Frequently asked questions

Outpatient Radiology Prior Authorization Protocol

Applies to UnitedHealthcare Community Plan Members

Overview

The Outpatient Radiology Prior Authorization Protocol is required for select Advanced Outpatient Imaging Procedures provided to certain UnitedHealthcare Community Plan members. Working with external physician advisory groups, UnitedHealthcare has developed the Outpatient Radiology Prior Authorization Protocol to support a more consistent application of current scientific clinical evidence and professional society guidance to Advanced Outpatient Imaging Procedures.

This Protocol is based on efforts to help improve compliance with evidence-based guidelines, limit preventable radiation exposure, and align our business processes to simplify the administrative experience for physicians, other health care providers, hospitals and facilities.

The clinical guidelines used for the Protocol were developed by a committee of practicing academic and communitybased radiologists and specialty consultants. They are based on guidelines and standards published by nationally and internationally recognized medical societies supplemented by material from peer-reviewed literature to reflect the most current evidence-based guidelines for imaging. All clinical guidelines are reviewed at least annually. Please note that the evidence-based clinical guidelines specific to radiology are posted on **UnitedHealthcareOnline.com**, and serve as a detailed reference tool to support ordering providers in selecting the appropriate imaging study. To access these guidelines, go to **UnitedHealthcareOnline.com** > Clinician Resources > Radiology > UnitedHealthcare Community Plan Radiology Prior Authorization Program > Authorization Resources: Reference Materials.

Questions	Answers
1. What is the Outpatient Radiology Prior Authorization Protocol?	Pursuant to the Protocol, prior authorization is required for certain of the following Advanced Outpatient Imaging Procedures: Magnetic Resonance Image (MRI), Magnetic Resonance Angiography (MRA), Computerized Axial Tomography (CT), Positron-Emission Tomography (PET), Nuclear Medicine, and select nuclear medicine studies, including nuclear cardiology. To see a complete list of services requiring prior authorization, go to **UnitedHealthcareOnline.com** > Clinician Resources > Radiology > UnitedHealthcare Community Plan Radiology Prior Authorization Program. Administrative claim denials may result if a provider does not obtain prior authorization. Providers cannot balance bill members for claims that are administratively denied.
2. Which providers are subject to the Protocol?	The Protocol applies to all providers who order or render Advanced Outpatient Imaging Procedures.
3. Is prior authorization required for imaging procedures rendered in an inpatient or emergency setting or at a hospital?	No. Prior authorization is NOT required for imaging procedures ordered through an emergency room treatment visit, while in an observation unit, when performed at an urgent care facility or during an inpatient stay. For these claims to be processed correctly, the place of service must indicate an inpatient, emergency room, observation or urgent care setting. Prior authorization is not required for imaging contrast agents or radiopharmaceuticals administered with an Advanced Outpatient Imaging Procedure.

UnitedHealthcare Community Plan

Questions	Answers
4. If a primary care physician refers a member to a specialist, and the specialist determines the need for an Advanced Outpatient Imaging Procedure that requires prior authorization, who should request the prior authorization?	The provider who will order the Advanced Outpatient Imaging Procedure is responsible for obtaining a prior authorization number before scheduling the Advanced Outpatient Imaging Procedures. In this scenario, the specialist is responsible for obtaining a prior authorization number before scheduling the imaging procedure.
5. Can the rendering provider or diagnostic facility initiate the prior authorization for the ordering provider?	No. The ordering provider who has determined the need for the imaging procedure must initiate the prior authorization request. The rendering provider may contact the ordering provider and request that they obtain a prior authorization number before the rendering provider/facility schedules or renders the imaging procedure.
6. How will the ordering provider know when the prior authorization process has been completed and a coverage decision has been issued?	Ordering providers will be notified of the coverage decision by fax. The ordering provider may also verify if a prior authorization request was approved by checking the status at **UnitedHealthcareOnline.com** or **UHCCommunityPlan.com**, or **866-889-8054** and selecting the appropriate option for UnitedHealthcare Community Plan members. The prior authorization number will be available for online verification 30 minutes after the number is issued.
7. What if the ordering provider is not a participating provider with UnitedHealthcare Community Plan?	For this Protocol, out-of-network providers can still submit a prior authorization request either through **UHCCommunityPlan.com**, if they are registered, or by calling **866-889-8054** and selecting the option for UnitedHealthcare Community Plan. The rendering provider may request a prior authorization on behalf of the nonnetwork ordering provider by calling **866-889-8054** and following the prompts for UnitedHealthcare Community Plan members.
8. What is the process if the rendering provider determines the prior authorization process has not been completed?	The rendering provider may contact the ordering provider and request that the ordering provider complete the prior authorization process.
9. Who is responsible for confirming that the prior authorization process has been completed and a coverage decision has been issued?	Rendering providers must confirm that the prior authorization process has been completed and a coverage decision has been issued **before rendering the Advanced Outpatient Imaging Procedures**. If the rendering provider determines the prior authorization process has not been completed and a coverage determination has not been issued, if required, and the ordering provider participates in UnitedHealthcare's network, UnitedHealthcare will use reasonable efforts to work with the rendering provider to urge the ordering provider to complete the prior authorization process and, and if applicable, obtain a coverage decision prior to rendering imaging procedures.

Questions	Answers
10. How can providers obtain and verify a prior authorization number?	To request or verify a prior authorization number: • **Online: UHCCommunityPlan.com** or **UnitedHealthcareOnline.com** > Notifications/ Prior Authorizations > Radiology Notification & Authorization– Submission & Status • **Phone: 866-889-8054** from 7 a.m. to 7 p.m., local time, Monday - Friday
11. What information may be requested to obtain a prior authorization?	Information that may be requested before a prior authorization can be considered include: • Member's plan name, member name, date of birth and member ID number • Ordering provider's name, NPI, tax ID number, • address, telephone and fax number • Imaging facility's name, address, telephone and fax number - if different than the ordering provider • 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, which may include 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. • Any other information that the provider believes will help in evaluating whether the imaging procedure ordered meets current evidence-based clinical guidelines, including but not limited to, prior diagnostic tests and consultation reports. • Dates of prior imaging studies performed. If the rendering provider is different from the ordering provider, the authorization number should be obtained and communicated by the ordering provider to the rendering provider.
12. Is the information requested from the provider during the online submission process the same as the information requested from the provider by telephone?	Yes, the information requested online and over the telephone is the same.
13. Who will be reviewing prior authorization requests?	Providers of various specialties, including radiology, will review prior authorization requests. Ordering or rendering providers may request a physician to physician discussion with the reviewing provider.

Questions	Answers
14. What is a case number, and when will a case number be issued?	A case number is assigned upon initiating the prior authorization process. If a prior authorization number request cannot be completed after the initiation of the request by either phone or online, the case number is used as a reference for providing missing clinical information. Case numbers are not valid for purposes of claim payment. The case number format is a 10-digit number (e.g., 1041401245).
15. When will a prior authorization number be issued and what makes the prior authorization number different from a case number?	Once the prior authorization process has been completed, and it is determined that the requested procedure is consistent with evidence-based clinical guidelines, a prior authorization number is issued. Unlike case numbers, prior authorization numbers are alpha/numeric and are valid for purposes of claim payment (e.g. A012345678).
16. Is a prior authorization number required for each Advanced Outpatient Imaging Procedure ordered?	Yes, a prior authorization number is required for each individual CPT code and each prior authorization number is CPT code specific.
17. What will happen if the ordering provider's office does not know the specific CPT code that needs to be ordered?	Call center representatives will assist the provider's office in identifying the appropriate CPT Code based on available clinical information.
18. Are any CPT code modifications allowed under the Protocol?	Under the CPT Code Crosswalk Table, for certain specified CPT code combinations, providers will not be required to modify the existing authorization record. However, for code combinations not listed on the CPT Code Crosswalk Table, the provider must modify the prior authorization record. For example, if the provider wishes to change the requested imaging procedure from without contrast to with contrast, the imaging procedure would require a modification with UnitedHealthcare Community Plan.
19. What is the process to modify a prior authorization request where either the CPT code authorized is not present on the CPT Code Crosswalk Table, and/or it does not match the procedure that needs to be performed?	In instances where the CPT code for the procedure for which prior authorization number has been obtained differs from the CPT code for the rendered procedure, and the code combination is not listed on the CPT Code Crosswalk Table, please follow the steps below to modify the request for a prior authorization number. • If the procedure being performed is for a contiguous body part, either the ordering or rendering provider must modify the original prior authorization number request by calling **866-889-8054** or online at **UnitedHealthcareOnline.com** > Notifications/Prior Authorizations > Radiology Notification & Authorization - Submission & Status. The request must be modified within two business days after the procedure is rendered. • If the procedure being performed is not for a contiguous body part, the ordering provider must obtain a new prior authorization number and a coverage decision must be issued prior to rendering the imaging procedure. An imaging procedure for a different, noncontiguous body part will be considered a new request for a prior authorization number.

Questions	Answers
20. How long is a prior authorization number valid?	The prior authorization number is valid for 45 days. UnitedHealthcare Community Plan will use the date the prior authorization number was issued as the starting point for the 45-day period in which the Advanced Outpatient Imaging Procedure must be completed. If a procedure is not completed within 45 days, a new prior authorization number must be obtained.
21. 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.
22. How can the ordering provider indicate that an Advanced Outpatient Imaging Procedure is clinically urgent?	The ordering provider may submit an urgent request for a prior authorization number if the provider determines that rendering the service urgently is medically required. Urgent requests should be requested by phone at **866-889-8054**. The ordering provider must state that the case is "clinically urgent" and explain the clinical urgency. UnitedHealthcare will respond to urgent requests within three hours of our receipt of all required information.
23. What if there is an urgent request that is not administered in an inpatient/ ER/ observation/urgent care clinic setting and is scheduled after hours, or on a weekend?	If the ordering provider determines that an Advanced Outpatient Imaging Procedure is medically required on an urgent basis, and a prior authorization number cannot be requested because it is outside of UnitedHealthcare's normal business hours, the service may be rendered and the prior authorization number must be requested retrospectively within two 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 could not have been requested during UnitedHealthcare's normal business hours.
24. If a prior authorization request is not approved, what information will the ordering provider receive?	The ordering 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.
25. Is there an appeal process if the prior authorization is not approved?	Yes. Appeal rights are sent in communications to providers with each adverse determination. All appeals will be managed by UnitedHealthcare Community Plan. An authorized representative, including a provider, acting on behalf of his/her patient, with the member's written consent, may file an appeal on behalf of their patient.
26. Should I include a prior authorization number on the claim form when submitting a claim(s)?	No, you do not need to include the prior authorization number on the claim form.

Questions	Answers
27. Does receipt of a prior authorization number guarantee that UnitedHealthcare will pay the claim?	No. Subject to federal regulations and Community Plan policies, 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 the provider participation agreement with UnitedHealthcare Community Plan. Please note that eligibility may change regularly and UnitedHealthcare Community Plan members must be eligible at the time of the imaging procedure. Eligibility can be confirmed for UnitedHealthcare Community Plan members at **UHCCommunityPlan.com**.
28. What is the impact to hospital-based providers' claims?	These claims are not subject to administrative denials and are only subject to clinical denials for lack of medical necessity
29. Who do I contact for more information on this Protocol?	If you have questions, contact your local UnitedHealthcare Network Management representative.

M54876-H 10/16 © 2016 United HealthCare Services, Inc.
Doc#: PCA-1-003356-09142016-10052016