Outpatient Radiology Prior Authorization Program for UnitedHealthcare Community Plan

Frequently asked questions

Overview

Prior authorization is required for select advanced outpatient imaging procedures provided to certain UnitedHealthcare Community Plan members. The advanced outpatient imaging procedures that are subject to prior authorization requirements are referred to as “Advanced Outpatient Imaging Procedures” in these frequently asked questions.

We use the prior authorization process to help support compliance with evidence-based guidelines and help reduce medical risk. It may help care experiences, outcomes and total cost of care for UnitedHealthcare Community Plan members.

We worked with external physician advisory groups to develop and update the Outpatient Radiology Prior Authorization Program to apply more consistent current scientific clinical evidence and professional society guidance to Advanced Outpatient Imaging Procedures.

We review the evidence-based clinical guidelines annually to align with current best practices. They are based on local and national coverage determinations, and guidelines and standards published by nationally and internationally recognized medical specialties, supplemented by material from peer-reviewed literature, to reflect the most current evidence-based guidelines for imaging. The clinical guidelines along with other related resources are available on **UHCprovider.com/radiology**.

Please use these frequently asked questions as a resource about the requirements of the Outpatient Radiology Prior Authorization Program.

General information and plan exclusions

1. Which advanced outpatient imaging procedures require prior authorization?

Prior authorization is required for certain of 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 services

For the most current listing of CPT® codes for which prior authorization is required pursuant to the protocol, refer to **UHCprovider.com/radiology**.

If you don't request prior authorization or verify that one has been obtained before rendering any Advanced Outpatient Imaging Procedure, this may result in an administrative claim denial. **You cannot bill members for the services.**

2. Is prior authorization required if UnitedHealthcare is the secondary payer?

No. Prior authorization isn't required when UnitedHealthcare is secondary to any other payer, including Medicare.

3. Who is responsible for requesting prior authorization for an Advanced Outpatient Imaging Procedure?

The ordering care provider's office is responsible for requesting prior authorization before scheduling the Advanced Outpatient Imaging Procedure. In some situations, however, the rendering care provider is responsible for requesting prior authorization. Question 7 has additional information about the rendering care provider's responsibilities.

4. How can I obtain and verify a prior authorization number?

You can initiate the prior authorization process online or by phone:

- **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 Medicaid from the "Plan type" dropdown
  - Click Continue, then Submit Clinical Request
  - Select the Community Plan logo

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

5. Does receipt of a prior authorization number guarantee that UnitedHealthcare will pay the claim?

No. Receipt of a prior authorization number does not 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 UnitedHealthcare Community Plan.

6. If a primary care provider refers a member to a specialist, and the specialist determines the need for an Advanced Outpatient Imaging Procedure, who is responsible for requesting prior authorization?

The care provider who orders the Advanced Outpatient Imaging Procedure is responsible for requesting a prior authorization number before scheduling the procedure. In this situation, the specialist is responsible for requesting a prior authorization number.

7. Can the rendering care provider or diagnostic facility initiate the prior authorization for the ordering provider?

No. The ordering care provider who has determined the need for the imaging procedure must initiate the prior authorization request. The rendering care provider may contact the ordering care provider and request that they obtain a prior authorization number before the rendering care provider/facility schedules or renders the imaging procedure. Question 9 has additional information about the rendering care provider's responsibilities.

8. What is the rendering care provider's responsibility when the ordering care provider does not participate in UnitedHealthcare's 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 Medicaid from the "Plan type" dropdown
  - Click Continue, then Submit Clinical Request
  - Select the Community Plan logo

- **Phone:** Call **866-889-8054** from 7 a.m.–7 p.m., local time, Monday–Friday. Select the option for Community 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.

9. Who is responsible for confirming that the prior authorization process has been completed and a prior authorization number has been issued?

Rendering care providers are responsible for confirming that the prior authorization process has been completed prior to rendering the Advanced Outpatient Imaging Procedure.

Prior authorization requirements

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

Prior authorization is required for services performed in outpatient and office-based settings.

11. Which places of service are not subject to prior authorization requirements?

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

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

12. Who reviews prior authorization requests?

Physicians in various specialties, including radiology, review prior authorization requests. Ordering or rendering care providers may request a physician to physician discussion with the reviewing care provider.

- Call **866-889-8054**, then, select option 3 and provide the 10-digit case number. If there is no case number or it is invalid, press *.

13. What information may be requested for a prior authorization request to be reviewed?

The following information may be requested:

- Member's name, address, phone number and date of birth, member identification (ID) and group number
- Ordering care provider's name, tax (ID) number(TIN)/National Provider Identifier (NPI) number
- Ordering care provider's mailing address, phone and fax number, and email address
- The imaging procedure(s) being requested with the CPT code(s)
- The working diagnosis with the appropriate ICD code(s)

- The member's clinical condition, including any symptoms, listed in detail, with severity and duration
- Treatments that have been received, including dosage and duration for drugs, and dates for other therapies
- Dates of prior imaging studies performed
- Any other information that the care provider believes will help in evaluating whether the service ordered meets current evidence-based clinical guidelines, including but not limited to, prior diagnostic tests and consultation reports

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

14. Does the prior authorization process have to be completed for each Advanced Outpatient Imaging Procedure ordered?

Yes. The prior authorization process must be completed for each individual CPT code. Each authorization number is CPT code-specific. A separate prior authorization is not required for imaging contrast agents or radiopharmaceuticals administered with an Advanced Outpatient Imaging Procedure. Authorization numbers are not required on the claim form.

15. If a freestanding clinic is attached to a hospital, and members are sent from the hospital to the clinic for an Advanced Outpatient Imaging Procedure, is prior authorization still required?

Yes. Prior authorization is required 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, prior authorization is not required for Advanced Outpatient Imaging Procedures rendered in, and appropriately billed with an emergency room, observation unit or urgent care center, or during an inpatient stay.

16. Will any professional component(s) claims be affected if the prior authorization process isn't completed?

If the prior authorization process is not completed, the professional component (modifier 26) will not be subject to administrative denial on the basis that the prior authorization process isn't completed.

If a clinical denial is received and the procedure is still performed, the professional component of the claim will be subject to denial for lack of medical necessity.

Urgent requests and retrospective authorization

17. Can the ordering care provider request a prior authorization number on an urgent basis, during UnitedHealthcare's normal business hours?

Yes. The ordering care provider may request a prior authorization number on an urgent basis if rendering the service urgently is medically required. Urgent requests must be requested by phone at **866-889-8054**. Select the option for Community Plan members. You must state that the case is "clinically urgent" and explain the clinical urgency. UnitedHealthcare will respond to urgent requests within 3 hours of our receipt of all required information.

18. Can an ordering care provider request a prior authorization number on an urgent basis, outside of the normal UnitedHealthcare business hours?

Yes. If a procedure is medically required on an urgent basis, outside of the normal UnitedHealthcare business hours, a prior authorization number must be requested retrospective.

- You must submit the request for prior authorization retrospectively within 2 business days after the date of service.
- Documentation must include an explanation as to why the procedure was required on an urgent basis and why a prior authorization number couldn't have been requested during normal UnitedHealthcare business hours.

CPT codes and modifications

19. When can the rendering care provider modify the CPT code for the imaging procedure being performed without contacting UnitedHealthcare?

The rendering care provider is not required to contact UnitedHealthcare to modify the existing prior authorization record for CPT code combinations listed in the **Radiology Prior Authorization Crosswalk Table**.

20. 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 70450 listed in the left column, and the procedure changes to the corresponding CPT code in the right column, CPT 70460, 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 70450 listed in the left column and the procedure changes to CPT code 70481, 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.

21. When must I contact UnitedHealthcare to modify the CPT code for the imaging procedure being performed?

You're required to contact UnitedHealthcare when the CPT code combination is not listed in the Radiology Prior Authorization Crosswalk Table. Please follow these steps to modify the request for a prior authorization number request:

If the procedure being performed is for a contiguous body part, either the ordering or rendering care provider must modify the original prior authorization number request. The request must be modified within 2 business days after the procedure is rendered either online or by phone.

- **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 Medicaid from the "Plan type" dropdown
  - Click Continue, then Submit Clinical Request
  - Select the Community Plan logo
- **Phone:** Call **866-889-8054**, 7 a.m.–7 p.m., local time, Monday–Friday. Select the option for Community Plan members.

If the procedure being performed is not for a contiguous body part, the ordering care provider must obtain a new prior authorization number

- UnitedHealthcare must issue a prior authorization number prior to the procedure being performed
- A procedure for a different, noncontiguous body part will be considered a new request for a prior authorization number

Case numbers and prior authorization numbers

22. What is a case number, and when is a case number assigned?

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 as a reference for providing missing clinical information
  - The case number format is a 10-digit number (e.g., 1041401245)
  - Case numbers are not valid for claim payment

23. When will a prior authorization number be issued, and what makes the prior authorization number different from a case number?

When the prior authorization process has been completed, a prior authorization number is issued. Unlike case numbers, prior authorization numbers are alphanumeric.

24. How long is a prior authorization number 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.

25. If a prior authorization number is valid for 45 days and a patient comes back within that time for follow-up and needs another imaging procedure, will a new prior authorization number be required?

Yes. A new prior authorization number must be obtained for each Advanced Outpatient Imaging Procedure.

26. How is the ordering care provider notified that the prior authorization process has been completed?

Once the prior authorization process has been completed, the ordering care provider will receive a letter via fax. If you elected to receive correspondence by email, you'll be notified by email when the letter is available online. If we determine during the prior authorization process that the service does not meet medical necessity criteria, a clinical denial is issued. We issue the member and ordering care provider a denial notice with the appeal process outlined.

27. Is the information requested during the online submission process the same as the information requested by telephone?

Yes. The information requested online and over the telephone is the same.

28. What happens if the wrong insurance information is presented to the ordering care provider and the prior authorization request is not initiated as required?

If a claim is denied for not completing the prior authorization process because the wrong insurance information was presented to the care provider, the rendering care provider may submit an appeal by contacting UnitedHealthcare. For more information, please refer to the Claims Reconsideration and Appeals Process outlined in the Provider Administrative Guide available at **UHCprovider.com/guides**.

29. Is there an appeal process if the prior authorization request is not approved?

Yes. The ordering care provider and the member will be informed in writing of the reason for the prior authorization denial, including the clinical rationale, as well as how to initiate an appeal. All appeals will be managed by UnitedHealthcare. An authorized representative, including a care provider, 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 UnitedHealthcare network representative.

PCA-1-25-00137-POE-FAQ_03142025

United Healthcare® Community Plan