MN103-0700
PO Box 1459
Minneapolis, MN 55440

P 1-800-873-4575
F 1-248-733-6070

myoptumhealthphysicalhealth.com

January 8, 2025

RE: **Updates to UnitedHealthcare® MedicareAdvantage® and AARP® MedicareAdvantage® Plans Clinical Submission Requirements for Chiropractic, Physical, Occupational and Speech Therapy Service**

Dear Provider:

Based on feedback from providers, UnitedHealthcare® has updated the prior authorization requirement for therapy and chiropractic services that became effective Sept. 1, 2024, for Medicare Advantage Individual and Group Retiree members.

Providers must continue to submit a prior authorization request for the entire plan of care, including the full duration and number of visits requested. However, for new authorization requests starting on or after Jan. 13, 2025, up to the first 6 visits of a member's initial plan of care will be covered without conducting a clinical review when the first 6 visits take place within 8 weeks of the first date of service.

Only care plans requesting more than 6 visits or care plans in excess of 8 weeks will be assessed for medical necessity. The initial consultation/evaluation still does not require prior authorization.

Coverage of the initial consultation and up to 6 visits of a member's requested plan of care within 8 weeks will apply without a clinical review under any of the following circumstances:

  - The member is new to your office.
  - The member presents with a new condition; or
  - The member has had a gap in care of 90 or more days.

- This change is being made to enable providers to begin treatment the same day as the member's initial consultation when clinically appropriate and ensure additional care is provided promptly. No changes are needed to your current clinical submission process.
- Authorization may be requested up to 10 business days after the member's initial consultation. The member's care may commence immediately. Up to the first 6 visits within 8 weeks will be covered regardless of the status of the authorization request.
- Providers are encouraged to submit claims for care following receipt of approved authorization.
- Coverage is subject to confirmation of member eligibility.
- Once the initial plan of care is complete, additional visits may be requested by submitting a request for authorization.

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Please continue to follow the submission process through the Optum Provider Portal.

The Patient Summary Form will have additional language stated below:

Subject to eligibility verification and timely filing, UnitedHealthcare will cover up to six (6) visits, over up to eight (8) weeks under any of the following conditions on an initial submission:

- *The member is new to your office.*
- *The member presents with a new condition.*
- *The member has had a gap in care of 90 or more days.*

Additionally, any treatment needs beyond the approved service levels will require a clinical submission for further review. Date extensions and modifications to this approval are not permitted.

When a prior authorization request is submitted, the provider will see the following message(s):

Your request qualifies for coverage of up to six (6) visits, over up to eight (8) weeks pending member eligibility and timely filing. If more than six (6) visits or more than eight (8) weeks is requested, it will be determined based on clinical review.

Additional information can be found here: Medicare Advantage: Prior authorization resources for outpatient therapy and chiropractic services | UHCprovider.com

For Information on how to submit: Welcome to WebAssist Optum Provider Portal Guide - Discover How to Submit a PSF-750 Online

Contact Information if provider has questions:

- Providers can call **800-873-4575**
- OptumCare and WellMed contracted providers, please refer to the number on member ID card for prior authorization instructions.

Sincerely,

Network Management
Optum