesn't need to update the original prior authorization number request.
- If the ordering health care professional obtains a prior authorization number for a CPT code listed in the left column and the procedure changes to a CPT code not listed in the right column, either the ordering or rendering health care professional must modify the original prior authorization number request. The modification must occur online or by calling us within 2 business days after the procedure is rendered.

When do I need to contact you to modify the CPT code for an imaging procedure?

Please contact us if the Radiology Prior Authorization Crosswalk Table doesn't list the CPT code combination. Please follow these steps to modify the existing prior authorization request:

- If the procedure is for a contiguous body part, either the ordering or rendering health care professional must modify the original prior authorization number request. We require that they modify the request within 2 business days after the procedure by:
 - Visiting [UHCprovider.com](https://uhcprovider.com) and sign in at the top-right corner using your One Healthcare ID and password. If you don't have one, go to [UHCprovider.com/access](https://uhcprovider.com/access).
 - Calling **866-889-8054**
- If the procedure isn't for a contiguous body part, the ordering health care professional must obtain a new prior authorization number
- We must issue a coverage decision prior to the procedure taking place
- We'll consider any procedure for a different, noncontiguous body part as a new prior authorization request

Case numbers and prior authorization numbers

What's a case number and when do you assign one?

A case number is assigned upon initiating the prior authorization process.

- If a prior authorization number request can't be completed after the request is initiated by phone or online, the case number is used to access case details during a physician-to-physician discussion or as a reference for providing missing clinical information
- The case number format is a 10-digit number (e.g., 1041401245)
- Case numbers aren't valid for claim payment

When do you issue a prior authorization number? How is it different from a case number?

When we complete the prior authorization process, we'll issue a prior authorization number. Unlike case numbers, these are alphanumeric.

How long is the prior authorization request valid?

It is valid for 45 calendar days and specific to the requested procedure for which you can perform 1 time for 1 date of service.

- We'll use the date the prior authorization number is issued as the starting point for the 45-day period in which you can complete the procedure
- Please request a new prior authorization number if you don't complete the procedure within 45 days

How do you notify the ordering health care professional of the completed prior authorization process?

The ordering health care professional will receive a fax of the completed prior authorization process. If you elect to receive correspondence by e-notification, we'll notify you when the letter is available online. If we determine during clinical coverage review that the service doesn't meet medical necessity criteria, we'll issue a clinical denial notice detailing the appeal process to the member and ordering health care professional.

What's a physician-to-physician discussion and do you require it?

The physician-to-physician discussion is an opportunity for the ordering health care professional to review the prior authorization request with one of our reviewing physicians (or our designee) to provide additional clinical information and/or discuss alternative approaches to the requested procedure. The ordering health care professional, a nurse practitioner or a licensed physician's assistant can have the discussion.

If a request doesn't meet evidence-based clinical guidelines or if additional information is necessary and:

- The member's benefit plan doesn't require covered services to be medically necessary, then we require a physician-to-physician discussion to complete the process
- The member's plan requires covered services to be medically necessary, then we don't require a physician-to-physician discussion. However, this discussion is available as an option for the ordering health care professional after we've issued a clinical denial. We may consider it an informal reconsideration, subject to certain state regulations.

Do you request the same information during the online submission process and over the phone?

Yes. The information we request online and over the phone is the same.



We're here to help

If you have questions, please contact your provider advocate or network representative.

For prior authorization system issues, help for portal login, access and functionality questions is available. For chat options and contact information, visit

UHCprovider.com/contactus.

Support is also available by calling **866-842-3278**, option 1.

What happens if the member provides the wrong insurance information to the ordering health care professional and we don't initiate the required authorization request?

If we deny a claim in this instance, the rendering health care professional may submit an appeal by contacting us.

For more information, please refer to the Claims Appeals and Reconsideration process outlined in the Provider Administrative Guide available at [UHCprovider.com/guides](https://uhcprovider.com/guides) > [Administrative Guide for Commercial and Medicare Advantage](#) > Claim Appeals and Reconsideration.

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