Outpatient Radiology Prior Authorization Program for Medicare Advantage

Frequently asked questions

Overview

We require prior authorization for certain advanced outpatient imaging procedures for most UnitedHealthcare® Medicare Advantage 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**.

Key points

The outpatient radiology prior authorization protocol applies to:

- Positron-emission tomography (PET)
- Nuclear medicine
- Nuclear cardiology

Prior authorization requirements apply to outpatient and office-based settings.

General

1. Does this protocol apply to all UnitedHealthcare Medicare Advantage plans?

No. The following plans are excluded from this protocol:

- Preferred Care Network and Preferred Care Partners of Florida
- Erickson Advantage® Plans
- UnitedHealthcare® Nursing Home and UnitedHealthcare® Assisted Living Plans (HMO SNP), (HMO-POS SNP), (PPO SNP)
- UnitedHealthcare Medicare DirectSM (PFFS)
- Sierra

In addition, the outpatient radiology prior authorization protocol does NOT apply to:

- UnitedHealthcare West capitated providers.
- UnitedHealthcare Medicare Advantage delegated provider groups (e.g., WellMed, OptumCare)

However, these **delegated provider groups** may have separate radiology prior authorization requirements.

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2. Which advanced outpatient imaging procedures require prior authorization?

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

- 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.

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

There are 2 ways to begin:

- **Online:** Through the UnitedHealthcare Provider Portal. Go to **UHCprovider.com** and select Sign In at the top-right corner
  - Sign in to the portal using your One Healthcare ID and password
    - If you are a new user and don't have a One Healthcare ID, visit **UHCprovider.com/access** to get started
  - Select Prior Authorizations & Notifications
  - Click Create a new request
  - In the "Create a new prior authorization submission" section:
    - Select Radiology from the "Prior authorization type submission" dropdown
    - Select Medicare from the "Plan type" dropdown
  - Click Continue > Submit Clinical Request
  - Select the appropriate Medicare logo (For DSNP requests, select the Dual Complete logo)
- **Phone:** Call **866-889-8054**, 7 a.m.–7 p.m., local time, Monday–Friday. Select the option for UnitedHealthcare Medicare Advantage members.

4. 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 federal regulations and Medicare Advantage policies.

Responsibilities

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

The ordering health care professional's office is responsible for requesting prior authorization before scheduling the advanced outpatient imaging procedure. In some situations, however, the rendering health care professional is responsible for requesting prior authorization. See below for additional information about the rendering health care professional's responsibilities.

6. 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 requesting prior authorization?

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

7. 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 using one of the following:

- **Online**: Through the UnitedHealthcare Provider Portal. Go to **UHCprovider.com** and select Sign In at the top-right corner
  - Sign in to the portal using your One Healthcare ID and password
    - If you are a new user and don't have a One Healthcare ID, visit **UHCprovider.com/access** to get started
  - Select Prior Authorizations & Notifications
  - Click Create a new request
  - In the "Create a new prior authorization submission" section:
    - Select Radiology from the "Prior authorization type submission" dropdown
    - Select Medicare from the "Plan type" dropdown
  - Click Continue > Submit Clinical Request
  - Select the appropriate Medicare logo (For DSNP requests, select the Dual Complete logo)
- **Phone:** Call **866-889-8054**, 7 a.m.–7 p.m., local time, Monday–Friday. Select the option for UnitedHealthcare Medicare Advantage 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.

8. 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.

9. Can the rendering health care professional or diagnostic facility initiate the prior authorization for the ordering health care professional?

No. The in-network ordering health care professional who has determined the need for the imaging procedure must initiate the prior authorization request. The rendering health care professional may contact the in-network ordering health care professional and request that they obtain prior authorization before the rendering health care professional/facility schedules or renders the imaging procedure.

Prior authorization requirements

10. 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.

11. 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

12. 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 phone:

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

13. How do I submit a radiology prior authorization request?

There are 2 ways to submit a request:

- **Online:** Through the UnitedHealthcare Provider Portal. Go to **UHCprovider.com** and select Sign In at the top-right corner
  - Sign in to the portal using your One Healthcare ID and password
    - If you are a new user and don't have a One Healthcare ID, visit **UHCprovider.com/access** to get started
  - Select Prior Authorizations & Notifications
  - Click Create a new request
  - In the "Create a new prior authorization submission" section:
    - Select Radiology from the "Prior authorization type submission" dropdown
    - Select Medicare from the "Plan type" dropdown
  - Click Continue > Submit Clinical Request
  - Select the appropriate Medicare logo (For DSNP requests, select the Dual Complete logo)
- **Phone:** Call **866-889-8054**, 7 a.m.–7 p.m., local time, Monday–Friday. Select the option for UnitedHealthcare Medicare Advantage members.

14. 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.

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

We may request that you provide us with the following information:

- 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
- Requested imaging procedure(s) and CPT code(s)
- 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.

16. 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.

17. 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 inpatient, emergency room, observation unit or urgent care center places of service.

18. 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.

Urgent requests and retrospective authorization

19. 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 during our normal business hours.

CPT codes and modifications

20. 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**.

21. How does the CPT Code Crosswalk Table work?

The Crosswalk Table reads from left to right. Two example scenarios:

Prior authorization given with this CPT® code		Claim is submitted with this CPT code	
70450	CT HEAD/BRN C-MATRL	**70460**	CT HEAD/BRN C+ MATRL
70450	CT HEAD/BRN C-MATRL	**70470**	CT HEAD/BRN C-/C+
70450	CT HEAD/BRN C-MATRL	**76380**	CT LMTD/LOCLZD F-UP STD
70460	CT HEAD/BRN C+ MATRL	**70450**	CT HEAD/BRN C-MATRL
70460	CT HEAD/BRN C+ MATRL	**70470**	CT HEAD/BRN C-/C+
70460	CT HEAD/BRN C+ MATRL	**76380**	CT LMTD/LOCLZD F-UP STD

- If the ordering health care professional obtains a prior authorization for CPT code 78012 listed in the left column, and the procedure changes to the corresponding CPT code in the right column, CPT 78014, we require no further action. In this case, the rendering health care professional doesn't need to update the original prior authorization.
- If the ordering health care professional obtains a prior authorization for CPT code 78070 listed in the left column and the procedure changes to CPT code 78072, which is not listed in the right column, either the ordering or rendering health care professional must modify the original prior authorization request. The modification must occur online or by calling us within 2 business days after the procedure is rendered.

Click **here** for a full view of the crosswalk table.

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

Please contact us if the Radiology Notification/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 request. We require that the request be modified within 2 business days in one of the following ways:

- **Online:** Through the UnitedHealthcare Provider Portal. Go to **UHCprovider.com** and select Sign In at the top-right corner
  - Sign in to the portal using your One Healthcare ID and password
    - If you are a new user and don't have a One Healthcare ID, visit **UHCprovider.com/access** to get started
  - Select Prior Authorizations & Notifications
  - Click Create a new request

- In the “Create a new prior authorization submission” section:
  - Select Radiology from the “Prior authorization type submission” dropdown
  - Select Medicare from the “Plan type” dropdown
- Click Continue

- **Phone:** Call **866-889-8054**, 7 a.m.7 p.m., local time, Monday–Friday. Select the option for UnitedHealthcare Medicare Advantage members.

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 to be a new request for a prior authorization number.

Case numbers and prior authorization numbers

23. 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 request can’t be completed after the request is initiated online or by phone, 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.

24. When do you issue a prior authorization number, and 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, prior authorization numbers are alphanumeric.

25. How long is the prior authorization request valid?

It’s 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 if you don’t perform the procedure within 45 days

If the procedure cannot be performed within the 45-day period, requests for a new prior authorization must be requested by phone at **866-889-8054**.

- If the day you are calling is still within the 45-day period, request to have the existing authorization withdrawn and request a new authorization.
  - You must state that the reason for withdrawal is because the procedure will not be performed during the initial authorization 45-day period.
- If the day you are calling is after the 45-day period, request a new authorization.
  - You must state that the reason for requesting a new authorization is because the procedure was not performed during the initial authorization 45-day period.

26. 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. If you elect to receive electronic notifications, 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.

27. 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.

28. What happens if the member provides the wrong insurance information to the ordering health care professional and we don't initiate the required prior 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**.

29. Is there an appeal process if the prior authorization request isn't approved?

Yes. The ordering health care professional and the member will be informed in writing of the reason for the prior authorization denial. This will include the clinical rationale, as well as how to initiate an appeal. All appeals will be managed by UnitedHealthcare. An authorized representative, including a health care professional, acting on behalf of their patient, with the member's written consent, may file an appeal on behalf of their patient.

Contact us

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

For prior authorization system issues, please call the UnitedHealthcare Help Desk at **866-842-3278**. Option 1, 7 a.m.–9 p.m. CT, Monday–Friday.

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