















## Submitted via email: <u>alexander\_billioux@uhc.com</u>

September 23, 2024

Alexander Billioux, MD Chief Medical Officer, Government Programs and Senior Vice President, Population Health & Social Care UnitedHealthcare Inc. 9900 Bren Road East Minnetonka, Minnesota 55343

Re: UnitedHealthcare Medicare Advantage: Prior Authorization Changes for Outpatient Therapy Services

Dear Dr. Billioux:

The American Occupational Therapy Association, the American Physical Therapy Association, and American Speech Language Hearing Association are looking forward to meeting with you on September 27th. In advance of that meeting and in follow up to our meeting with John Prible, VP of External Affairs, and Alexis Ahlstrom, VP of Policy, on September 6, 2024, we are outlining our concerns below on behalf of the undersigned provider associations that represent more than 500,000 rehabilitation healthcare providers and post-acute care facilities.

Respectfully, we request the rescission or suspension of UnitedHealthcare's (UHC) <u>prior authorization</u> <u>program</u> that started on September 1, 2024 for outpatient therapy and chiropractic services provided in multidisciplinary offices and outpatient hospital settings, excluding services in the home.

The standard of practice for rehabilitative services in any setting is to identify immediate plan of care needs and initiate such care during the same encounter as the initial evaluation. The healthcare provider's professional responsibility is to perform an initial evaluation, analyze the findings, engage patients based on their goals, and apply professional judgment to establish a plan of care to effectively address each patient's functional limitations. Delayed implementation of the plan of care will adversely impact return to function and ultimately increase the overall cost of care. It is also unreasonable and contrary to the intent of the recent CY 2024 MA FAQs to expect the Medicare beneficiary to have their care interrupted for multiple days after a rehabilitation evaluation awaiting a prior authorization to continue care.

Delays in care associated with prior authorization have real consequences. Peer reviewed research including a study co-sponsored by OptumLabs®, indicates that delayed rehabilitation services can lead to unintended downstream costs, increased visits, extended opioid use and poor rehabilitation outcomes.<sup>1</sup>

<sup>&</sup>lt;sup>1</sup> APTA Cosponsored Study. (2019): Direct Access to Physical Therapy for LBP Saves Money, Lowers Utilization Better When It is Unrestricted. <u>https://www.apta.org/news/2019/11/08/apta-cosponsored-study-direct-access-to-physical-therapy-for-lbp-saves-money-lowers-utilization-better-when-its-unrestricted</u>

We request a rescission or delay of the program because the implementation of these new authorizations are a departure from UHC's efforts <u>announced</u> last summer to expedite care for enrollees and ease administrative burden for providers, for which we commend UHC. Additionally, the prior authorization program recently implemented appears to be in conflict with the following requirements of CY2024 Medicare Advantage and Part D Final Rule as outlined in the Centers for Medicare and Medicaid Services (CMS) CY2024 MA FAQs.

- Prior authorization may only be used by MA coordinated care plans to confirm the presence of diagnoses or other medical criteria, to ensure that the furnishing of a service or benefit is medically necessary or, for supplemental benefits. Therefore, prior authorization should not function to delay or discourage care.
- For MA coordinated care plans, approval of a prior authorization request for a course of treatment must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, the patient's medical history, and the treating provider's recommendation.

Various organizations and providers have received email clarifications to some questions from their UHC's designated point of contact; however, it does not appear that UHC has broadly disseminated this information with sufficient detail or clarity. For example, *on August 22, 2024,* a State provider association contacted its local UHC representative inquiring whether this policy applied to skilled nursing facility (SNF) providers because SNF was not listed as a place of service on the policy announcement, but the <u>Coverage Determinations Guidelines</u> resource referenced in the announcement are SNF coverage guidelines. On *August 30, 2024,* the association received the following email response from its local UHC representative:

"This will not apply to anyone skilled under Part A (POS 31). If the SNF is billing part B services under place of service code 32 this program will not apply. If the SNF is billing the part B services under any of the below place of service codes it would apply for the below POS codes with the CPT codes for the program and would only pertain to the lines of business in the policy.

Prior authorization is required for the following place of service codes:

- 11 Office
- 19 Off-Campus Outpatient Hospital
- 22 On-Campus Outpatient Hospital
- 24 Ambulatory Surgical Center
- 49 Independent Clinic
- 62 Comprehensive Outpatient Rehabilitation Facility"

In addition to the above example, there are additional challenges and concerns that need to be resolved and clearly explained if this program is to remain in place, including:

1. Could UHC provide rationale for implementing such a broad prior authorization program? It would be helpful to understand what claims data, research, and/or evidence UHC has utilized in developing this program.

- 2. To simplify how to navigate the program, could UHC provide a guidance document or webpage for providers to follow to ensure expeditious response to requests for prior authorization?
- 3. Has UHC provided notification to its beneficiaries that this program has been implemented?
- 4. Will UHC provide notification to the beneficiary that a request for continued care has been denied?
- 5. When denials for continued care are issued, will UHC provide detailed guidance as to why the request was denied so the provider can address errors and resubmit the request to ensure a prompt response?

Our organizations have concerns regarding whether UHC's program to apply prior authorization for these services is appropriate under the above referenced regulations, especially given the potential clinical harm in delaying these services. The broad application of this program is leading to delays or discouraging clinically necessary care, without regard for the patient's clinical needs.

While we are seeking rescission of this policy, we urge UHC to immediately suspend implementation to permit time to address concerns identified by providers and beneficiaries. Additional time is necessary to narrow the scope of the program and consider exemptions for high-risk patient populations.

Thank you in advance for your consideration and for agreeing to meet on September 27, 2024.

Respectfully submitted,

American Chiropractic Association ADVION (formerly National Association for the Support of Long Term Care) American Health Care Association American Occupational Therapy Association American Physical Therapy Association Alliance for Physical Therapy Quality and Innovation American Speech Language Hearing Association National Association of Rehabilitation Providers and Agencies

CC: Daniel Frank Chief Clinical Officer Optum Health

> Robert Hunter Senior Vice President, Medicare Advantage Products UnitedHealthcare Inc