UnitedHealthcare Community & State

Hoosier Care Connect Health Plan

Prior Authorization 101

Presented by Jodie Hattery –VP Provider Relations IN,KY, and OH

United Healthcare®

Agenda

- Admission Notification vs. Prior Authorization
- Introduction to Prior Authorization
- How to submit Advance/Admission Notification
- How to obtain a Prior Authorization for:
  - Medical
  - Behavioral Health
  - Vision
  - Dental
- How to dispute a Prior Authorization denial
- How to appeal a denial decision
- General appeal information for all service lines

Our Service Lines

- UnitedHealthcare

- Optum Behavioral Health

- March Vision

- UnitedHealthcare Dental

Introduction to Prior Authorization

The process to request Prior Authorization differs slightly depending on the service line.

- Medical
- Behavioral Health
- Dental
- Vision

Medical

Prior Authorization Requirements for Indiana Hoosier Care Connect

Effective June 1, 2021

Prior Authorization: Requesting medical necessity review and approval before rendering a service is required by UnitedHealthcare policy for some services. It's required under the direction of the UnitedHealthcare Health Services Department and is an essential part of any managed care organization. Advance notification is required to give UnitedHealthcare timely communication of services so we can do a prospective, concurrent and retrospective care review.

*Prior authorization is ***not required*** for emergency or urgent care.

Admission Notification

Admission Notification: General Acute Care and Nursing facilities are required to notify UHC when a member has been admitted into their facility. This must be done within 24 hr. (also referred to as ‘head in the bed’) of member admission.

To notify UnitedHealthcare of an Admission

a) Via Phone

b) Via fax paper form

c) Online – easiest and most efficient method

d) Electronic Data Interchange (EDI) 278N Transaction

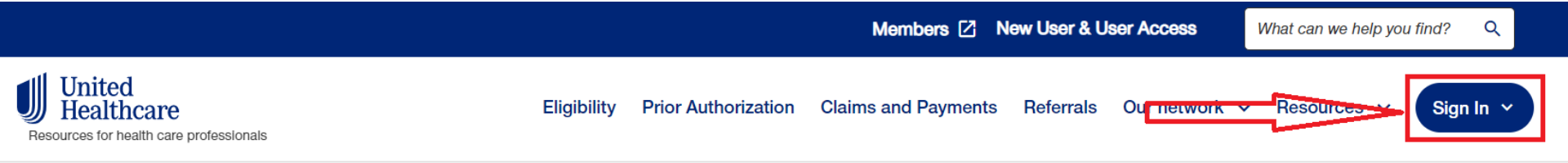
Admission Notification - EDI 278N Transaction

- Use the Hospital Admission Notification (278N) transaction to exchange admission notification data between an inpatient facility and UnitedHealthcare in a standard format.
- It can be transmitted directly to UnitedHealthcare or through a clearinghouse in either batch or real-time format.
- To get started, contact your vendor or clearinghouse. Most clearinghouses already send 278N transactions to UnitedHealthcare and can work with you to submit notifications in the appropriate format.
- For additional information regarding the EDI 278N Transaction please visit our website at: EDI 278N: Hospital Admission Notification | UHCprovider.com

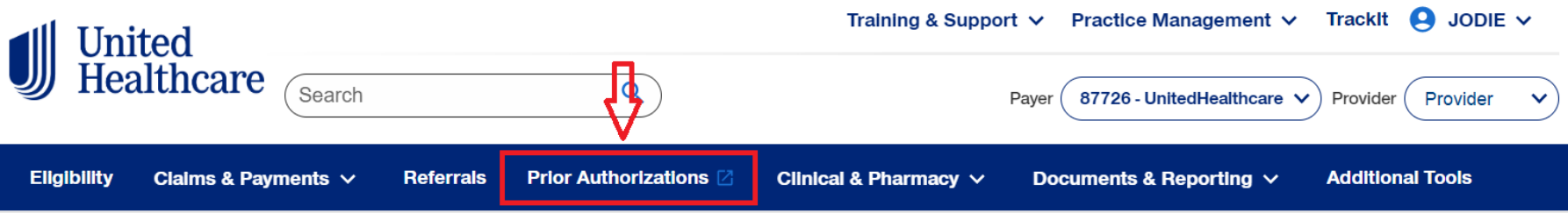
Medical

How to Request a Prior Authorization from our Community Plan of Indiana Homepage

From the www.uhcprovider.com homepage click on "Sign In"



After logging into our UnitedHealthcare Provider Portal, click on "Prior Authorization"



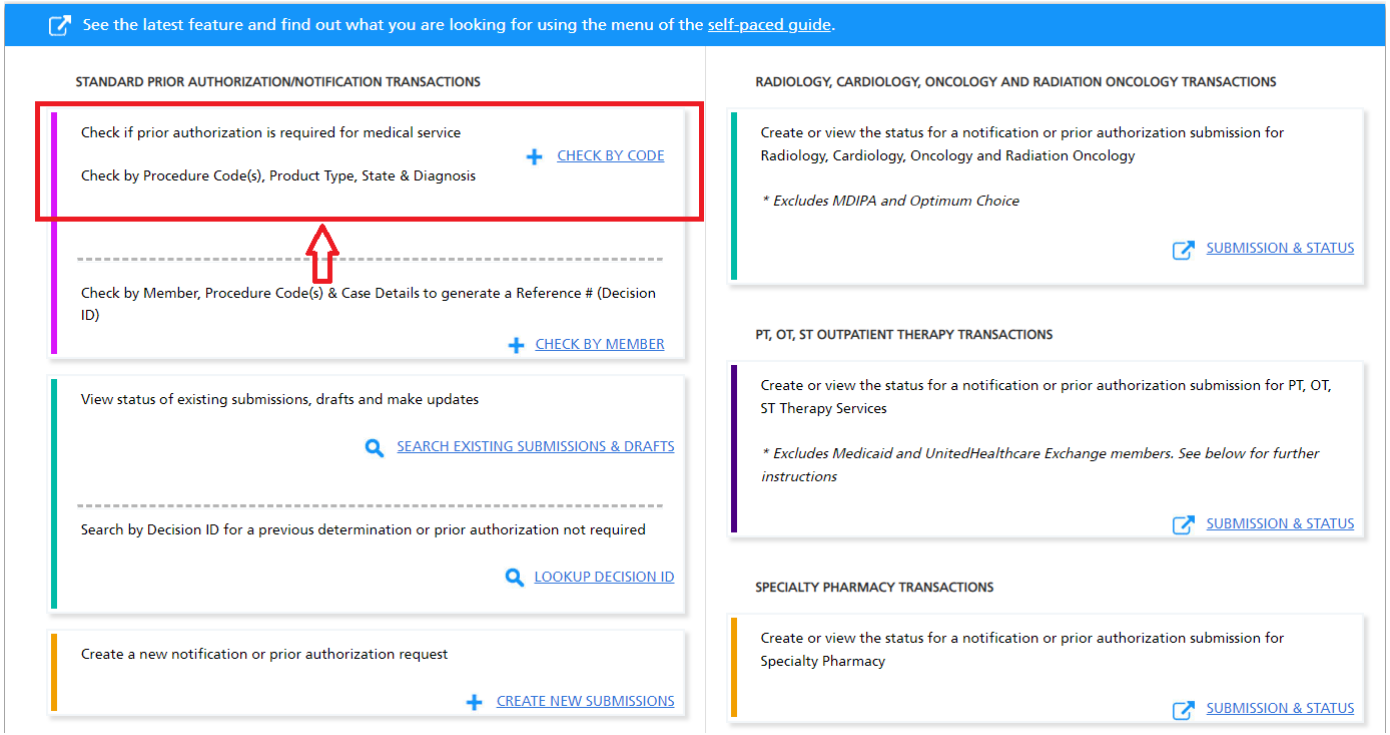
How to Check Prior Authorization Requirements

Use the Prior Authorization and Notification Tool to:

- Determine if Notification or Prior Authorization is required
- Complete the Notification or Prior Authorization process
- Upload medical notes or attachments
- Check request status information and advance notification/lists

How to Check Prior Authorization Requirements

Click “Check by Code” in the “Check if Prior Authorization is required for medical service” box



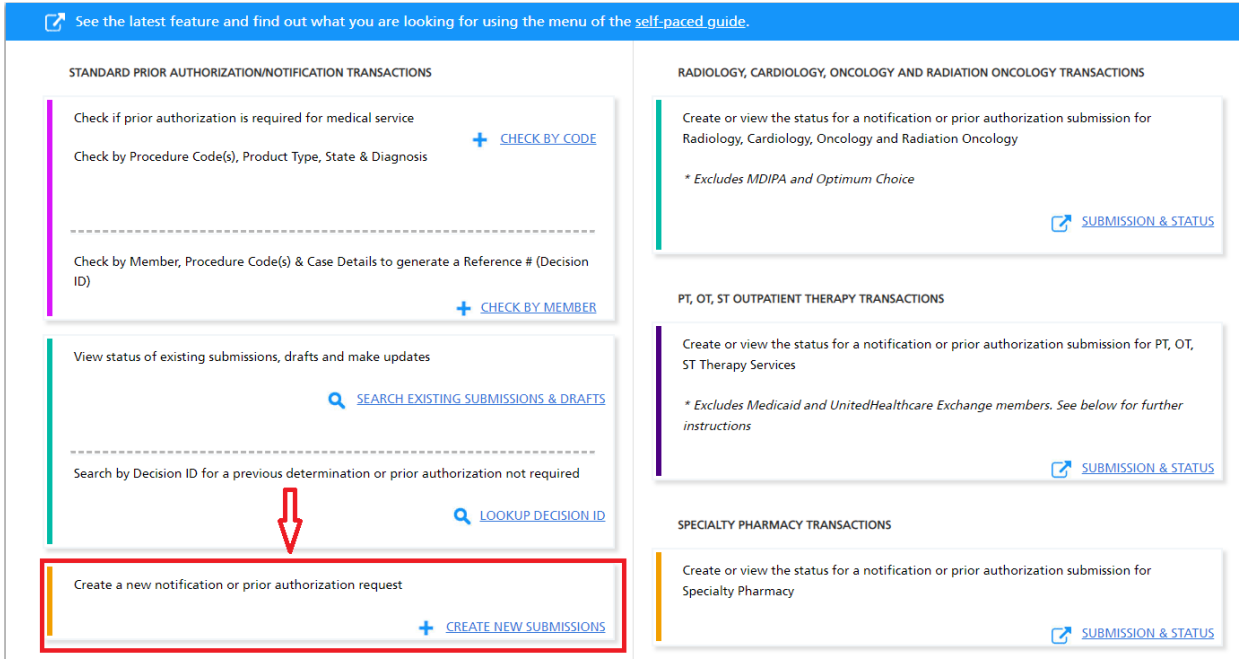
Medical – How to Request a Prior Authorization

How to submit Prior Authorization once you have confirmed it is required:

a) Via fax paper form

b) Via phone: 877-610-9785

c) Online via the PAAN Tool



Medical - Radiology/Cardiology Prior Authorization Requirements

Utilize the list available online (at the link below) to determine if a Radiology or Cardiology service requires Prior Authorization

https://www.uhcprovider.com/content/dam/provider/docs/public/commplan/in/priorauth/IN-Hoosier-Connect-Effective-6-1-2021.pdf

Search the list by utilizing Ctrl “+” F on your keyboard and typing in the CPT code that best represents the service to be performed.

Remember: for Radiology and Cardiology services, you will follow the same process that you do for all other medical services as seen in the previous slide (slide 12).

Medical – How to Appeal an Adverse Decision

If your request is denied, you may request a Peer-to-Peer by calling 800-955-7615.

If provider disagrees with the Peer-to-Peer decision, you may file an appeal. Even if a Peer-to-Peer is not completed, you still may file an appeal. All steps in the process are outlined in the decision letter sent by the authorization team.

Escalate to the Advocate team if it is taking longer than the state mandated turn around time to receive a decision.

Prior Authorization Decision Turn-Around-Times

Type of Request	Decision TAT	Practitioner Notification of Approval	Written Practitioner/Member Notification of Denial
Non-urgent Pre-service	Within 7 calendar days of receipt of medical record information required but no longer than 14 calendar days from receipt	Within 24 hours of the decision	Within 2 business days of the decision
Urgent/Expedited Pre-service	Within 72 hours of request receipt	Within 72 hours of the request	Within 72 hours of the request
Concurrent Review	Within 1 business day	Notified within 24 hours of determination	Notified within 24 hours of determination and member notification within two business days
Retrospective Review	Within 30 calendar days of receiving all pertinent clinical information	Within 30 days of determination	Within 30 days of determination

BEHAVIORAL HEALTH

Behavioral Health

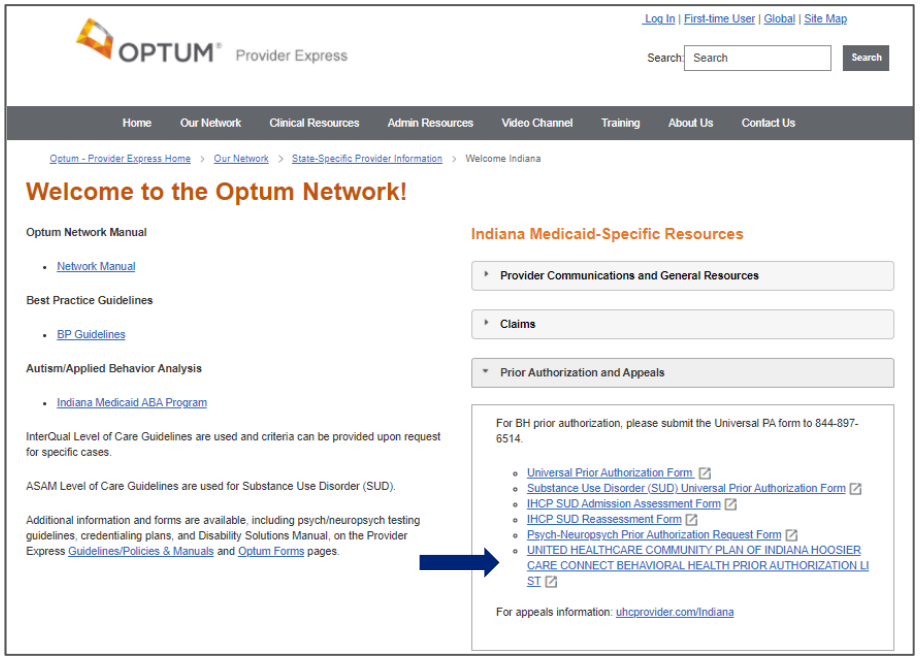
How Do I determine if a Behavioral Health Service Requires Prior Authorization?

Most outpatient Behavioral Health services do NOT require an authorization.

Call the number on the back of the member's card to determine if authorization is required.

- Or -

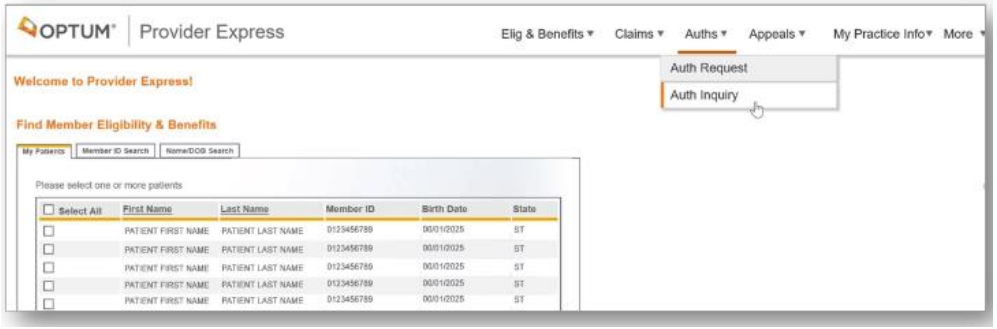
[Provider Express - Indiana Medicaid]



Behavioral Health

How do I request Behavioral Health Prior Authorization?

- Initiate phone authorization process by calling 877-610-9785 or the number on the back of the member's ID card
- Securely login to Provider Express and select "Auth Request" from the "Auths" dropdown box
- To check on status, select "Auth Inquiry"
- Utilize the paper Universal Prior Authorization Form from Provider Express - Indiana Medicaid and clicking "Prior Authorizations and Appeals"
- Fax to 844-897-6514



Prior Authorization and Appeals

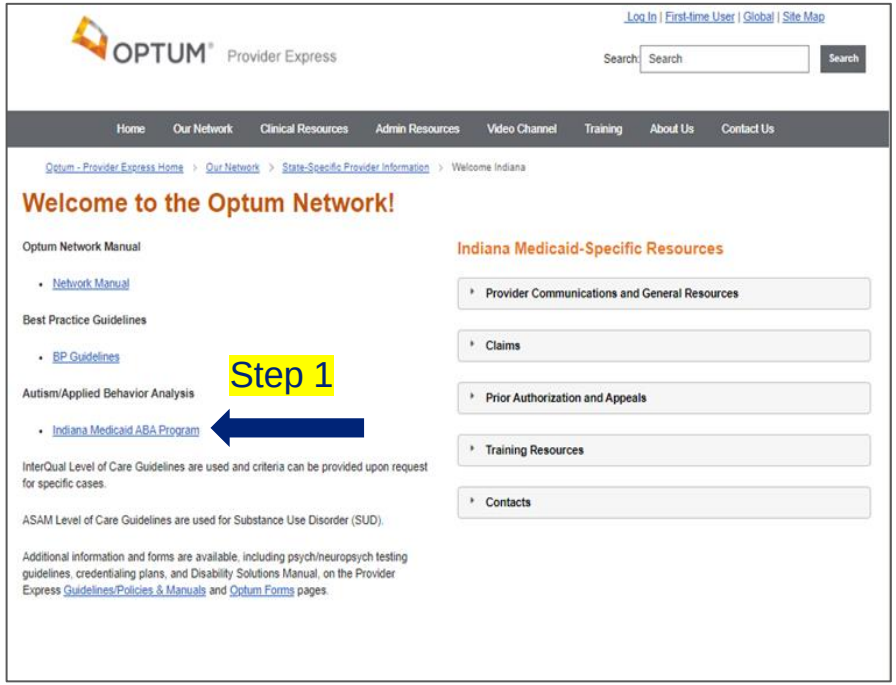
For BH prior authorization, please submit the Universal PA form to 844-897-6514.

- Universal Prior Authorization Form
- Substance Use Disorder (SUD) Universal Prior Authorization Form
- IHCP SUD Admission Assessment Form
- IHCP SUD Reassessment Form
- Psych-Neuropsych Prior Authorization Request Form

For appeals information: uhcprovider.com/Indiana

Behavioral Health

How do I request Prior Authorization for ABA Therapy Services?



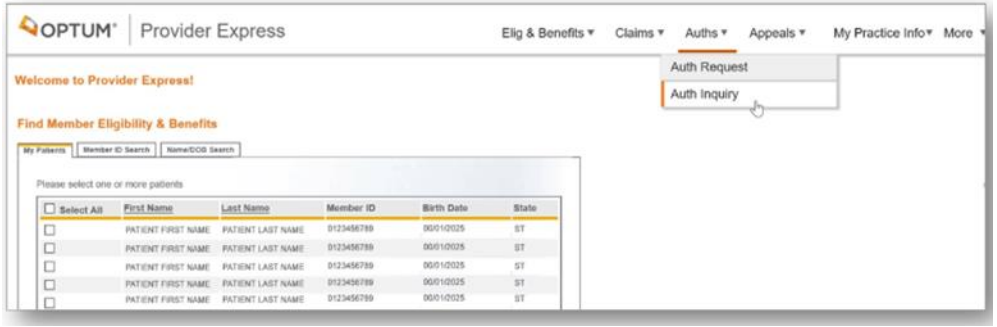
[Provider Express - Indiana Medicaid]

Behavioral Health

When should you escalate to your Provider Advocate?

If you submit a Prior Authorization request and do not receive a response within the required turn-around-time; do the following:

1. Check the Provider Express portal



2. Call the number on the back of the member's ID card

3. If 1 and 2 do not provide a response, please reach out to your Provider Relations Advocate

How to Appeal an Authorization Decision

In the event an authorization is denied, and an appeal is necessary, make sure to include the following information with your appeal:

- Member Name
- Member Date of Birth
- Member RID
- PA Request
- Denial letter
- Any additional supporting documentation and send to:

National Appeals Team
Attn: Appeals Department/Retrospective Review
P.O. Box 30512
Salt Lake City, UT 84130-0512
Fax: (855) 312-1470
Phone Number: (866) 556-8166

DENTAL

Dental

Summary of Dental Services requiring Prior Authorization

United Healthcare | Dental Benefit Providers

- Endodontics (root canals, root treatments)
- Periodontics (gum tissue treatment)
- Prosthodontics (dentures)
- Oral surgery (extractions, correction of oral issues)
- Orthodontics (braces), and moderate/deep sedation anesthesia

Dental

How do I determine if a Dental Service requires Prior Authorization?

- For a complete listing of procedures requiring authorization, refer to the benefit grid in the UnitedHealthcare Community Plan of Indiana Hoosier Care Connect Dental Provider Manual at www.uhcdentalproviders.com.

- When requesting Prior Authorization, the practitioner must submit planned procedures for approval with clinical documentation supporting necessity before initiating treatment.

- For questions concerning Prior Authorization, dental claim procedures, or to request clinical criteria, please call the Provider Services Line at **1-844-402-9118**.

Dental

How do I request Prior Authorization?

- You can submit your Prior Authorization request online at www.uhcdentalproviders.com
- You can also submit your Prior Authorization request via mail at the following address:

  Prior Authorization
  P.O. Box 1313
  Milwaukee, WI 53201

- Please include with your Prior Authorization request, a completed ADA Claim Form with the box titled "Request for Predetermination/Preauthorization" checked.

Dental Authorization Timelines

The following Authorization timelines will apply to requests for authorization:

We will make a determination and provide written notification on *expedited authorizations* within 72 hours of receipt of the request.

We will make a determination and provide written notification on *standard authorizations* within 7 calendar days of receipt of the request.

Authorization approvals will expire 180 days from the date of determination.

VISION

Vision – Prior Authorization

- March Vision Care does not require prior authorization for most routine vision services.

- For routine exams, frames, and lenses, please check member eligibility and obtain a confirmation on the www.eyeSynergy.com provider portal.

- For Medically Necessary contact lenses and fittings, providers need to submit a pricing request form.

VISION

How do I request a March Vision Care services Prior Authorization?

- Obtain confirmation by logging into www.eyeSynergy.com and search for member, verify eligibility & benefits, and generate a confirmation number.
- Confirmation number is an 11-digit identification number generated when your office verifies benefits & eligibility.
- Benefits that generally require confirmation numbers include, but are not limited to:
  - Replacement frames and lenses
  - Medically necessary contact lenses for Medicaid members
  - Two pairs of glasses in lieu of bifocals
  - Prescription sunglasses

Vision

How do I request a March Vision Care services Prior Authorization?

For Medically Necessary contact lenses, providers need to submit a pricing request form *prior* to submitting the claim for reimbursement. Email the completed form with the patient's current eye exam/doctor's notes to providers@marchvisioncare.com

Medically-Necessary-Form-Editable.pdf (marchvisioncare.com)

Prior Authorization Appeals Process- All Service Lines

- All Providers may appeal a Prior Authorization adverse determination.
- An appeal can be filed within 60 calendar days from the date of the adverse determination.
- Submitted appeals will be acknowledged within 3 business days.

Prior Authorization Appeals Process- Outcomes

- A decision on the appeal is made within 30 calendar days unless it is expedited.
- Expedited appeals are resolved within 48 hours of receiving the appeal and every attempt is made to notify the member orally as well as in writing.
- A notification of standard appeal decision is sent within 5 business days of the resolution.
- In rare cases, a 14-day extension may be required. If this is required, both the member and provider are notified.
- Appeal notification letters indicate how to file an appeal based on the type of service.

What are my options if the authorization is denied?

Utilization Management (UM) Appeals Process

- Peer to Peer within 14 days
  Call 800-955-7615
- Next level Appeal
- Fair Hearing

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Your Medical Network Provider Advocate Team

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Your FQHC Provider Advocate Account Manager

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Your Skilled Nursing Provider Engagement Team

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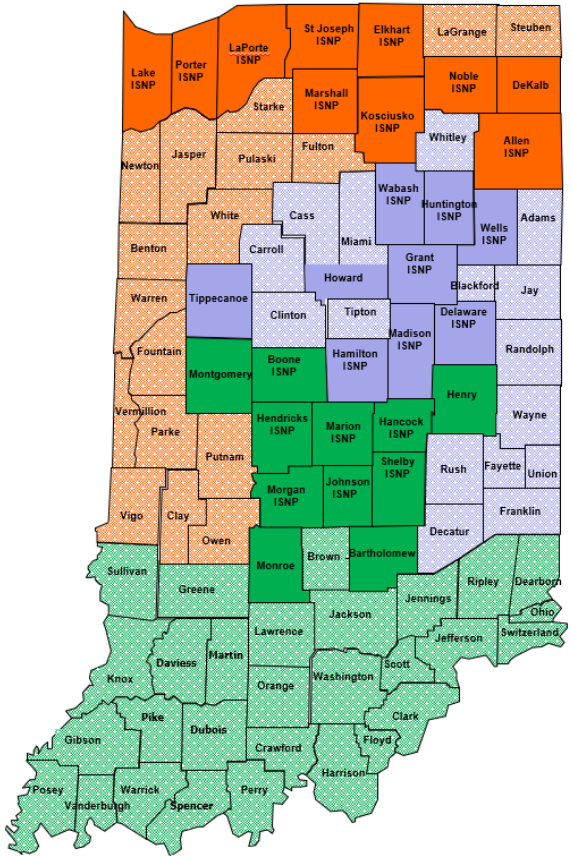

Your Optum Behavioral Health Advocate Team

Belen Stewart
Provider Advocate
Behavioral Health
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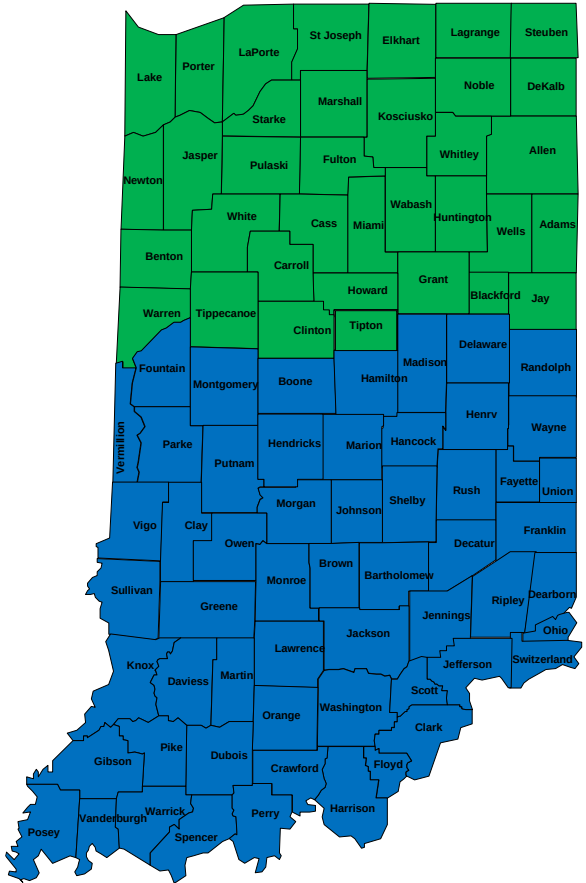
Belen.Stewart@optum.com

Open Position



Your Optum Behavioral Health ABA Advocate

Nacole Thompson
Provider Advocate
ABA Therapy- all counties
952-406-6449
Nacole.Thompson@optum.com

Your Dental Advocate Team

Catrice Campbell
Provider Advocate
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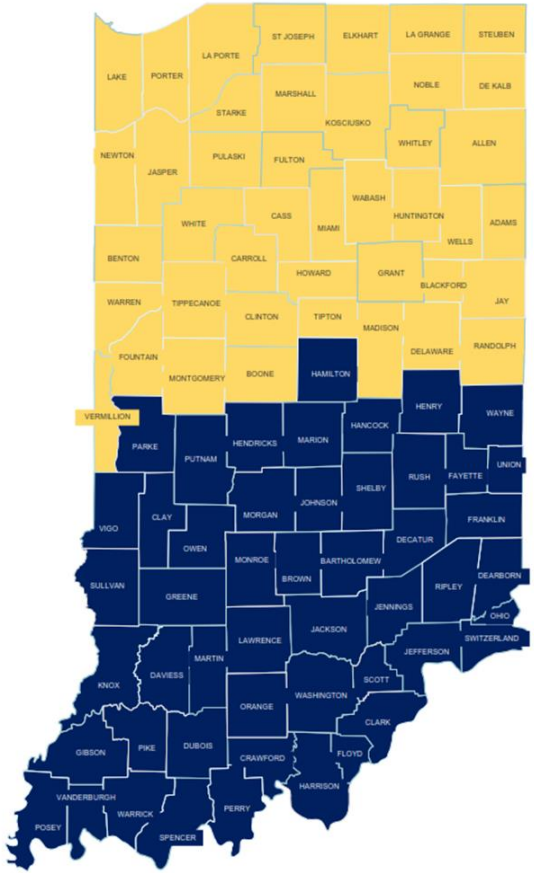
Kristy Jachowske
Provider Advocate
TBD
Kristy_jachowske@uhc.com
Kristy will be in training thru November



Your March Vision Advocate

Cassandra Pattison
Sr. Provider Relations Advocate
210-474-5592
Cassandra_Pattison@uhc.com
(Cassandra covers all Indiana counties)

Provider Reference Appendix

Provider Service Line Website Links

- United Health Community Plan (Medical): www.uhcprovider.com/INcommunityplan
- UHC Dental: www.uhcdentalproviders.com
- MarchVision: www.marchvisioncare.com
- Optum Behavioral Health: www.providerexpress.com

Questions and Answers

Thanks for Attending Today’s Session