UnitedHealthcare Prior Authorization Policy for Medicare Advantage and Medicaid Managed Care Plans: Patient Fact Sheet

Overview

In fall 2024, UnitedHealthcare (UHC) announced it was requiring prior authorization for physical and occupational therapy, speech-language pathology, and chiropractic services. This began for UHC members covered under Medicare Advantage plans on September 1 and for patients covered by Medicaid managed care plans on October 1. We want to make sure patients understand what this process means for their care.

A therapist or chiropractor can conduct an evaluation, but UHC must approve the treatment services. For example, if a speech-language pathologist submits a treatment plan and supporting medical record documentation to UHC requesting 12 treatment sessions, UHC could:

- Approve the request;
- Deny the request (which may require an appeal and additional delays in approval); or
- Partially approve the request (e.g., approve eight sessions).

Once the number of approved visits is used up, a patient may need another prior authorization request if they need additional therapy.

Based on data shared by UHC, it takes an average of four to 10 business days to approve these requests. Initiating treatment prior to getting approval from UHC places providers at significant financial risk if the services are not approved.

Below are four ways patients can advocate for themselves to get the care they need.

Call UHC Directly

If approval of a patient's services is significantly delayed, denied, or only partially approved, the patient can contact UHC directly using the member phone number listed on their UHC insurance card. Patients should ask UHC why the services were denied or partially denied and what additional information UHC needs to approve the services. This information may be included in the patient's Explanation of Benefits (EOB), but sometimes the EOB does not specifically state UHC's reasoning for full or partial denial. Health care providers may be able to use this information to submit a successful request for reconsideration or appeal.

Contact Their State Insurance Commissioner

Patients can also contact their state insurance commissioner to register their concerns about how UHC is delaying access to the care they need. The National Association of Insurance Commissioners website has contact information for state insurance commissioners.

Register a Complaint With the Medicare Beneficiary Ombudsman

Medicare Advantage patients can register a complaint with the Medicare Beneficiary Ombudsman (MBO), an individual who serves as a liaison between Medicare patients and the federal Medicare program. If patients have been unable to resolve their concerns with their plan by calling 1-800-MEDICARE, they can ask a 1-800-MEDICARE representative to submit their complaint or inquiry to the MBO. The MBO will help to ensure that the inquiry is resolved appropriately.

Contact Their State Medicaid Agency

Medicaid managed care patients can contact their state Medicaid agency for the appropriate beneficiary hotline to file a complaint about their plan's handling of their care.