PAYMENT COMMITTEE REPORT
TO
LEGISLATIVE COMMITTEE
APRIL 22, 2025

March 14, 2025, the U.S. Senate passed the Continuing Resolution (CR) to fund the federal government through Sept. 30 but failed to address dozens of critical policies, including funding for a needed payment boost under the Medicare Physician Fee Schedule.

Please read the statement from APTA President Kyle Covington, PT, DPT that is being released tonight:

https://www.apta.org/news/2025/03/14/medicare-physician-fee-schedule-cuts

The CR does extend telehealth flexibilities, and the Medicare work geographic index floor though September 30.

As APTA reported earlier, Congress passed a CR in December 2024 that funded the government through March 14 and extended telehealth waivers but failed to provide extra funding to address the 2025 fee schedule. It was expected this additional funding would be included in this new package-that second failure sparked an outcry from various health care provider and patient groups including APTA and the AMA.

While Congress failed to address the fee schedule, lawmakers are seeking other options to address Medicare payment, including a potential stand-alone bill to address all of the health care policies that were left out of the CR package. In addition, House leaders have stated that they could address the fee schedule in the upcoming budget reconciliation package; however, the timing of when Congress will take up that legislation is unclear.

UHC Continues Refinement of Prior Authorization Policy

Process changes, such as more real-time information and a shortened form for fewer visits, are meant to allow PTs to treat patients quicker.
Date: Friday, March 21, 2025

In another update to a process that began last summer, UnitedHealthcare has implemented changes to its prior authorization requirements in certain Medicare Advantage plans for PT treatment visits following an initial evaluation when services are provided in office and outpatient hospital settings. As a result of continued APTA advocacy and communication with UHC, the insurer contacted APTA staff in March with the stated changes, indicating they are made to help ensure timely provision of services to patients.

The latest revisions include:

Technology updates that provide therapists with real-time coverage information. When patient information is entered into the submission portal, real-time member eligibility information will be available so that providers can begin treatment immediately, including the same day as the initial consultation, when clinically appropriate.

A shortened submission form is now available in the provider portal for initial prior authorization requests of six or fewer visits over eight weeks, eliminating the need for additional documentation. UHC reminds providers that a prior authorization request is still required for all visits within the entire plan of care, including the full duration and number of visits. If that number of visits is six or fewer, providers can use the new shorter form. For subsequent requests beyond the initial plan of care, the provider will need to submit for a new authorization .

Upon completing the submission process, real-time coverage for initial requests of six visits over eight weeks will be confirmed and visible in the portal the same day. An initial request for prior authorization applies to a patient who is new to the provider, has a new condition, or has had a gap in care of 90 days or more.

If more than six visits are requested, the first six will be immediately covered, and the remaining visits will be reviewed for medical necessity.

In its communications with APTA, UHC said there would not be a published statement or messaging to providers with this new information. Providers are directed to this FAQ for more information: Changes to prior authorization requirement for Medicare Advantage outpatient therapy services - UnitedHealthcare Medicare Advantage plans.

As APTA has reported earlier, the association's advocacy brought other changes to UnitedHealthcare policies that will somewhat ease certain prior authorization requirements. These changes are outlined below.

As of Jan. 13, UHC allows up to six follow-up visits after an initial evaluation without requiring a clinical review. Previously, a clinical review was required before any follow-up visits could occur, which APTA strongly argued would delay needed services and hinder effective care. In announcing the change, UHC said that "based on feedback from providers, UnitedHealthcare has updated the prior authorization requirement for physical, speech, and occupational therapy and chiropractic services that became effective Sept. 1, 2024, for UnitedHealthcare Medicare Advantage individual and group retiree members."
Provisions of the Policy

Coverage for the six visits applies under any one of the following circumstances:

The patient is new to the PT's office.
The patient presents with a new condition.
The patient has had a gap in care of 90 or more days.

Providers must continue to submit a prior authorization request for the entire plan of care, including the full duration and number of visits requested. In addition, the six visits must occur within eight weeks of the initial evaluation. Only care plans requesting more than six visits or

care plans exceeding eight weeks will be assessed for medical necessity. The initial consultation/evaluation still does not require prior authorization.

Additionally, UHC provided the following information:

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 that additional care is provided promptly. No changes are needed to the current clinical submission process.

Authorization for additional visits may be requested up to 10 business days after the patient's initial consultation. The patient's care may commence immediately. Up to the first six visits within eight 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.

UHC Resources

Providers are instructed to continue to follow the submission process via the UnitedHealthcare Provider Portal, and UHC directs those with questions to read the Skilled Nursing Facility, Rehabilitation, and Long-Term Acute Care Hospital Medical Policy or visit its Prior Authorization and Notification webpage; or to call 800-873-4575. The company also has posted an overview of the policy changes that includes an extensive Q&A.

Providers contracted by OptumCare and WellMed should refer to the number on the member ID card for prior authorization instructions.

In addition, UHC released these two notices announcing the changes:

Medicare Advantage: Updates to prior authorization requirement for outpatient therapy and chiropractic services | UHCprovider.com

Changes to prior authorization requirement for Medicare Advantage outpatient therapy services, updated Jan. 8, 2025 | UnitedHealthcare Medicare Advantage plans