UnitedHealthcare Community & State
2023 IHCP Works Annual Seminar

Hoosier Care Connect Health Plan

Prior Authorization

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 (UHC)
- Optum Behavioral Health (OBH)
- March Vision
- UnitedHealthcare Dental

Medical

Admission Notification

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

To notify UnitedHealthcare of an Admission

- Via Phone
- Via fax paper form
- Online via the Prior Authorization and Admission Notification (PAAN) tool
- Electronic Data Interchange (EDI) 278N Transaction (easiest and most preferred method)

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.

Introduction to Prior Authorization

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

- Medical
- Behavioral Health
- Dental
- Vision

Prior Authorization Requirements for Indiana Hoosier Care Connect

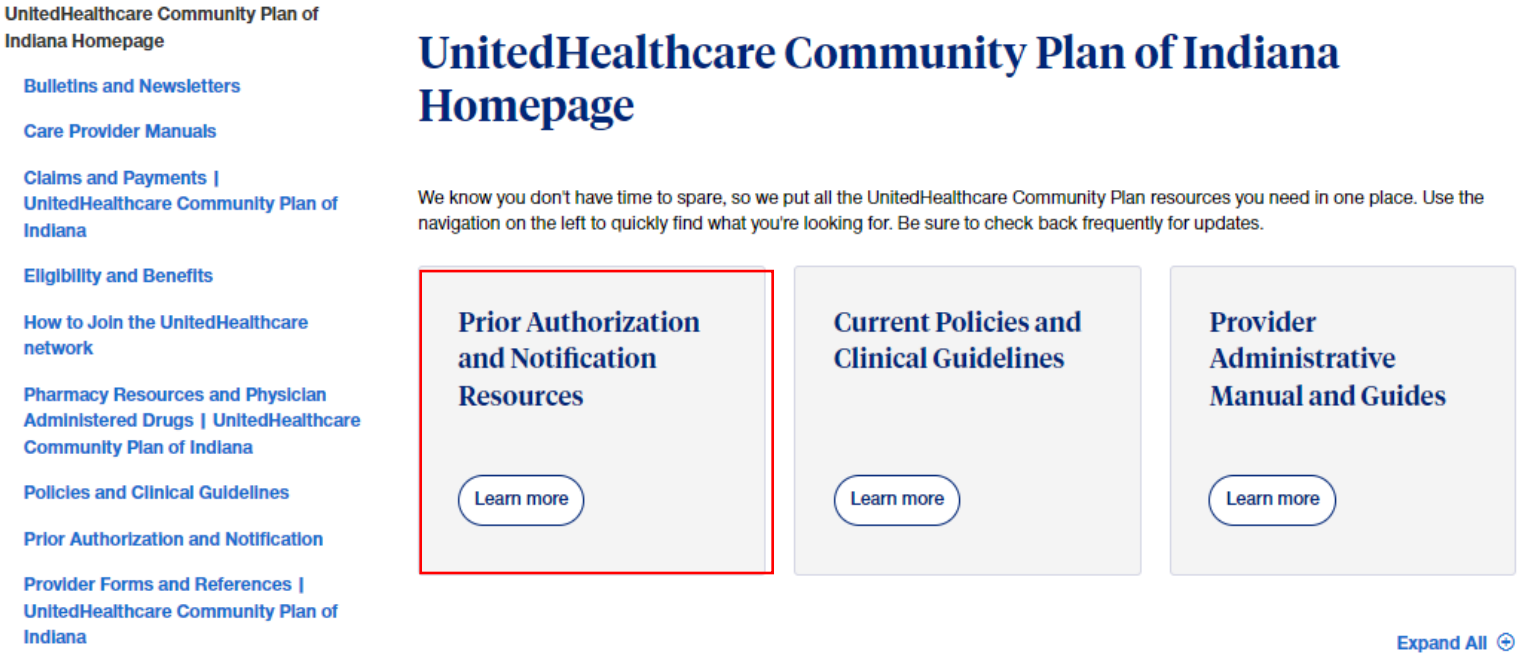
Prior Authorization: Requesting medical necessity review and approval before rendering a service is required by UnitedHealthcare policy for some services. It's required under the direction of the UnitedHealthcare Health Services Department and is an essential part of any managed care organization. Advance 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.

Medical How to Check Prior Authorization Requirements

Providers can check Prior Authorization requirements at:

UnitedHealthcare Community Plan of Indiana Homepage | UHCprovider.com



Prior Authorization and Notification | UnitedHealthcare Community Plan of Indiana

Last update: June 23, 2023

We have online tools and resources to help you manage your practice's notification and prior authorization requests.

Need to submit or check the status of a prior authorization request? Go to UHCprovider.com/priorauth to learn about our Prior Authorization and Notification tool.

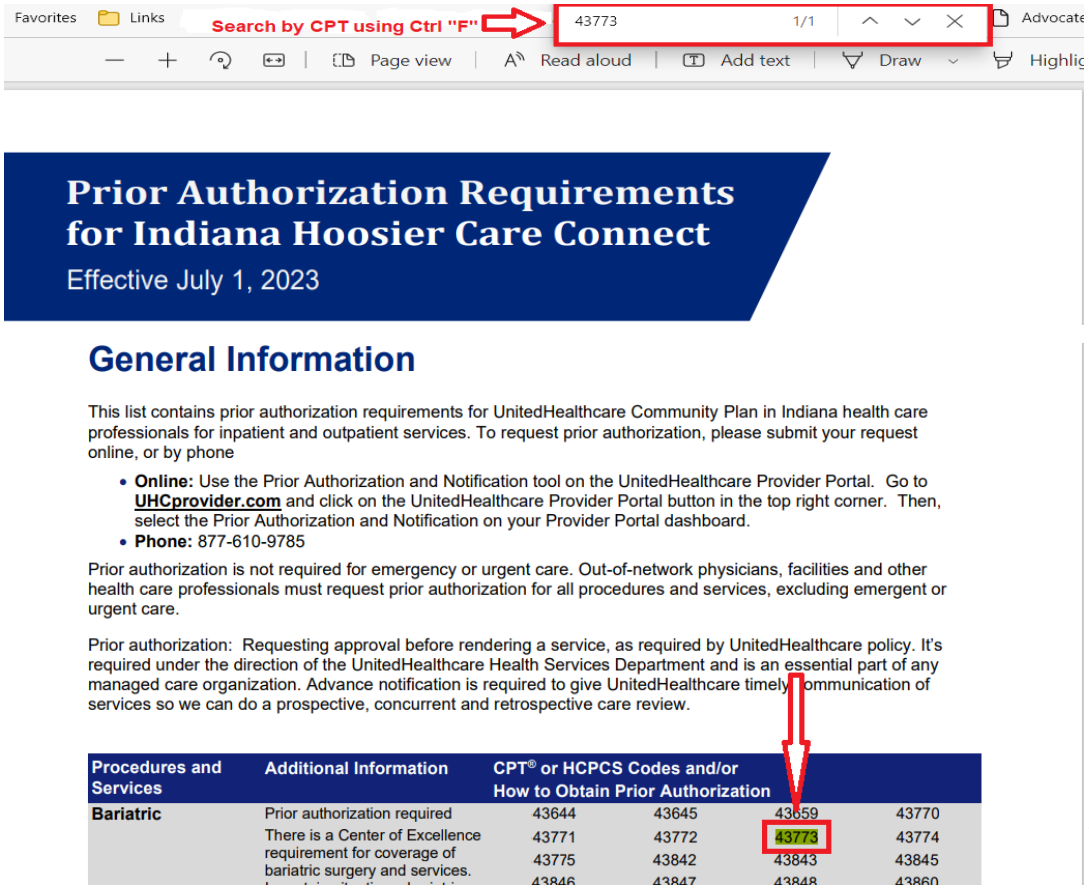
Go to Prior Authorization and Notification Tool

Current Prior Authorization Plan Requirements

- UnitedHealthcare Community Plan Prior Authorization Indiana Hoosier Care Connect - Effective July 1, 2023

Medical How to Check Prior Authorization Requirements cont.

[UnitedHealthcare Community Plan Prior Authorization Indiana Hoosier Care Connect - Effective July 1, 2023 (uhcprovider.com)]



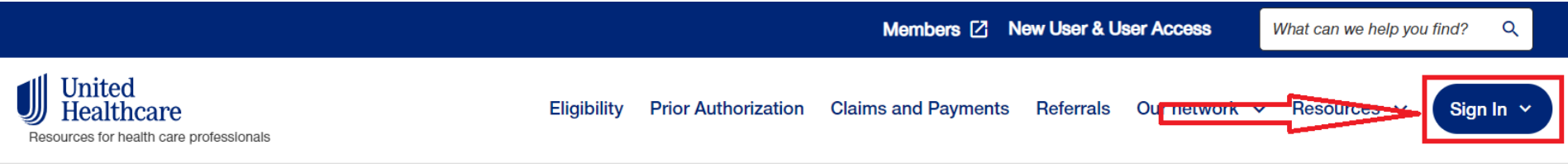
Medical How to Check Prior Authorization Requirements Via PAAN

Use the Prior Authorization and Notification Tool via our UnitedHealthcare Provider Portal to:

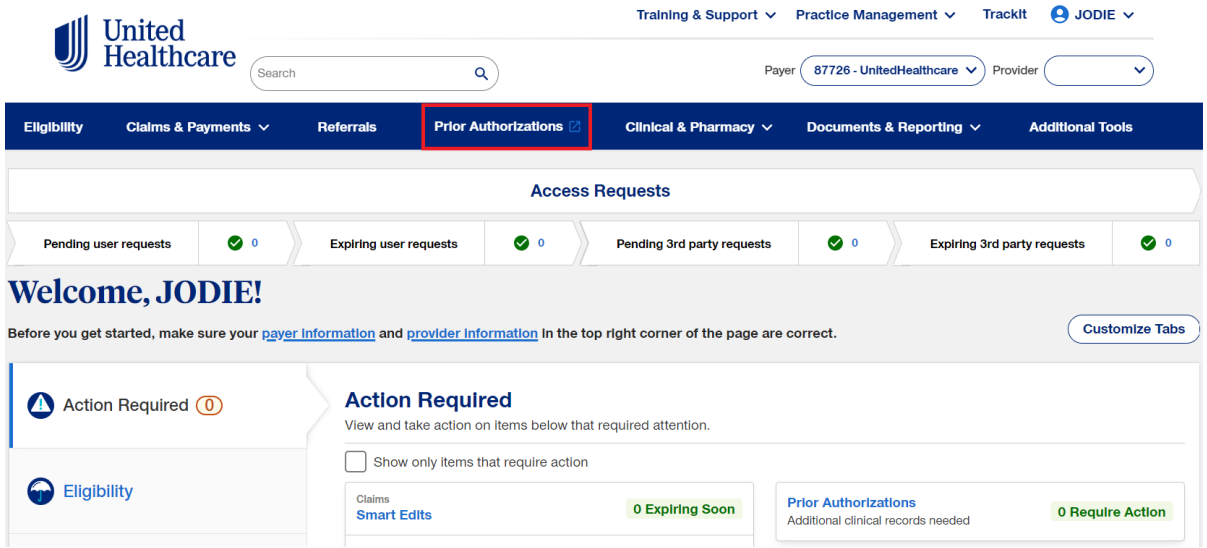
- Determine if notification or prior authorization is required
- Complete the notification or prior authorization process
- Upload medical notes or attachments
- Check request status and advance notification/lists

Medical How to Check Prior Authorization Requirements via PAAN

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

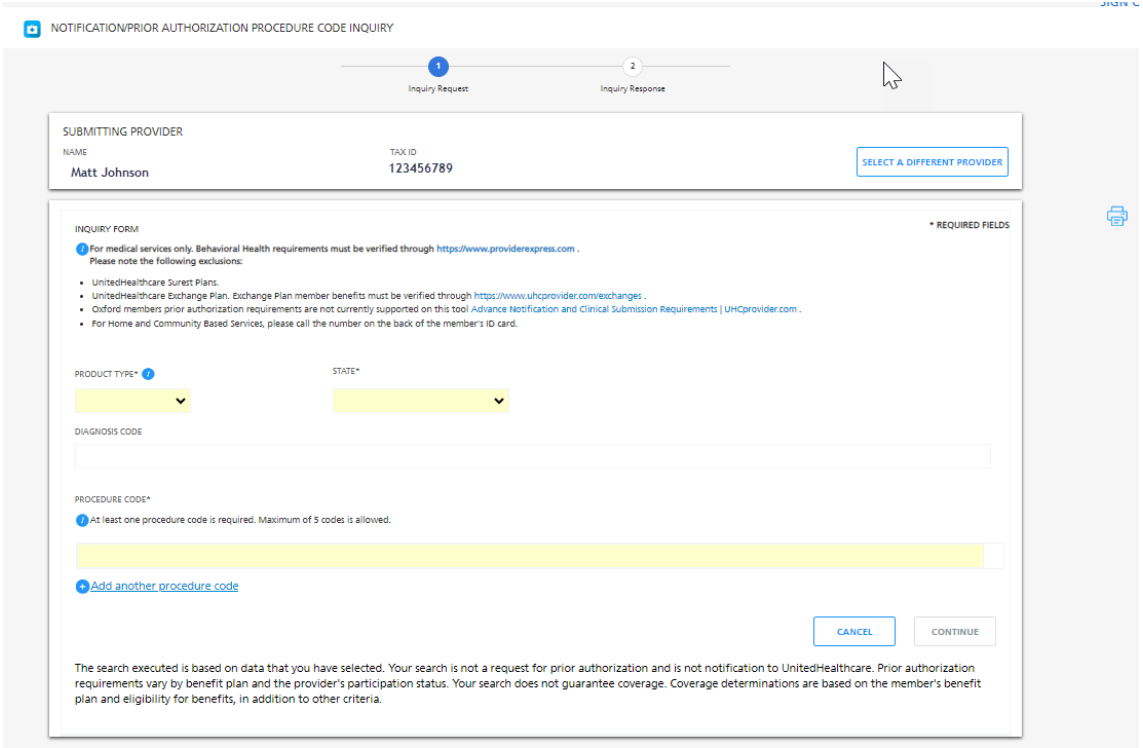


After logging into our UnitedHealthcare Provider Portal, click on the "Prior Authorizations and Notifications" tab and select "Check if Required"



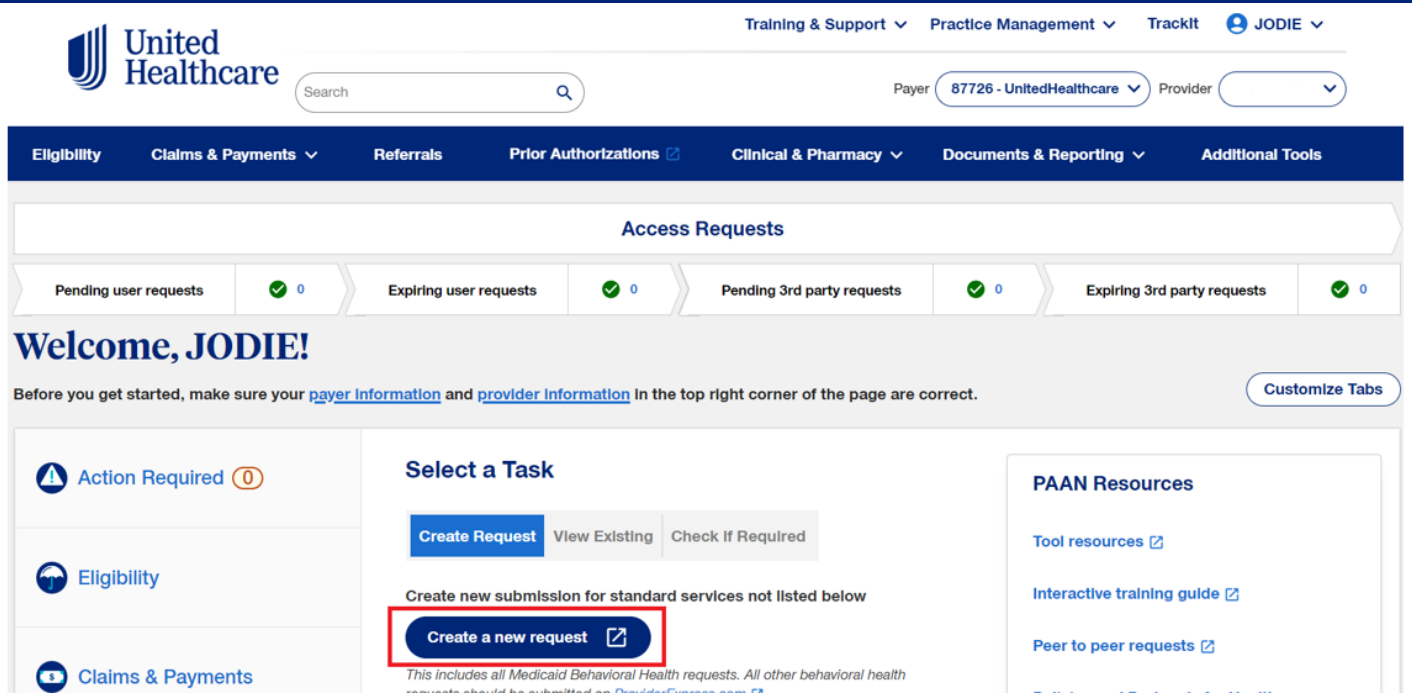
Medical How to Check Prior Authorization Requirements

On the next screen, select the Product Type, State, and Procedure Code



Medical How to Request a Prior Authorization

- Online PAAN Tool
- Fax paper form
- Phone: 877-610-9785



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-8-1-2023.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 slides.

Medical Prior Authorization Submission Tips

- If the provider you are trying to select is not an option, select another provider within the group for the authorization.
- Use the “Find Facility” search tool to locate the facility where the service will be performed.
- Use the wildcard symbol (*) to help you find the results you are looking for. Typing in less with a wildcard will help return the results you are looking for.
- UnitedHealthcare Community Plan uses InterQual for medical care determinations.
- You can access our UnitedHealthcare Community Plan of Indiana Clinical Guidelines here

Medical Tips to Avoid Prior Authorization Denials

- Be thorough and complete all the requested documentation
- Ensure that you are answering all authorization questions

Medical Management Guidelines

Admission authorization and guidelines

All prior authorizations must have the following:

- Patient name and Medical ID number
- Ordering care provider or health care professional name and TIN/NPI
- Rendering care provider or health care professional and TIN/NPI
- ICD-10 Diagnosis Codes
- Anticipated date(s) of service
- Primary and secondary procedure code(s) and number of units or visits, etc., when applicable
- Service setting
- Facility name and TIN/NPI, when applicable

Medical

Prior Authorization Requests Must be Timely

- Problem: UHC does not receive ***routine*** Prior Authorization requests for scheduled services well in advance of the service date.
    - Submit your Prior Authorization request online, via the PAAN tool as soon as the service/procedure is scheduled. For example, if a surgery is scheduled two months in advance, submit the Prior Authorization as soon as possible after scheduling. This will result in a timely determination well in advance of the scheduled service date.

Medical Avoiding Adverse Determinations and/or Peer-to-Peer Reviews

- Problem: UHC often does not receive complete clinical information with the authorization request to make a medical necessity determination
  - Following the suggestions below will result in less adverse determinations, more timely decision turn-around-times, a reduction in the need for Peer-to-Peer reviews, and/or requests for additional clinical information:
    - Submitting Prior Authorizations online via the PAAN tool
    - Submission of all required clinical information
    - Completion of all fields within the online request leaving no fields blank and avoiding answering with “N/A”

Medical How to Appeal an Adverse Decision

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

If provider disagrees with the Peer-to-Peer decision, they may file an appeal. Even if a Peer-to-Peer is not completed, provider may still 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.

Medical Peer-to-Peer Process

- Peer-to-Peer reviews can be requested 7 calendar days from verbal notification of an adverse determination (this includes Inpatient Level of Care denials.)
- A Peer-to-Peer review should be requested by facilities when Inpatient Level of Care is denied.
- A Peer-to-Peer review can also be requested if a Prior Authorization for a scheduled procedure is denied.
- A Prior Authorization request that does not meet coverage criteria or lacks sufficient information upon submission may “pend” for a Peer-to-Peer

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 48 hours of request receipt	Within 48 hours of the request	Within 48 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

Medical Avoiding Adverse Determinations and/or Peer-to-Peer Reviews

As mentioned previously, completion of all fields within the online request, leaving no fields blank, and avoiding answering questions with “N/A”, will result in more timely decisions.

The best way to accomplish this is to be familiar with the Clinical/Medical Policies that apply to the service you are requesting Prior Authorization for.

For example, a provider that specializes in Bariatric Surgery should be familiar with our Community Plan of Indiana’s “Bariatric Surgery” Medical Policy.

Medical Clinical Policies - Example

Indiana Medicaid Bariatric Surgery Medical Policy

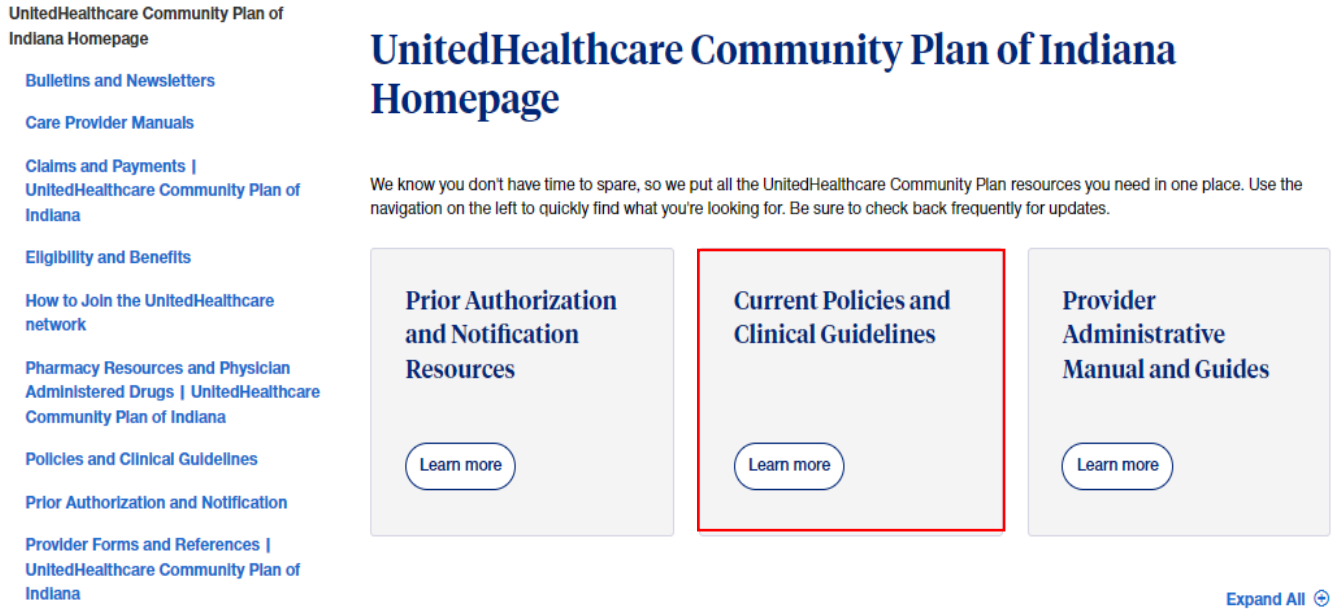
Surgical Services Provider Reference Module

Bariatric Surgery and Revisions

Bariatric surgery is recognized as medically necessary when used for the treatment of morbid obesity. Providers must report ICD-10 diagnosis code E66.01 – *Morbid obesity* with the most specific procedure code available that represents the procedure performed.

Medical Be Familiar with our Clinical Policies

- Providers can view our Clinical Policies here



Medical Be Familiar with Clinical Policies

- Bariatric Surgery
- UHC follows in this order:
    - State and Federal Medical Policy Regulations
    - UnitedHealthcare Medical Policy
    - InterQual Medical Policy

Bariatric Surgery (for Indiana Only) – Community Plan Medical Policy

Last Published 04.01.2023
Effective Date: 04.01.2023 – This policy addresses bariatric surgery.

Medical Clinical Policies

- UHC Medicaid Bariatric Surgery Medical Policy
- https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan/in/bariatric-surgery-in-cs.pdf

United Healthcare Community Plan

UnitedHealthcare® Community Plan
Medical Policy

Bariatric Surgery (for Indiana Only)

Policy Number: CS007IN.03
Effective Date: April 1, 2023

Instructions for Use

Table of Contents	Page
Application	1
Coverage Rationale	1
Applicable Codes	1
U.S. Food and Drug Administration	3
References	4
Policy History/Revision Information	4
Instructions for Use	5

Related Policies
None

Medical Process to Dispute a Prior Authorization Decision & File Appeal

- When there is an initial adverse determination of a prior authorization request:
  - Provider's next available step is a Peer-to-Peer review
  - If the denial is upheld, the provider can then appeal the determination
  - If no Peer-to-Peer was requested and an appeal was filed, then the provider is no longer eligible for a Peer-to-Peer
  - Provider will receive a letter of adverse determination; it will detail steps needed to request a Peer-to-Peer and/or an appeal

Medical External Review

- When requested, an external review of a Prior Authorization can be performed by an Independent Reviewer Organization (IRO)
- Member must file the external review request within 120 calendar days from receiving the appeal decision
- We utilize the State's recommended list of Independent Review Organizations (IROs) to conduct the external review
- A decision by the IRO is made within 72 hours if expedited and within 15 business days for standard appeals
- The decision by the IRO is binding and not disputable by UnitedHealthcare

Medical State Fair Hearings

- FSSA maintains a fair hearing process which allows members the opportunity to appeal the Contractor's decisions. Members can find out how to submit a request for a State Fair Hearing here.
- Members must first exhaust all grievance and appeal options with UnitedHealthcare.
- Members may file for a State Fair Hearing within 120 calendar days from the adverse determination notice of the final appeal.
- The member and member's representative as well as a representative of UnitedHealthcare attends the hearing.
- If the member is dissatisfied with the outcome of the hearing, they may request an Independent Review Organization (IRO) review within 10 days of the administrative law judge's decision.

Medical Retroactive Authorizations & Medical Claim Review

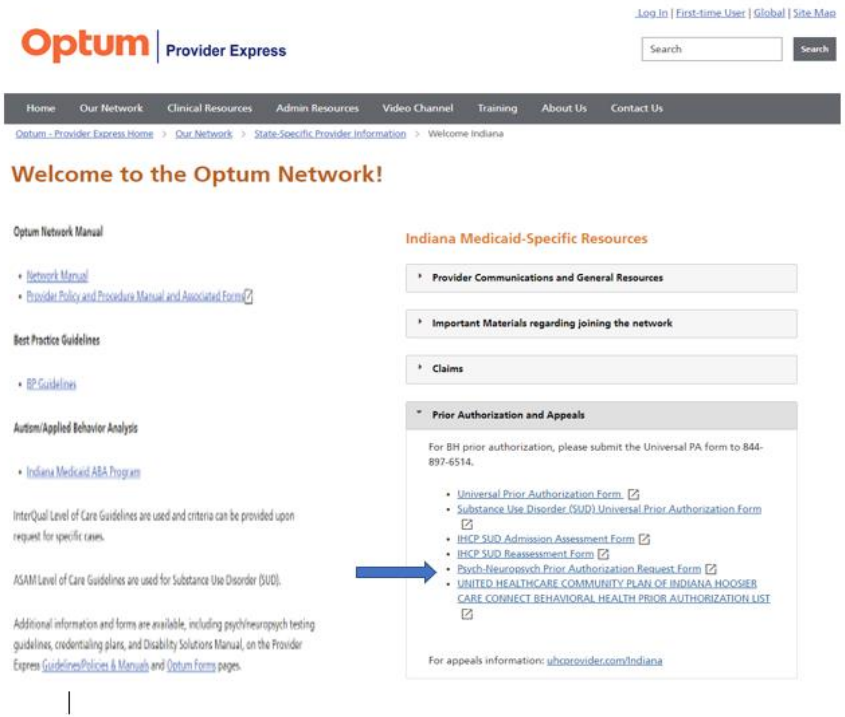
- Retroactive Authorization:
    - Retroactive Authorizations will be issued when the “No Authorization” denial was due to eligibility issues
- Medical Claim Review (MCR) performs Medical Necessity reviews on denied claims when a Prior Authorization/Admission Notification was not obtained or if Inpatient Level of Care was denied during the members inpatient stay
    - Example: Provider obtains authorization for a particular code, then upon entering the surgical site the provider must perform an additional or different service than what was originally approved
    - The claim would be filed, denied and then reviewed by the Medical Claim Review team upon submission of a Claim Reconsideration with documentation that supports medical necessity attached

BEHAVIORAL HEALTH

Behavioral Health

How to determine if a Behavioral Health Service Requires Prior Authorization

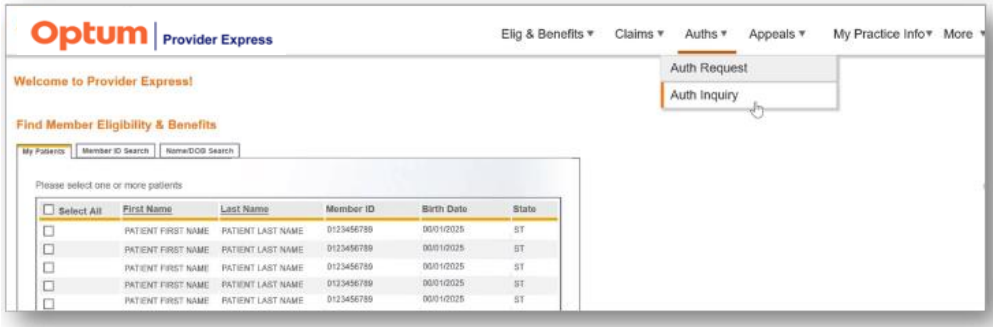
- Most outpatient Behavioral Health services do NOT require an authorization
- Call the number on the back of the member's card to determine if authorization is required
- Or check online at: [Provider Express - Indiana Medicaid]

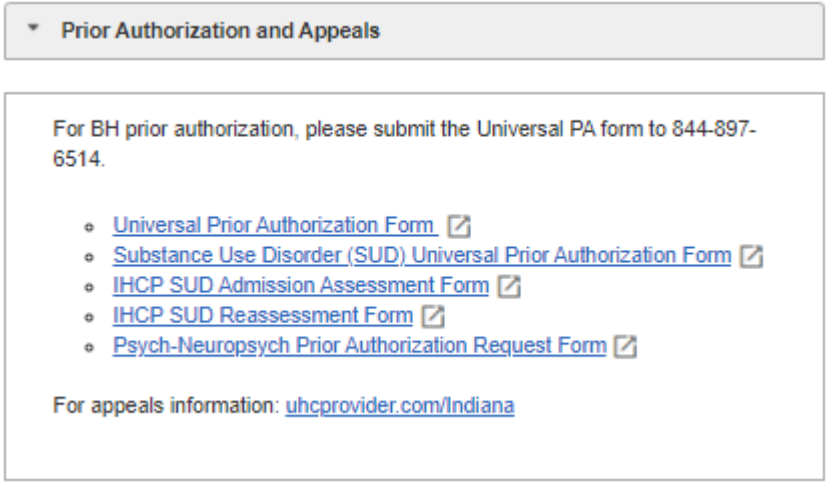


Behavioral Health

How to request Behavioral Health Prior Authorization

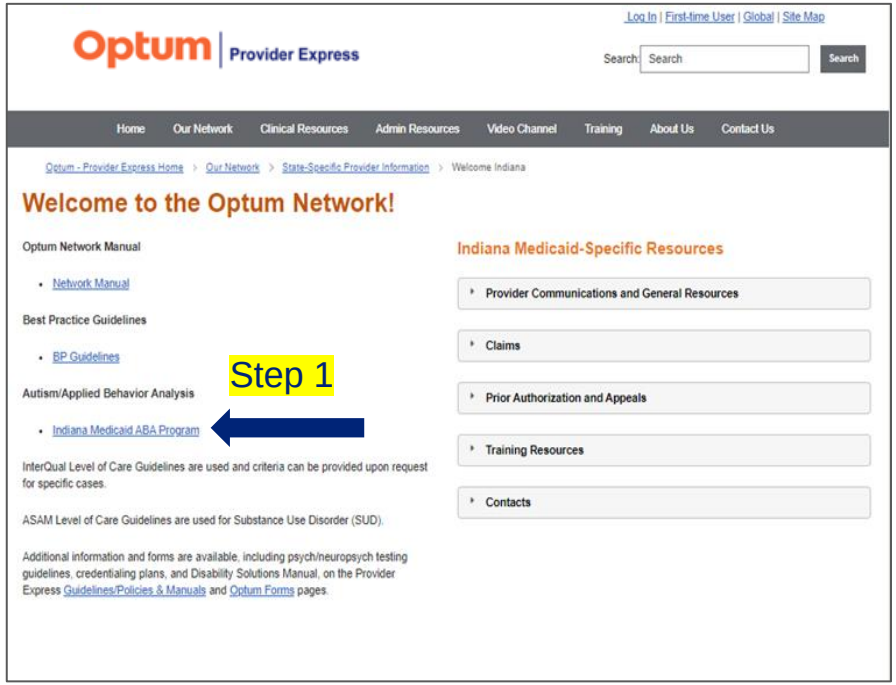
- Initiate phone authorization process by calling 877-610-9785 or the number on the back of the member's ID card.
- Securely login to Provider Express and select "Auth Request" from the "Auths" dropdown box
- To check on status, select "Auth Inquiry"
- Utilize the paper Universal Prior Authorization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

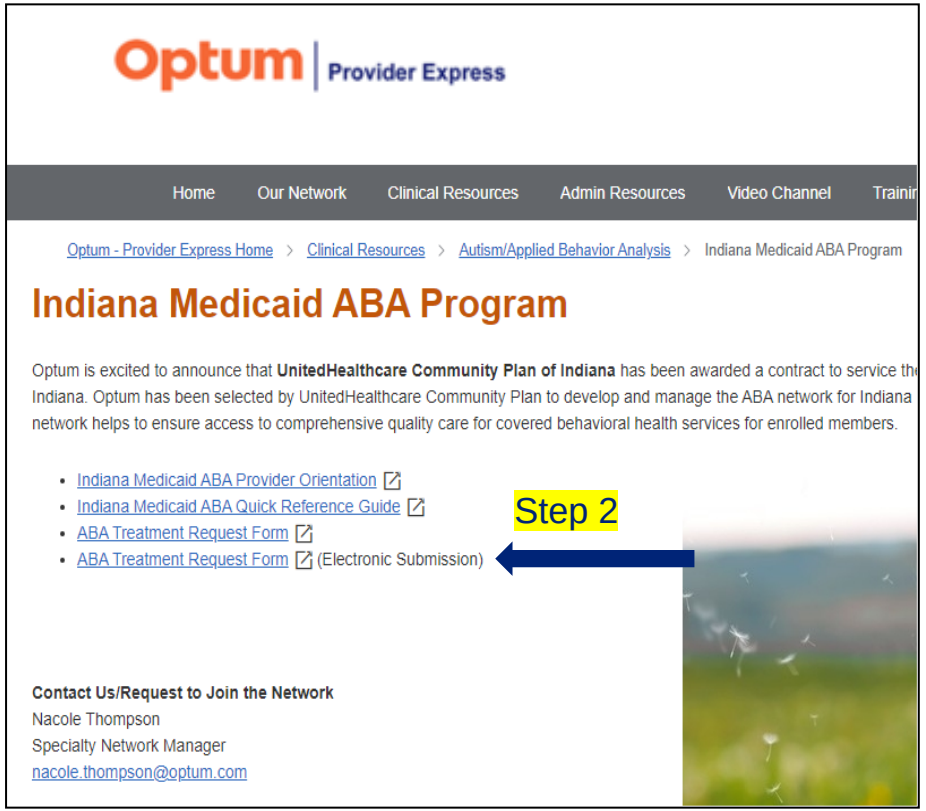




Behavioral Health

How to request Prior Authorization for ABA Therapy Services





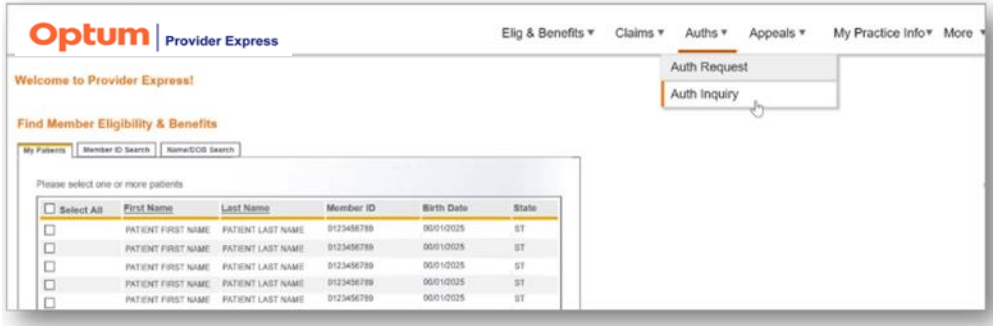
[Provider Express - Indiana Medicaid]

Behavioral Health

When to escalate to a Provider Advocate

If provider submits a Prior Authorization request and does 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 Optum Behavioral Health Advocate

Behavioral Health

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 the 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 to 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 to request Prior Authorization

- Dental providers can submit Prior Authorization requests online at www.uhcdentalproviders.com
- They can also submit Prior Authorization requests via mail at the following address:

  UnitedHealthcare Dental
  Attn: Prior Authorization
  P.O. Box 1313
  Milwaukee, WI 53201

- Please include with the 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 48 hours of receipt of the request.

We will make a determination and provide written notification on *standard authorizations* within 5 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 benefit 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 to request a March Vision Care 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 benefits & eligibility are verified
- 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 to request a March Vision Care 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

Medical

Behavioral Health

Dental

Vision

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 calendar 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 the 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

Type of Request	Decision TAT	Practitioner Notification of Approval	Written Practitioner/Member Notification of Denial
Non-urgent Pre-service	Within 7 business 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 48 hours of request receipt	Within 48 hours of the request	Within 48 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

Medical Network Provider Advocate Team

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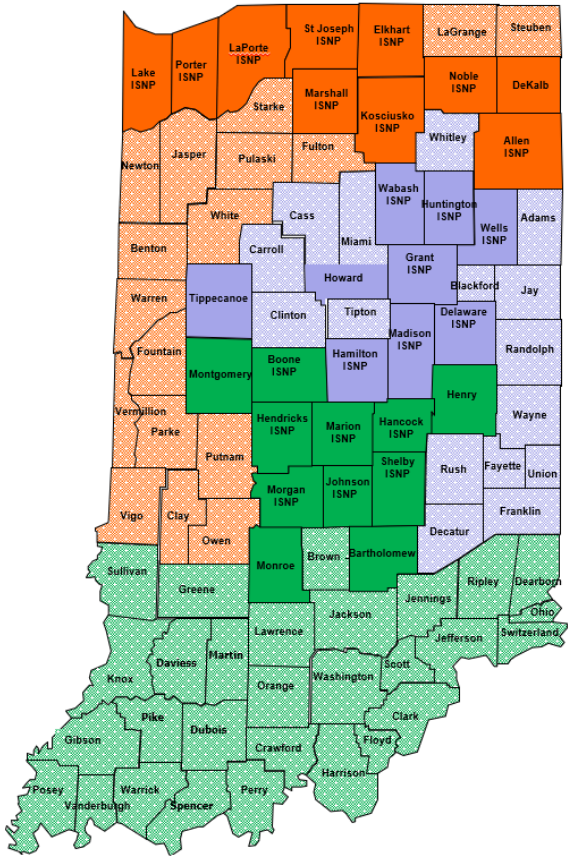

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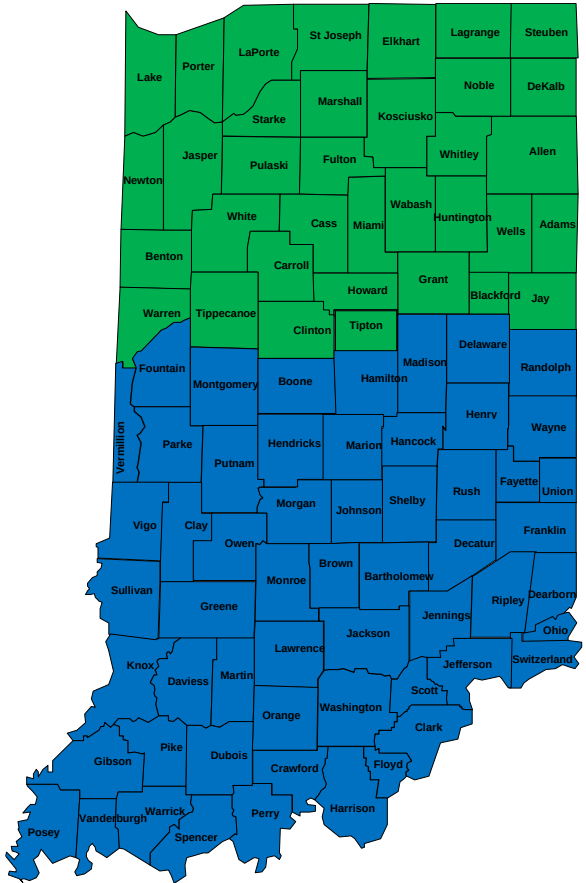

Dental Advocate

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March Vision Advocate

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(Vicky 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: Provider Express - Indiana Medicaid

Questions and Answers

Thanks for Attending Today's Session