



UnitedHealthcare Community & State

Hoosier Care Connect

Prior Authorization 101

Presented by Lynette Gatewood, Provider Engagement Manager - SNF

United
Healthcare®

Agenda

- Admission Notification vs. Prior Authorization
- Introduction to Prior Authorization
- How to obtain a Prior Authorization
 - MEDICAL
 - BEHAVIORAL HEALTH
 - VISION
 - DENTAL
- How to submit Advance/Admission Notification
- How to dispute a prior authorization denial
- How to appeal a denial decision
- When to escalate to the Provider Advocate Team

Our Service Lines

- ❖ UnitedHealthcare



- ❖ Optum Behavioral Health



- ❖ March Vision



- ❖ UnitedHealthcare Dental



Introduction to Prior Authorization

- Medical
- Behavioral Health
- Vision
- Dental

The process to request prior authorization differs slightly depending on the service line.



MEDICAL



Prior Authorization Requirements for Indiana Hoosier Care Connect

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 (also referred to as 'head in the bed').

- Weekday admissions, you must notify us within 24 hours.
- Weekday and holiday admissions, you must notify us by 5pm local time on the next business day.

To notify UnitedHealthcare of an Admission

- a) Via Phone
- b) Via fax paper form,
- c) Online – easiest and most efficient method!

Admission Types:

Planned/elective admissions for acute care

Unplanned admission for acute care

Skilled Nursing Facility admissions

Admissions following outpatient surgery

Admissions following Observations



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 status of request and advance notification/lists.

STANDARD PRIOR AUTHORIZATION/NOTIFICATION TRANSACTIONS

Check if prior authorization is required for medical service

 [CHECK BY CODE](#)

Check by Procedure Code(s), Product Type, State & Diagnosis

Check by Member, Procedure Code(s) & Case Details to generate a Reference # (Decision ID)

 [CHECK BY MEMBER](#)

View status of existing submissions, drafts and make updates

 [SEARCH EXISTING SUBMISSIONS & DRAFTS](#)

Create a new notification or prior authorization request

 [CREATE NEW SUBMISSIONS](#)



How to submit prior authorization once you have confirmed it is required:

- a) Through the UnitedHealthcare Provider Portal
Prior Authorization and Notification tool
- b) By fax paper form
- c) By phone: **877-610-9785**

Create a new notification or prior authorization request



[CREATE NEW SUBMISSIONS](#)

How to dispute the prior authorization decision - If your request is denied you may request a Peer-to-Peer Review by calling **800-955-7615**.

How to appeal the dispute decision – Provider may file an appeal if they disagree with the Peer-to-Peer decision. If a Peer-to-Peer was not requested the provider has the right to file an appeal. All steps in the process are included in letter from the authorization team.

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

- We will provide a decision for standard/non-emergency requests within 7 calendar days of when we receive clinical information.
- Urgent requests will have a decision rendered within 72 hours of receipt of clinical information
- If we need additional information, response times may vary.

Quickest way to determine if prior authorization is required.

- Search the online list (Ctrl F on your keyboard to search the list)

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

How to obtain Radiology/Cardiology Prior Authorization?

- For Radiology/Cardiology you will follow the same process that you do for all other medical services. You can access a list of radiology/cardiology services that require a Prior Authorization.
- EviCore no longer manages the authorization process for Radiology/Cardiology.

RADIOLOGY, CARDIOLOGY, ONCOLOGY AND RADIATION ONCOLOGY TRANSACTIONS

Create or view the status for a notification or prior authorization submission for Radiology, Cardiology, Oncology and Radiation Oncology

** Excludes MDIPA and Optimum Choice*

 [SUBMISSION & STATUS](#)

Type of Request	Decision TAT	Practitioner Notification of Approval	Written Practitioner/Member Notification of Denial
Non-urgent Pre-service	Within seven working days of receipt of medical record information required but not longer than 14 calendar days of 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

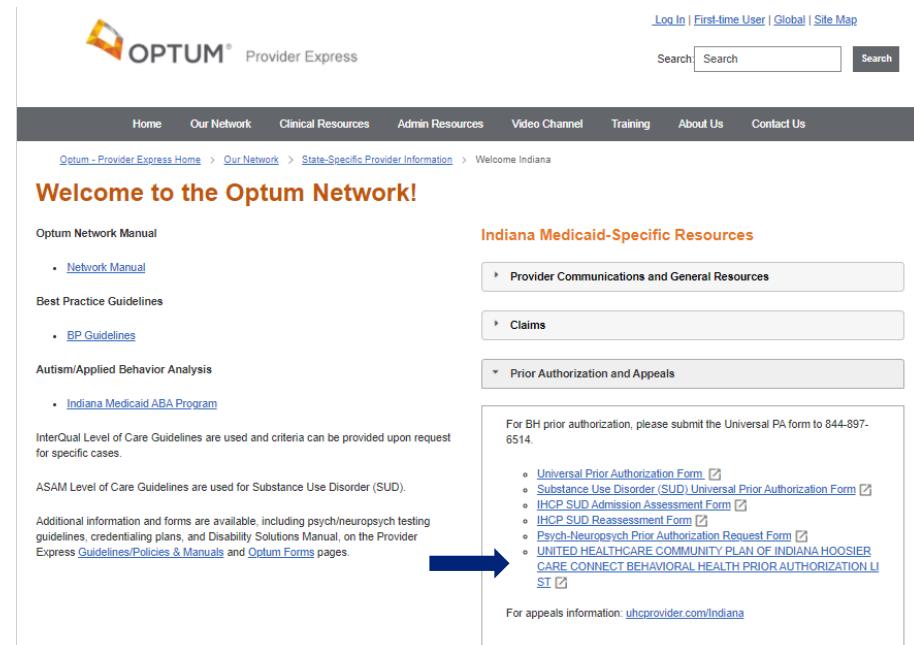
How do I determine if a Behavioral Health service requires Prior Authorization

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



The screenshot shows the Optum Provider Express website. At the top, there is a navigation bar with links for Home, Our Network, Clinical Resources, Admin Resources, Video Channel, Training, About Us, and Contact Us. The 'Our Network' link is highlighted. On the right side of the header, there are links for Log In, First-time User, Global, and Site Map. Below the header, there is a search bar with a 'Search' button. The main content area has a title 'Welcome to the Optum Network!' and a sub-section 'Indiana Medicaid-Specific Resources'. This section contains links for 'Provider Communications and General Resources' (which is expanded), 'Claims' (which is collapsed), and 'Prior Authorization and Appeals' (which is collapsed). A blue arrow points to the 'Prior Authorization and Appeals' link. Below these sections, there is a note: 'For BH prior authorization, please submit the Universal PA form to 844-897-6514.' and a list of forms: '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', and 'UNITED HEALTHCARE COMMUNITY PLAN OF INDIANA HOOSIER CARE CONNECT BEHAVIORAL HEALTH PRIOR AUTHORIZATION LIST'. At the bottom, there is a note: 'For appeals information: [uhcprovider.com/Indiana](#)'.



Behavioral Health

How do I request Behavioral Health Prior Authorization

- Initiate phone authorization process by calling 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 paper Universal Prior Authorization Form from [Provider Express - Indiana Medicaid](#) and clicking "Prior Authorizations and Appeals."

OPTUM® Provider Express

Elig & Benefits ▾ Claims ▾ Auths ▾ Appeals ▾ My Practice Info ▾ More ▾

Auth Request

Auth Inquiry

Welcome to Provider Express!

Find Member Eligibility & Benefits

My Patients Member ID Search Name/DOB Search

Please select one or more patients

<input type="checkbox"/> Select All	First Name	Last Name	Member ID	Birth Date	State
<input type="checkbox"/>	PATIENT FIRST NAME	PATIENT LAST NAME	0123456789	00/01/2025	ST
<input type="checkbox"/>	PATIENT FIRST NAME	PATIENT LAST NAME	0123456789	00/01/2025	ST
<input type="checkbox"/>	PATIENT FIRST NAME	PATIENT LAST NAME	0123456789	00/01/2025	ST
<input type="checkbox"/>	PATIENT FIRST NAME	PATIENT LAST NAME	0123456789	00/01/2025	ST
<input type="checkbox"/>	PATIENT FIRST NAME	PATIENT LAST NAME	0123456789	00/01/2025	ST

▼ 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](#)

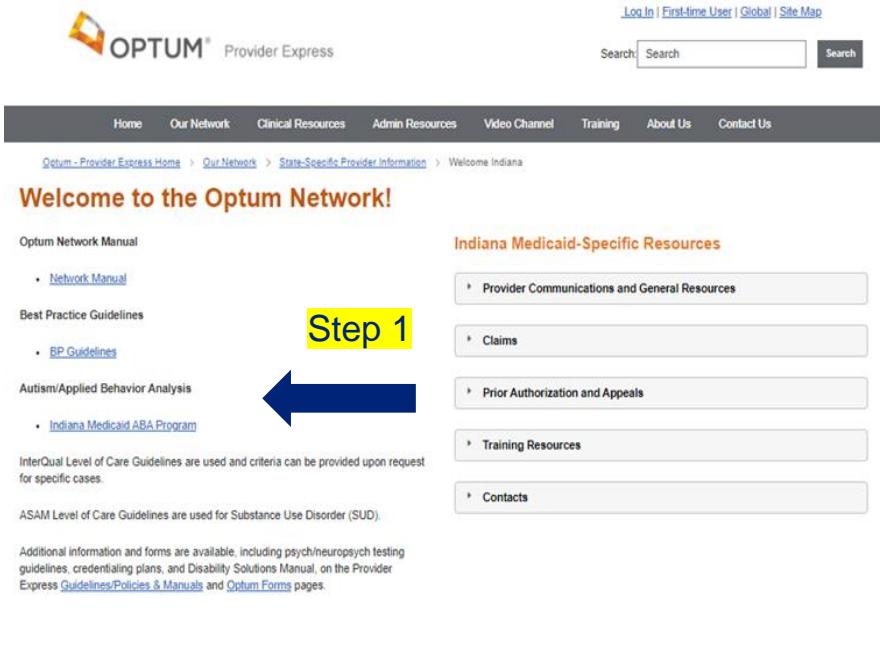


Fax to 844-897-6514

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Behavioral Health

How do I request Prior Authorization for ABA Therapy services?



OPTUM® Provider Express

Log In | First-time User | Global | Site Map

Search: Search Search

Home Our Network Clinical Resources Admin Resources Video Channel Training About Us Contact Us

Optum - Provider Express Home > Our Network > State-Specific Provider Information > Welcome Indiana

Welcome to the Optum Network!

Optum Network Manual

- Network Manual

Best Practice Guidelines

- BP Guidelines

Autism/Applied Behavior Analysis

- Indiana Medicaid ABA Program

InterQual Level of Care Guidelines are used and criteria can be provided upon request for specific cases.

ASAM Level of Care Guidelines are used for Substance Use Disorder (SUD).

Additional information and forms are available, including psych/neuropsych testing guidelines, credentialing plans, and Disability Solutions Manual, on the Provider Express [Guidelines/Policies & Manuals](#) and [Optum Forms](#) pages.

Indiana Medicaid-Specific Resources

- Provider Communications and General Resources
 - Claims
 - Prior Authorization and Appeals
 - Training Resources
 - Contacts

Step 1

A large blue arrow points from the "Indiana Medicaid-Specific Resources" section to the "Indiana Medicaid ABA Program" page on the right.



OPTUM® Provider Express

Home Our Network Clinical Resources Admin Resources Video Channel Training

Optum - Provider Express Home > Clinical Resources > Autism/Applied Behavior Analysis > Indiana Medicaid ABA Program

Indiana Medicaid ABA Program

Optum is excited to announce that **UnitedHealthcare Community Plan of Indiana** has been awarded a contract to service the Indiana. Optum has been selected by UnitedHealthcare Community Plan to develop and manage the ABA network for Indiana. This network helps to ensure access to comprehensive quality care for covered behavioral health services for enrolled members.

- Indiana Medicaid ABA Provider Orientation
- Indiana Medicaid ABA Quick Reference Guide
- ABA Treatment Request Form
- ABA Treatment Request Form (Electronic Submission)

Step 2

A large blue arrow points from the "Indiana Medicaid ABA Program" page back to the "Indiana Medicaid-Specific Resources" section on the left.

Contact Us/Request to Join the Network

Nacole Thompson
Specialty Network Manager
nacole.thompson@optum.com

A blurred image of a field of dandelions is visible on the right side of the page.

1. Provider Express - Indiana Medicaid



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Include complete record for appeal of Auth decision. Be sure to include member information.

- Name
- DOB
- RID
- PA Request
- Denial letter
- Any additional supporting documentation

National Appeals Team

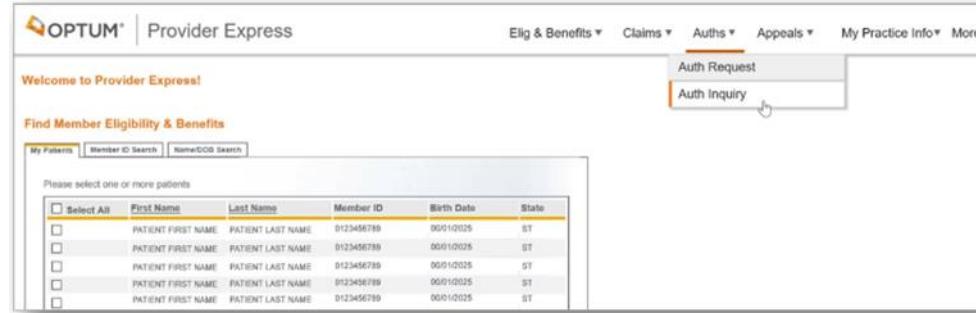
Attn: Appeals
Department/Retrospective Review
P.O. Box 30512
Salt Lake City, UT 84130-0512
Fax: (855) 312-1470
Phone Number: (866) 556-8166

Behavioral Health

When should you escalate to your Provider Advocate?

If you are not hearing back after submitting an Authorization request

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, and you have already called to inquire the status of an authorization, please allow 2 days before reaching out to a Provider Relations Advocate.



DENTAL



Summary of Dental Services that require prior authorization:

The categories of dental services that require prior authorization are:

- preventative (teeth cleanings, protective services, space maintenance)
- 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.

- To make sure that desirable quality of care standards are achieved and to maintain the overall clinical effectiveness of the program, there are times when prior authorization is required prior to the delivery of clinical services. These services may include specific restorative, endodontic, periodontic, prosthodontic and oral surgery procedures. For a complete listing of procedures requiring authorization, refer to the benefit grid within the Provider Manual.
- Prior authorization means the practitioner must submit those 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**.
- You can submit your authorization request electronically, by paper through mail, or online at uhcdentalproviders.com.
- All documentation submitted should be accompanied with ADA Claim Form and by checking the box titled: “Request for Predetermination/Preauthorization” section of the ADA Dental Claim Form.

Authorization Submission Mailing Address:

Prior Authorization

P.O. Box 1313

Milwaukee, WI 53201





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





- March Vision Care does not require prior authorization for most routine vision services
- For routine exams, frames and lenses, you just need to check member eligibility and obtain a confirmation on the eyesynergy.com provider portal
- For medically necessary contact lenses and fittings, providers need to submit a pricing request form



- To obtain a confirmation, log in to eyeSynergy.com. There you can search for members, verify their eligibility and view their benefits, and generate a confirmation.

Confirmation Numbers

A confirmation number is an 11-digit identification number received when your office verifies member benefits and eligibility. Verification is obtained by speaking with a Call Center Representative, or by accessing the IVR or providers.eyesynergy.com. Confirmation numbers affirm member eligibility for requested benefits and services. However, confirmation numbers are not required for all services. You are strongly encouraged to verify benefits and eligibility prior to rendering services.

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.



- 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.

Form Link: marchvisioncare.com/docs/Medically-Necessary-Form-Editable.pdf

Provider Reference Appendix



Provider Service Line Website Links

- United Health Community Plan (Medical): www.uhcprovider.com/INcommunityplan
- UHC Dental: www.uhcdentalproviders.com
- March Vision: www.marchvisioncare.com
- Optum Behavioral Health: Provider Express - IN Medicaid



Meet Your Advocate Teams

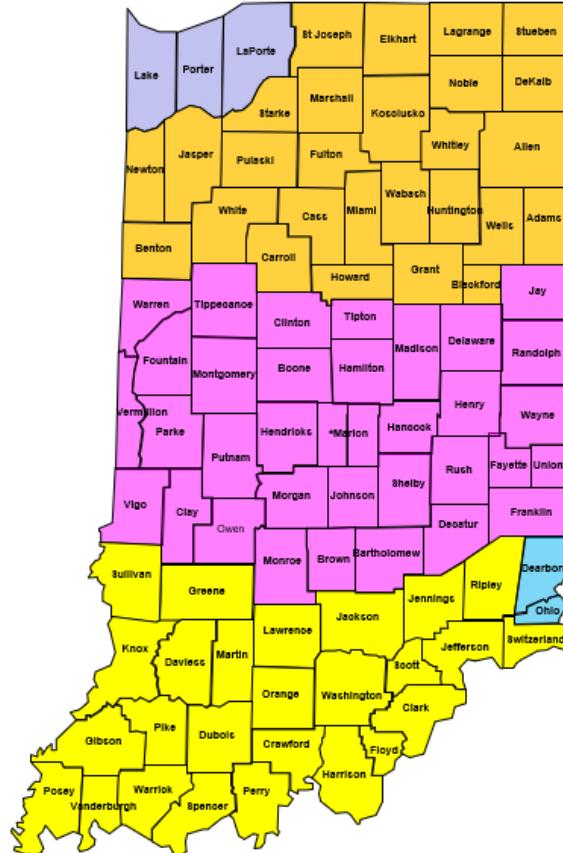
Your Medical Network Provider Advocate Team

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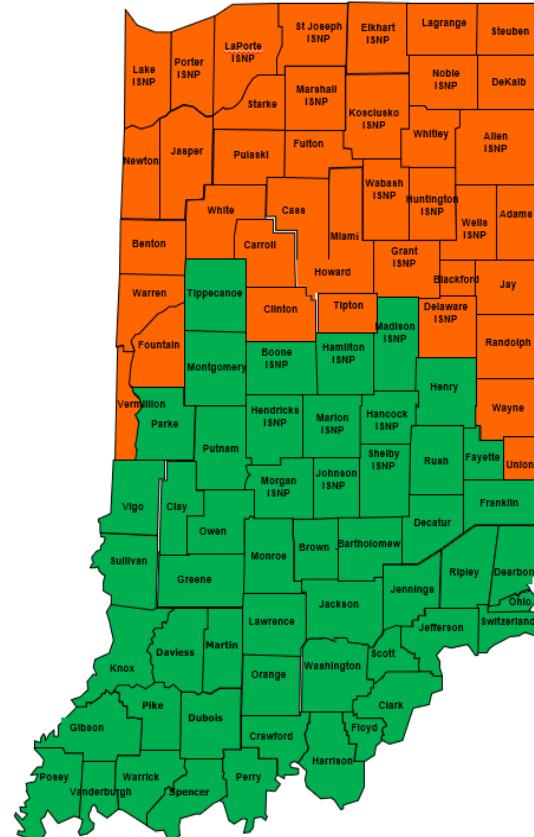
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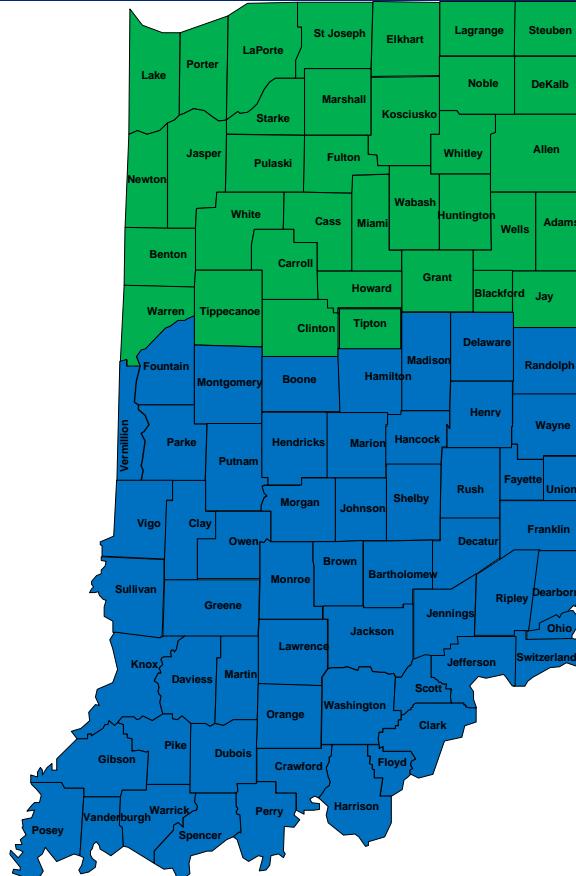
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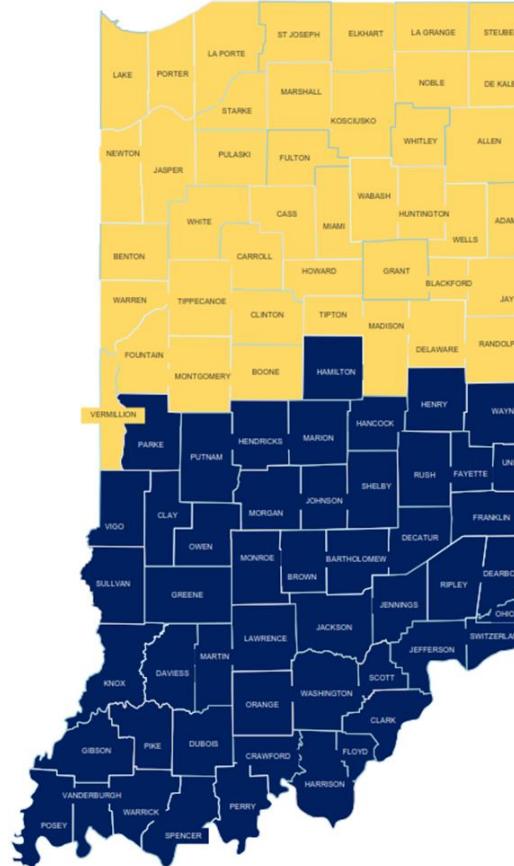
(Cassandra covers all Indiana counties)



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Questions and Answers

Thank You for Attending Today's Session





Thank you