

Outpatient radiology prior authorization program

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 information and plan exclusions

Does the radiology prior authorization program apply to all UnitedHealthcare commercial and Individual Exchange plans?

No. Prior authorization doesn't apply to all UnitedHealthcare commercial and Individual Exchange plans. The following benefit plans are excluded:

- UnitedHealthcare Options preferred provider organization (PPO): Health care professionals aren't required to follow this protocol for Options PPO benefit plans because members enrolled in these benefit plans are responsible for requesting prior authorization

Exception: Health care professionals are required to follow this protocol for Options PPO benefit plans for members in Colorado. These members are not responsible for requesting prior authorization.

- UnitedHealthOne – Golden Rule Insurance Company, group number 705214 only
- M.D.IPA, Optimum Choice, Inc. or OneNet PPO
- Oxford Health Plans
- UnitedHealthcare Indemnity/Managed Indemnity
- Benefit 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 cardiology
- Outpatient and office-based settings

Some commercial and Individual Exchange plans are excluded from the protocol.

- UMR
- UnitedHealthcare Shared Services (UHSS)
- Medicare Advantage, Medicaid or CHIP plans – members of these plans are subject to the administrative guide, member manual or supplement of that affiliate
- Individual Exchange plans offered in Nevada and Colorado are subject to the administrative guide, member manual or supplement of that affiliate

Any existing requirements about prior authorization and/or precertification for the above listed excluded entities remain in place.

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 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 in one of the following ways:

- **Online:** Use the Prior Authorization and Notification tool in the UnitedHealthcare Provider Portal. To access the portal, go to UHCprovider.com, select Sign In and enter your One Healthcare ID. If you don't have a One Healthcare ID, [register now](#).
- **Phone:** Call **866-889-8054**, 7 a.m.–7 p.m., local time, Monday–Friday

Does receipt of an authorization number guarantee that UnitedHealthcare will 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 will I know if a clinical coverage review is required to determine if the service is medically necessary?

When we receive notification of an advanced outpatient imaging procedure, and the member's benefit plan requires services to be medically necessary in order to be covered, we'll conduct a clinical coverage review to determine whether the service is medically necessary pursuant to the prior authorization process. You don't need to determine whether prior authorization is required in a given case or for a given member. Once you notify us of a planned service, we'll confirm whether a clinical coverage review is required.



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. Keep reading 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 is the rendering health care professional's responsibility when the ordering health care professional doesn't participate in the UnitedHealthcare network?

If a non-participating ordering health care professional is unwilling to complete the prior authorization process, the rendering health care professional is required to complete the process.

If a non-participating health care professional is registered to use our secure applications, they can still initiate the prior authorization process using one of the following:

- **Online:** Use the Prior Authorization and Notification tool in the UnitedHealthcare Provider Portal. To access the portal, go to UHCprovider.com, click Sign In and enter your One Healthcare ID. If you don't have a One Healthcare ID, [register now](#).
- **Phone:** Call us at **866-889-8054** and select the option for UnitedHealthcare commercial and Individual Exchange members

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

If an administrative denial is appealed by the rendering health care professional, we will uphold the denial on the basis that the ordering health care professional doesn't participate in our network and the rendering health care professional didn't complete the prior authorization process as required.

Who's responsible for confirming that the prior authorization process has been completed and a coverage decision has been issued?

Before performing the advanced outpatient imaging procedure, the rendering health care professional is responsible for confirming that the prior authorization process has been completed and a coverage decision has been issued.

If the rendering health care professional is in our network and determines the prior authorization process hasn't been completed and a coverage determination hasn't been issued, if required, we'll use reasonable efforts to work with them to encourage completion of the process and, if applicable, obtain a coverage decision prior to rendering the procedure.

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



Prior authorization requirements

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.

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

We require prior authorization when services are 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 1 for providers, then option 3. Be sure to provide the 10-digit case number. If there is no case number or it is invalid, press*.

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
- The 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.

Does the prior authorization process have to be completed for each outpatient imaging procedure ordered?

Yes. The prior authorization process must be completed for each individual 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 the prior authorization process isn't completed?

The professional component (modifier 26) will not be subject to administrative denial if the prior authorization process isn't completed.

If a clinical denial is received and the procedure is still performed, the global, technical and professional components will be subject to denial for lack of medical necessity, including professional claims billed with modifier 26.

Can the ordering health care professional request a prior authorization number on an urgent basis?

Yes. The ordering health care professional may request a prior authorization number on an urgent basis if rendering the service urgently is medically required.

- **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 being performed without contacting UnitedHealthcare?

The rendering health care professional won't be required to contact UnitedHealthcare 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.

- 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 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 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 UnitedHealthcare 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 request. We require that they modify the request within 2 business days after the procedure by:
 - Visiting UHCprovider.com and selecting Sign In and entering your One Healthcare ID. If you don't have a One Healthcare ID, [register now](#).
 - 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 is a case number assigned?

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 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 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 alpha/numeric.

How long is a prior authorization number valid?

- The prior authorization number is valid for 45 calendar days. It is specific to the procedure requested, to be performed 1 time, for 1 date of service within the 45-day period.
- UnitedHealthcare will use the date the prior authorization number was issued as the starting point for the 45-day period in which the procedure must be completed
- If the procedure is not completed within 45 days, a new prior authorization number must be requested

How is the ordering health care professional notified that the prior authorization process has been completed?

Once the prior authorization process has been completed, the ordering health care professional will receive a letter by fax. If you elected to receive correspondence by e-notification, you'll be notified by e-notification when the letter is available online. If we determine during the clinical coverage review that the service does not meet medical necessity criteria, a clinical denial is issued. We will issue the member and ordering health care professional a denial notice that outlines the appeal process.

What is a physician-to-physician discussion, and when is one required?

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



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.

If a request does not meet evidence-based clinical guidelines or if additional information is necessary and the member's benefit plan requires services to be medically necessary in order to be covered, while a physician-to-physician discussion is not required, it is available as an option to the ordering health care professional. A physician-to-physician discussion can also be performed after a clinical denial has been issued. Subject to certain state regulations, this discussion may be considered an informal reconsideration.

Is the information requested during the online submission process the same as the information requested by phone?

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

What happens if the wrong insurance information is presented to the ordering health care professional 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 health care professional, the rendering health care professional may submit an appeal by contacting UnitedHealthcare
- For more information, please refer to the claims reconsideration and appeals process outlined in the [UnitedHealthcare Provider Administrative Guide](#)

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