October 16, 2024

Alexander Billioux, MD
Chief Medical Officer, Government Programs
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:

On behalf of the American Occupational Therapy Association (AOTA), the American Physical Therapy Association (APTA), and the American Speech-Language-Hearing Association (ASHA), thank you and your colleagues for meeting on October 2. We believe we share a mutual goal of ensuring timely access to medically necessary services for Medicare and Medicaid beneficiaries who receive these benefits through UHC.

However, we remain concerned that prior authorization serves as an impediment to care and creates an unnecessary administrative burden for therapists and the patients they treat. We do not believe data supports concerns regarding utilization raised during our meeting.

Despite the figures shared regarding the average processing times for requests and indications that the portal has not malfunctioned, we continue to receive complaints from our members. Providers report that they wait eight to ten calendar days for responses and that they have had to fax in requests when the portal was not accessible. While patients may have been notified, there is significant confusion regarding the reason for this change. This creates additional burden for clinicians who must try to explain the process to their patients. As a result, we reiterate our request that UHC rescind this process immediately. Additional rationale for our request is provided below.

A Better Understanding of Utilization Trends Underlying New Policy Is Needed

During the meeting, you mentioned that the prior authorization program was put into place in order to address a trend in the growth of both volume and duration of therapy visits. An analysis, obtained by AOTA, of the Medicare Part B therapy services provided between 2009 and 2021 showed that while there was an increase in the number of beneficiaries receiving therapy services during this time, there was essentially no growth in the number of claims per beneficiary receiving those services (i.e. in the duration of therapy). A literature review shows that much of this growth could be attributed to a variety of factors such as the shift from providing care in inpatient settings to providing similar services in outpatient settings.[1, 2, 3] While the Medicare Payment Advisory Commission (MedPAC) reports that the average number of visits per beneficiary has increased for other Part B healthcare services, our data shows this was not the case for therapy services between 2009 and 2021.

Given the discrepancy between our understanding of therapy utilization trends under Part B and your description of current utilization, we would appreciate if you could share more information

about the data by which you made the decision to implement a prior authorization policy, as data on MA utilization is not publicly accessible.

Clarification Regarding the Process Is Still Required

The information shared during the meeting was helpful, but there are several outstanding issues for which we seek additional clarification.

Processing Time

You noted that the average processing time is four business days, but our members continue to report that their requests are taking an average of eight to ten business days. For some patients with multiple comorbidities or who are clinically complex, waiting two weeks to determine if the services will be covered could be detrimental and increase downstream costs for recovery due to delayed treatment. For example, a patient with a swallowing disorder could aspirate, leading to hospitalization and even pneumonia. In other circumstances, an inability to swallow could lead to difficulty eating which in turn could lead to weight loss and even malnutrition. Delayed physical therapy could impede restoration of mobility, reducing the ability to return to independent function.

We would also be interested in understanding the average appeal processing time as UHC gains more experience with this process. Processing times that are prolonged and inconsistent can contribute to preventable adverse events, increased costs, and patient dissatisfaction with both their clinician and their health insurance provider.

More Granular Data Regarding Approved and Partially Approved Requests

You indicated that approximately 86% of requests are either approved or partially approved. We respectfully request a more detailed analysis to determine what percentage of these requests are fully approved versus partially approved. We have received reports from providers in 38 states that have not received one prior authorization approval for the full number of visits requested since September 1, 2024.

We also request that UHC share the average number of visits that are approved. Our members state that they are approved for eight visits and then must request additional visits if needed. Given that therapy services are often provided multiple times a week (depending on the patient’s clinical presentation), a clinician might be requesting prior authorization every two weeks, which is a substantial administrative burden and possibly delays or even prolongs ongoing treatment. Also, an understanding of what data, evidence, and research that demonstrates that a specific dosage, such as eight visits, is appropriate helps us ensure that the most relevant criteria are being used by UHC to drive patient care decisions.

Similarly, it would be helpful to know if there is a “deadline” to use the approved visits. Our members report that when the process began on September 1, the requests were approved without a deadline. However, as the month of September wore on, the approvals came back stating that the services had to be used either by the end of the calendar month, within 30 days of approval, or within another specified period. We believe therapists should be able to utilize approved visits within a reasonable period based on the patient’s clinical presentation, not on an artificial deadline established by UHC.

Appeals Data

In addition to data regarding average appeals processing time, it would be helpful to know the number of denials that are overturned on appeal in the clinician/patient’s favor. While UHC has processed more than 200,000 requests since this requirement was applied, appeals data is also

critically important in light of the additional administrative burden and delays in care. We would appreciate UHC's analysis of the overturn on appeal rate in favor of the clinician and/or patient.

Settings to Which Prior Authorization Is Applied
Providers are not clear on exactly which settings are subject to the prior authorization policy. While skilled nursing facilities are not listed on the place of service codes on the webpage, nursing facility providers have received confirmation from UHC representatives that patients receiving Part B therapy in a skilled nursing facility need prior authorization. In fact, prior authorization requests have been submitted on behalf of patients of nursing facilities and they have been approved. This clarity is necessary so that patients are not subject to unnecessary prior authorizations and delays of care.

The Financial Liability for Denials Inappropriately Rests With Clinicians

In the meeting, it was stated that the prior authorization process does not require the clinician to delay initiation of care. We would appreciate that UHC update the educational materials provided to patients and clinicians making this clear.

However, while prior authorization does not prohibit initiation of treatment before approval is granted, doing so before receiving approval creates an additional and potentially significant financial risk for clinicians. This is particularly true of therapy services, which are often provided multiple times a week.

For example, while UHC has stated that requests are approved within an average of four business days, many of our members report that they are hearing back within eight to ten business days. Regardless of the processing period, multiple therapy visits may have been provided in the time between when the request was submitted and denied. If that is the case, the financial liability for the provider is consequential.

Thank you for considering this additional feedback based on the data you presented during the meeting. Given these outstanding concerns, we would appreciate an opportunity to meet again to determine what information could reassure UHC that prior authorization is not required. An additional conversation will provide our organizations with details we can use to help our members successfully navigate the prior authorization process to ensure timely access for patients awaiting rehabilitation services.

Respectfully submitted,

American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association

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[1] Burke, L.G., Burke, R.C., Orav, E.J., Bryan, A. F., Friend, T. H., Richardson, D. A., Jha, A. K., & Tsai, T. C. (2023). Trends in performance of hospital outpatient procedures and associated 30-day costs among Medicare beneficiaries from 2011 to 2018. *Healthcare*, Volume 11, Issue 4. https://doi.org/10.1016/j.hjdsi.2023.100718
[2] Abrams, K., Balan-Cohen, A., & Durbha, P. (2018, August 15). *Growth in outpatient care: The role of quality and value incentives.* Deloitte Insights. https://www2.deloitte.com/us/en/insights/industry/health-care/outpatient-hospital-services-medicare-incentives-value-quality.html
[3] McGough, M., Ortaliza, J., Wager, E., & Cox, C. (2024, August 20). *Health Spending: What are trends in health utilization and spending in early 2024?* Peterson-Kaiser Family Foundation Health System Tracker. https://www.healthsystemtracker.org/chart-collection/what-are-the-recent-trends-in-health-utilization-and-spending/#Hospital%20outpatient%20visits%20per%201,000%20people,%202000-2022