UnitedHealthcare Community Plan

2024 IHCP Works Annual Seminar

Prior Authorization

Presented by Stacey Keyes Provider Relations Advocate

PCA-04-24-01026-UHN-PRES_05282024

United Healthcare

Agenda

1. Admission Notification
2. Introduction to Prior Authorization
3. How to submit advance/admission notification
4. How to obtain a prior authorization for:
   - **Medical**
   - **Behavioral Health**
   - **Dental**
   - **Vision**
5. How to dispute a prior authorization denial
6. How to appeal a denial decision
7. General appeal information for all service lines

Our Service Lines

- UnitedHealthcare

- Optum® Behavioral Health

- March® Vision Care

- UnitedHealthcare Dental

Admission Notification

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

Notify UnitedHealthcare of an Admission:

- Electronic Data Interchange (EDI) 278N Transaction (easiest and most preferred method)
- Online via the Prior Authorization and Admission Notification (PAAN) tool: www.uhcprovider.com/#/paan
- Via phone at 877-842-3210 8a.m.-8 p.m. ET Monday– Friday
- Via Fax at 844-897-6514: Prior-Authorization-Request-Form.pdf(uhcprovider.com)

Note: Non-member specific information is available without logging in, this includes Crosswalks, Administration Guides, Peer to Peer Request, Etc.
Member specific is available after log into UHCprovider.com

Admission Notification – EDI 278N Transaction

- Use the Hospital Admission Notification (278N) transaction to exchange admission notification data between an inpatient facility and UHC 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 used

Medical	Behavioral health	Dental	Vision

Prior Authorization Requirements for Indiana Hoosier Care Connect & Indiana Pathways for Aging

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

Medical: Check Prior Authorization Requirements

Providers can check prior authorization requirements at:

[UnitedHealthcare Community Plan of Indiana Homepage]

Medical: Check Prior Authorization Requirements (cont.)

[Prior authorization requirements for Indiana MLTSS Pathways Effective August 1, 2024]

Prior Authorization and Notification | UnitedHealthcare Community Plan of Indiana

Last update: July 19, 2024

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

To submit and manage your prior authorizations, please sign in to the UnitedHealthcare Provider Portal. Additional information on prior authorizations is available on **uhcprovider.com/priorauth**.

Sign in

Current Prior Authorization Plan Requirements

- **UnitedHealthcare Community Plan Prior Authorization Indiana Hoosier Care Connect - Effective Aug. 1, 2024**
- **UnitedHealthcare Community Plan Prior Authorization Indiana MLTSS Pathways - Effective Aug. 1, 2024**

Medical: Check Prior Authorization Requirements (cont.)

[Prior authorization requirements for Indiana MLTSS Pathways Effective August 1, 2024]

Note: Use Ctrl-F to search for a specific CPT or HCPCS

Prior authorization requirements for Indiana MLTSS Pathways

Effective August 1, 2024

General information

This list contains prior authorization requirements for participating UnitedHealthcare Community Plan of Indiana health care professionals providing inpatient and outpatient services. Please submit your request in 1 of the following ways:

- **Online:** Use the Prior Authorization and Notification tool on the UnitedHealthcare Provider Portal. To get started, go to **UHCprovider.com** and click Sign In in the top-right corner to log in using your One Healthcare ID and password. Then, select the Prior Authorization and Notification tab on your dashboard. If you don't have a One Healthcare ID, visit **UHCprovider.com/access**.
- **Phone:** Call **877-610-9785**

Prior authorization is not required for emergency or urgent care. However, out-of-network physicians, facilities and other health care professionals must request prior authorization for all procedures and services.

Note: You are required to request approval before rendering services. The UnitedHealthcare Health Services department requires prior authorization as an essential part of any managed care organization. Advance notification is required to provide UnitedHealthcare timely communication of services so we can do a prospective, concurrent and retrospective care review.

Procedures and services	Additional information	CPT® or HCPCS codes and how to obtain prior authorization			
Bariatric	Prior authorization is required.	43644	43645	43659	43770
	There is a Center of Excellence requirement for coverage of bariatric surgery and services.	43771	43772	43773	43774
		43775	43842	43843	43845
	In certain situations, bariatric	43846	43847	43848	44799

Medical: Check Prior Authorization Requirements (cont.)

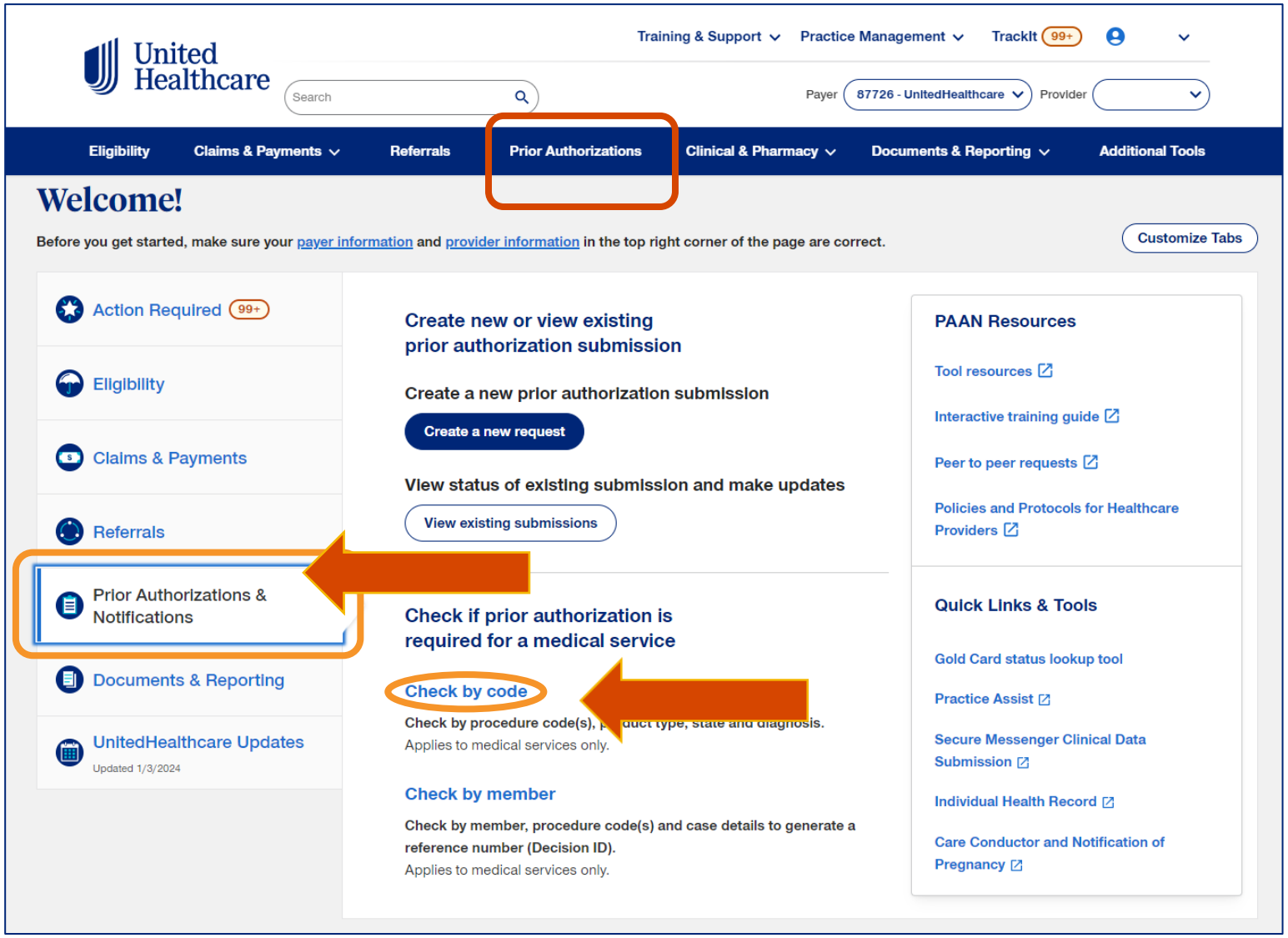
Use the Prior Authorization and Notification tool via our UnitedHealthcare Provider Portal to:

Prior Authorization Tool

- 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

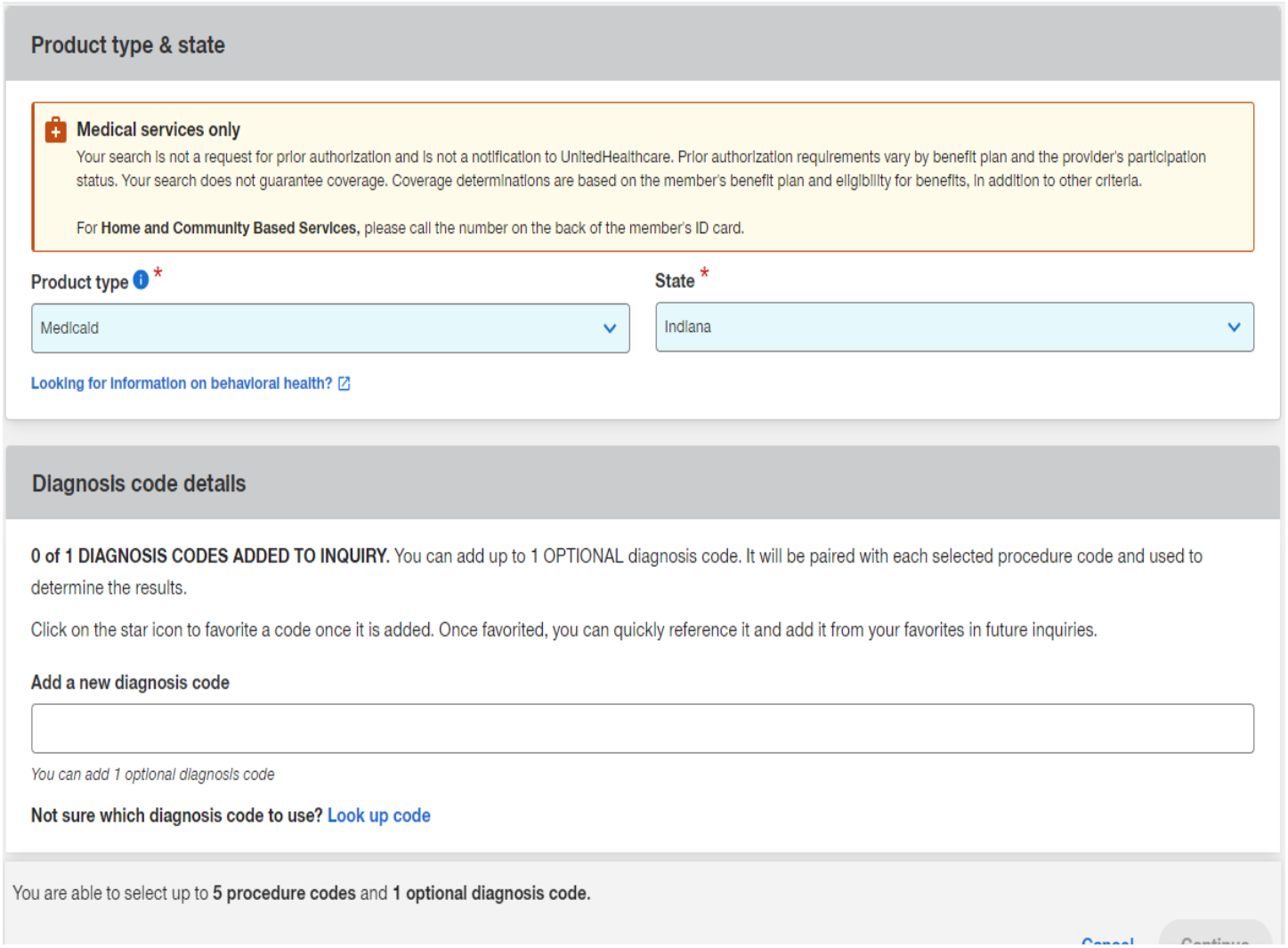
Medical: Check Prior Authorization Requirements (cont.)

1. Sign in to the UnitedHealthcare Provider Portal, from UHCprovider.com
2. Select the “Prior Authorizations and Notifications” tab
3. Select “Check by code”



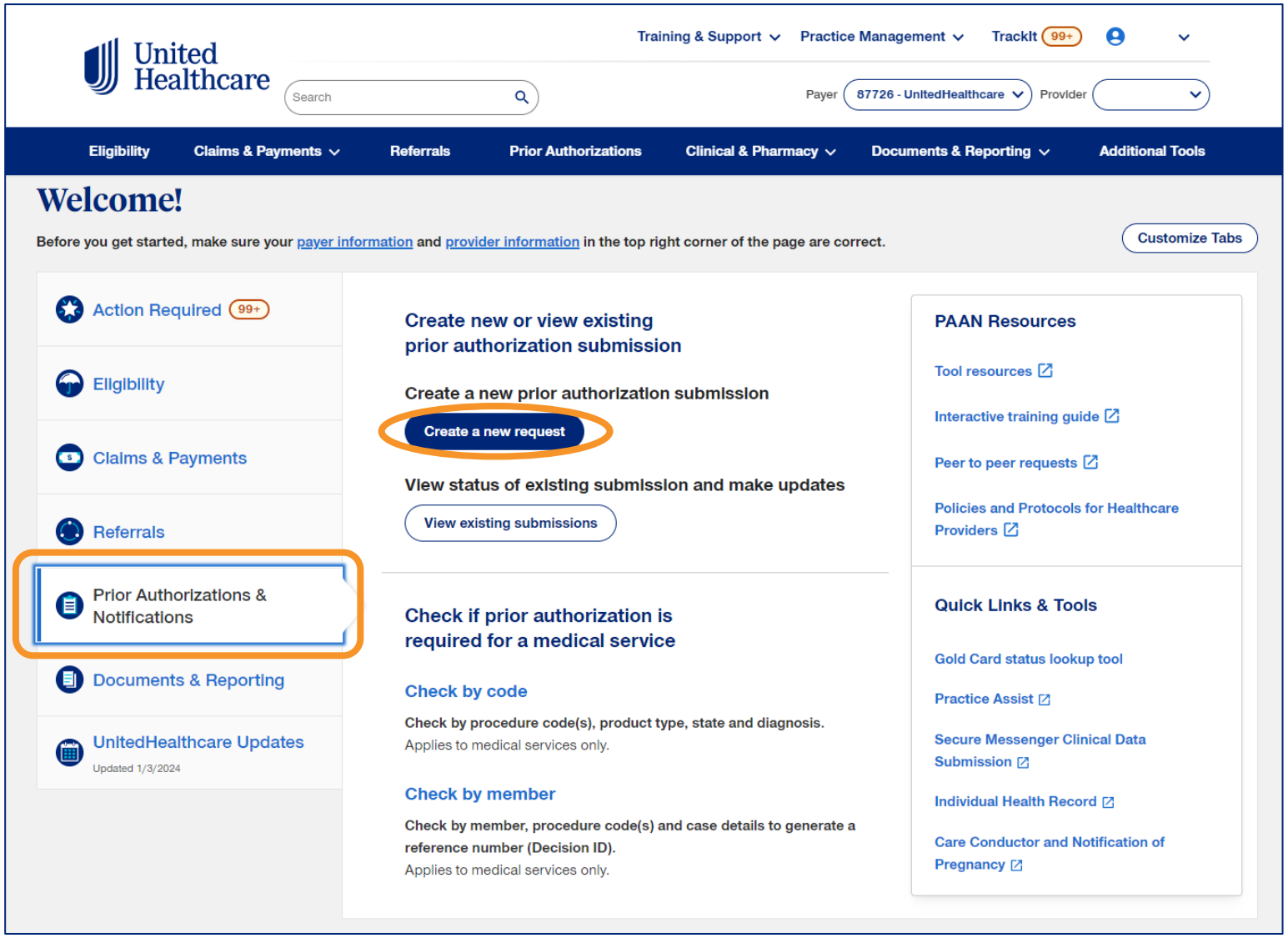
Medical: Check Prior Authorization Requirements (cont.)

1. Select the product type and state
2. Enter the diagnosis code (optional)
3. Enter the procedure code(s)



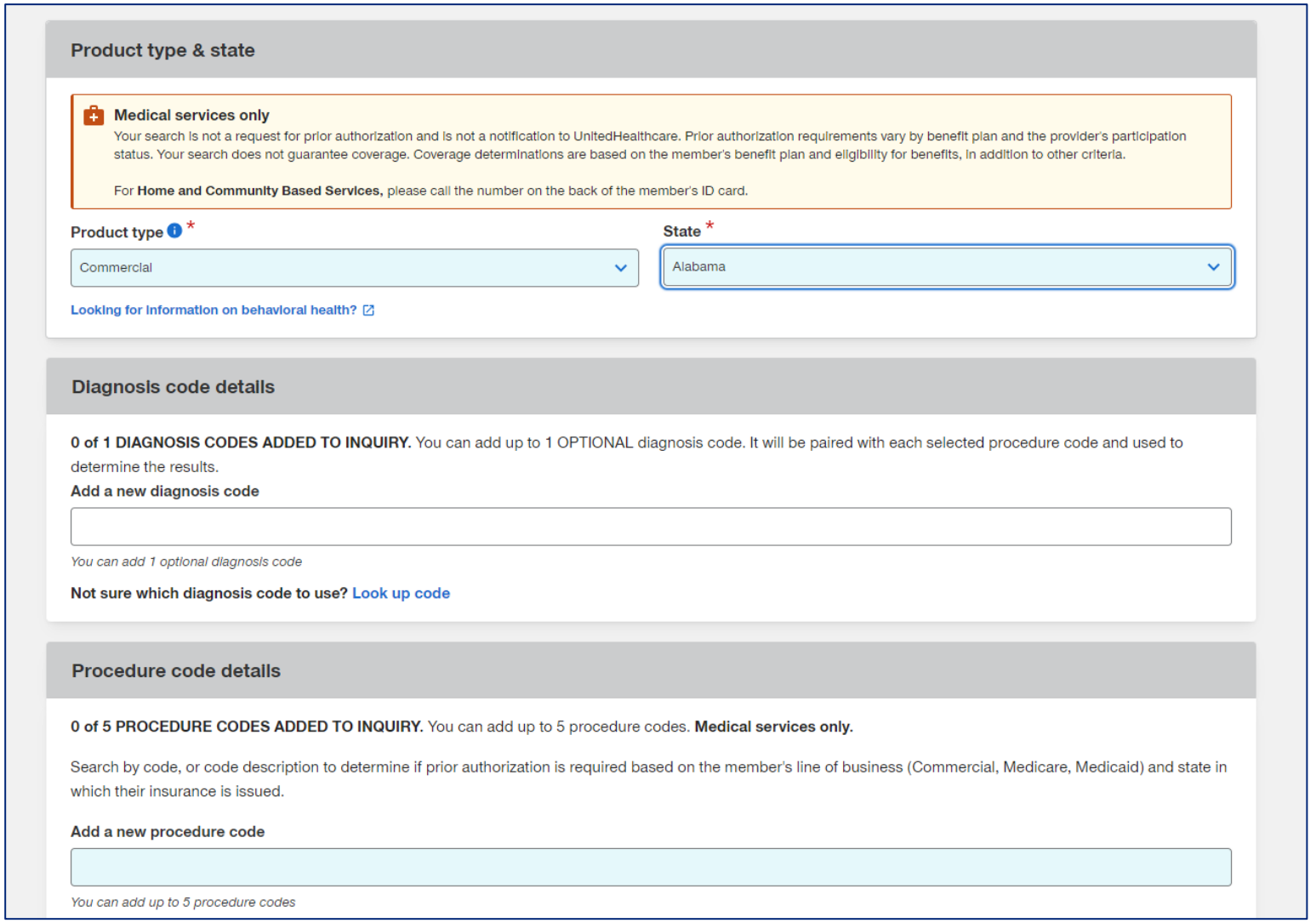
Medical: Create New Prior Authorization

1. Sign in to the UnitedHealthcare Provider Portal, from UHCprovider.com
2. Select the “Prior Authorizations and Notifications” tab
3. Select “Create a new request”



Medical: Creating a New Prior Authorization

1. Select the product type and state
2. Enter the diagnosis code (optional)
3. Enter the procedure code(s)



Medical: Radiology/Cardiology Prior Authorization Requirements

- Use the lists available online (at the links below) to determine if a radiology or cardiology service requires prior authorization.
- Prior authorization requirements for Indiana Hoosier Care Connect Effective Aug. 1, 2024 - UnitedHealthcare Community Plan of Indiana (uhcprovider.com)
- Prior authorization requirements for Indiana PathWays for Aging Effective August 1, 2024 (uhcprovider.com)
- 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 asterisk symbol (*) to help you find the results you are looking for. Typing 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
- 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.

- Solution: Submit your prior authorization request online, via the PAAN tool Prior Authorization Tool, as soon as the service/procedure is scheduled.

- For example, if a surgery is scheduled 2 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

- Solution: Following the suggestions below will result in less adverse determinations, more timely decision turnaround 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 a provider's Prior Authorization request is denied, they may request a peer-to-peer review by calling 1-800-955-7615 from 9 a.m.–6 p.m. ET, Monday–Friday

- If provider disagrees with the peer-to-peer decision, they may file an appeal. Once an appeal is filed a provider cannot go back and request a peer-to-peer review. Please note that even if a peer-to-peer review is not completed, "a" 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 by going to (UnitedHealthcare Community Plan of Indiana Homepage "Contact Us" and reviewing Medical Provider Advocates by Counties Served (For Medical Providers) 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 review

Medical: Prior Authorization Decision Turnaround Times

UnitedHealthcare Community Plan of Indiana Care Provider Manual - PathWays for Aging Provider Manual (uhcprovider.com)

Type of request	Decision Turnaround Times	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 2 business days
Retrospective review	Within 30 calendar days of receiving all pertinent clinical information	Within 30 calendar days of determination	Within 30 calendar days of determination

Medical: Clinical Policies – Example

Over the next few slides we are going to review clinical policies and will be using Bariatric Surgery as the example, clinical policies will apply to all medical services.

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 Other Clinical Policies Cont.

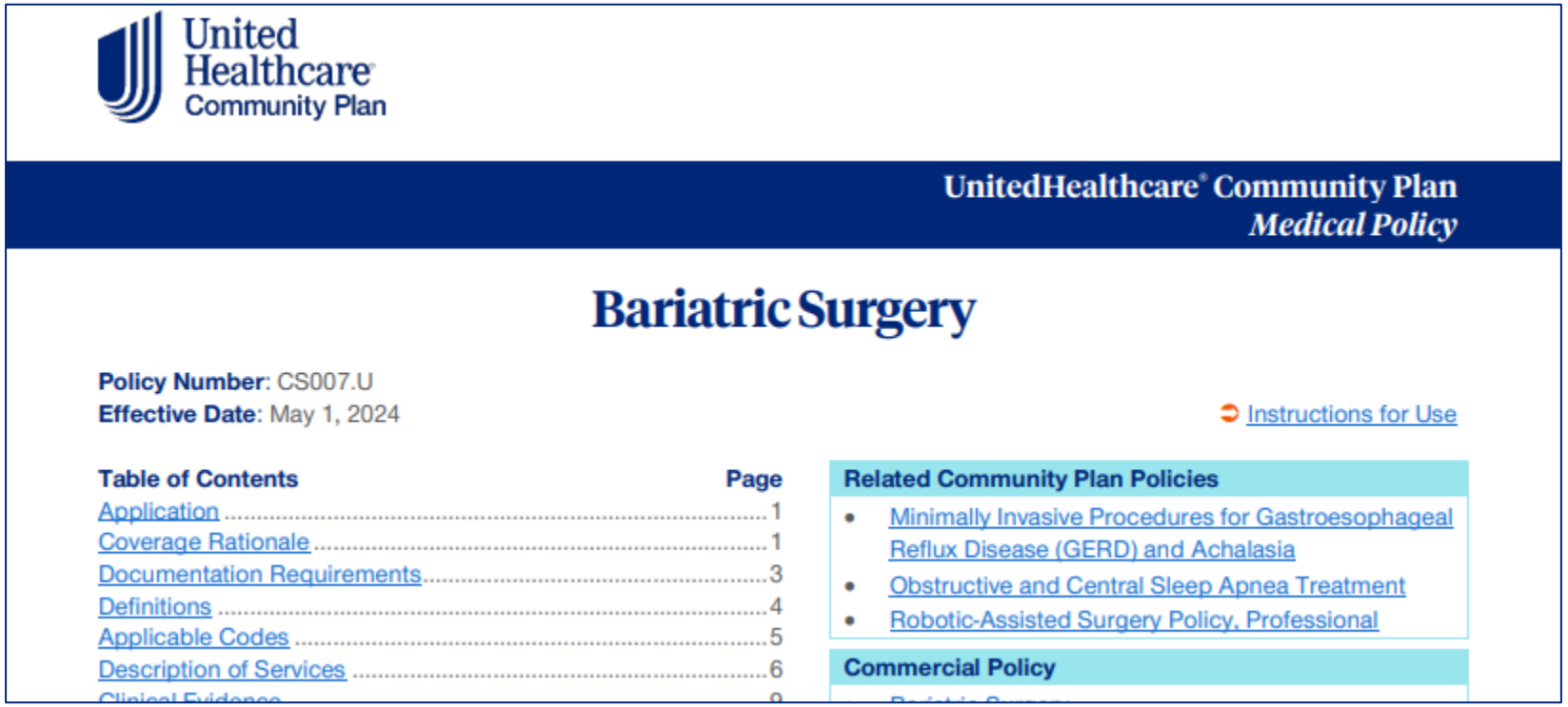
Bariatric surgery

- UHC follows in this order:
  - State and federal medical policy regulations
  - UnitedHealthcare medical policy
  - InterQual medical policy

Medical: Clinical Policies

UHC Medicaid Bariatric Surgery Medical Policy

https://www.uhcprovider.com/content/dam/provider/docs/public/policies/medicaid-comm-plan/bariatric-surgery-cs.pdf



United Healthcare Community Plan

UnitedHealthcare® Community Plan
Medical Policy

Bariatric Surgery

Policy Number: CS007.U
Effective Date: May 1, 2024

Instructions for Use

Table of Contents	Page
Application	1
Coverage Rationale	1
Documentation Requirements	3
Definitions	4
Applicable Codes	5
Description of Services	6
Clinical Evidence	9

Related Community Plan Policies

- Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) and Achalasia
- Obstructive and Central Sleep Apnea Treatment
- Robotic-Assisted Surgery Policy, Professional

Commercial Policy

Medical: Process to Dispute a Prior Authorization Decision and 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 review
- Provider will receive a letter of adverse determination; it will detail steps needed to request a peer-to-peer review 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 IROs to conduct the external review
- A decision by the IRO is made within 72 hours if expedited, or within 15 business days for standard appeals
- The decision by the IRO is binding and not disputable by UnitedHealthcare

Medical: State Fair Hearings

- The Indiana 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 review within 10 calendar days of the administrative law judge's decision

Medical: Retroactive Authorizations and Medical Claim Review

- Retroactive authorization:
  - Retroactive authorizations will be issued when the “No authorization” denial was due to eligibility issues

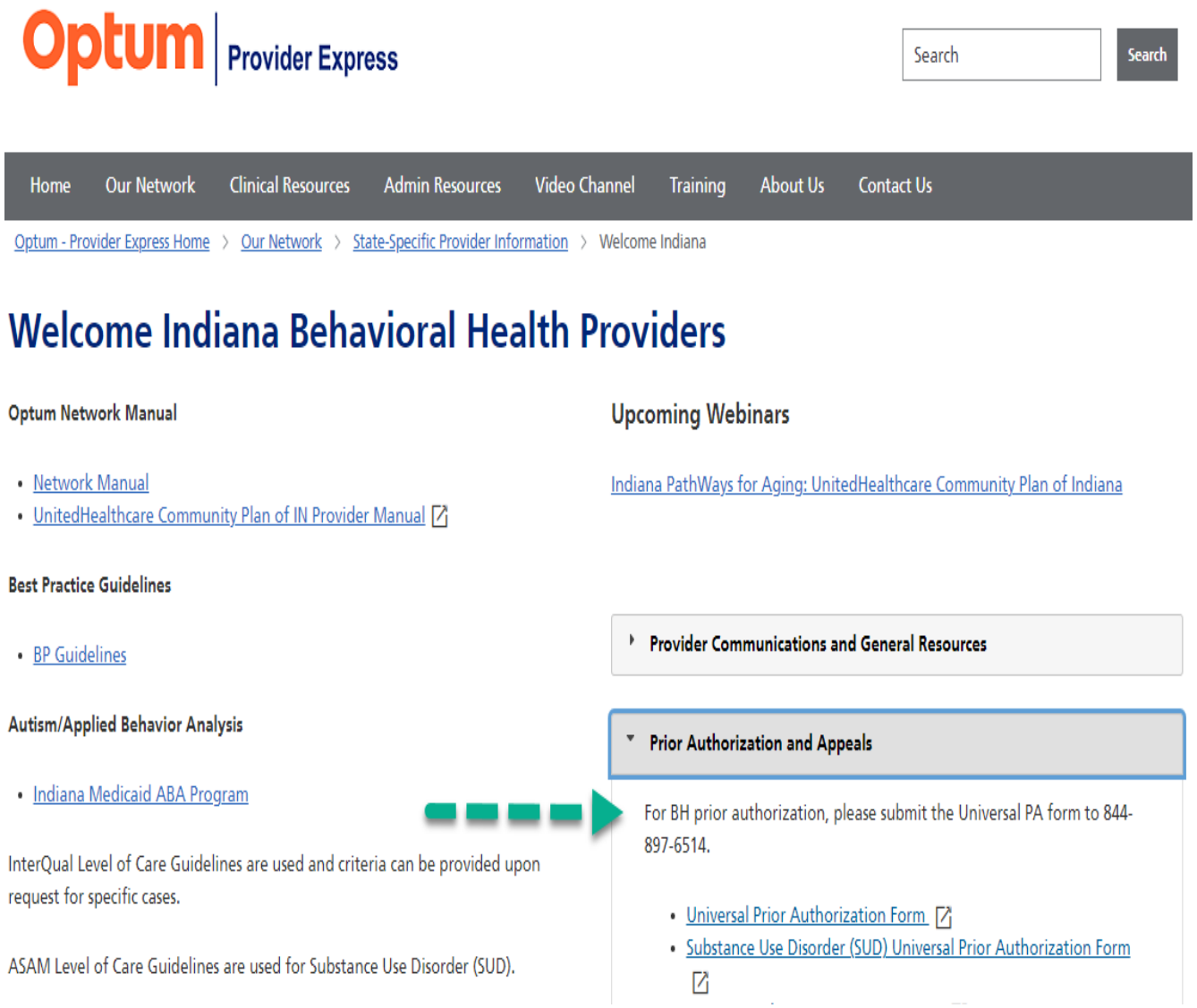
- Medical claim review (MCR) performs medical necessity reviews on denied claims when a prior authorization/admission notification was not obtained or if inpatient level of care was denied during the member’s inpatient stay
  - Example: Provider obtains authorization for a particular code, then upon 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

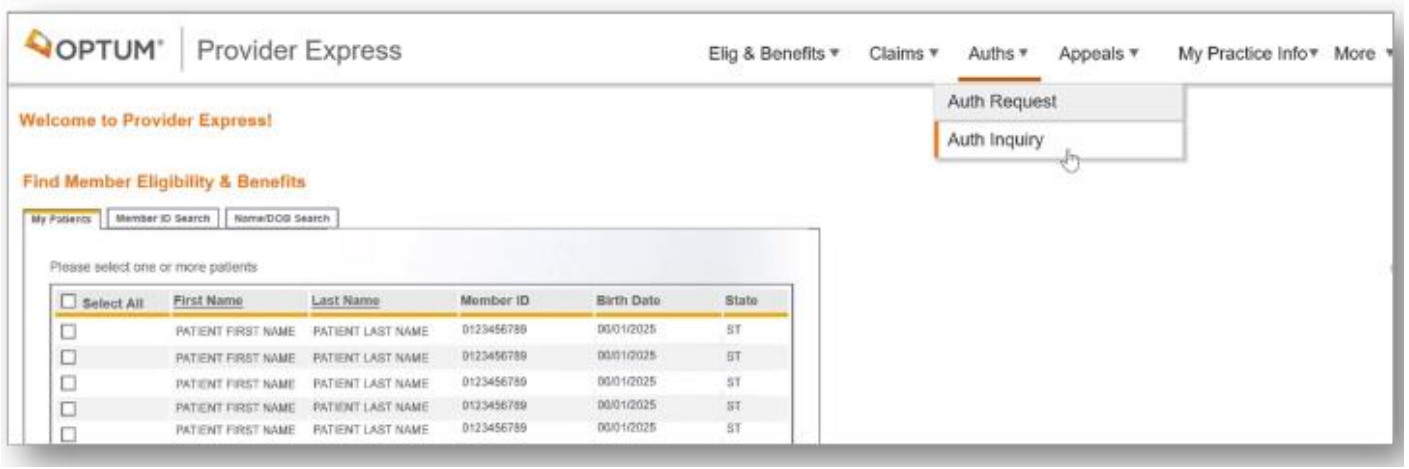
Behavioral Health: Determine Prior Authorization Requirements

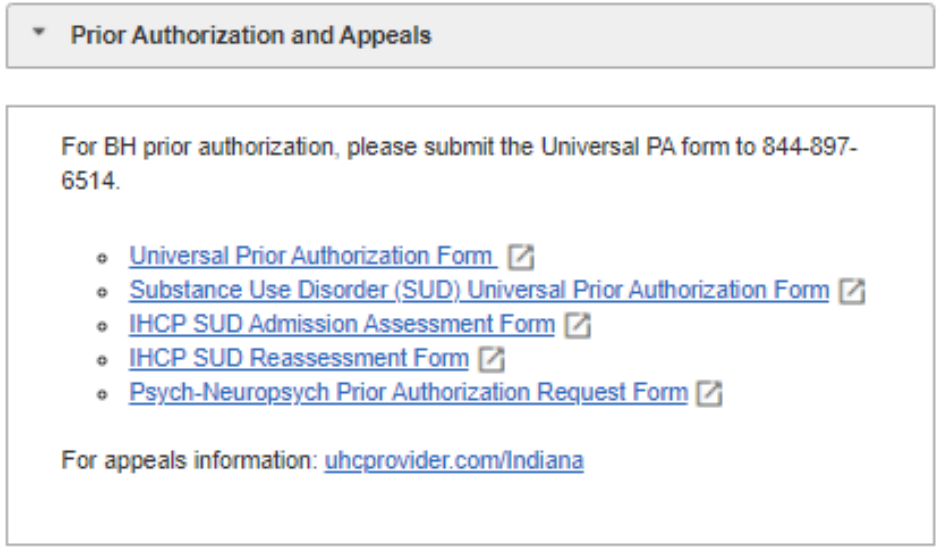
- Most outpatient behavioral health services do NOT require a prior authorization
- Call the number on the back of the member's card to determine if a prior authorization is required
- Or check online at: Provider Express - Indiana Medicaid



Behavioral Health: Request Prior Authorization

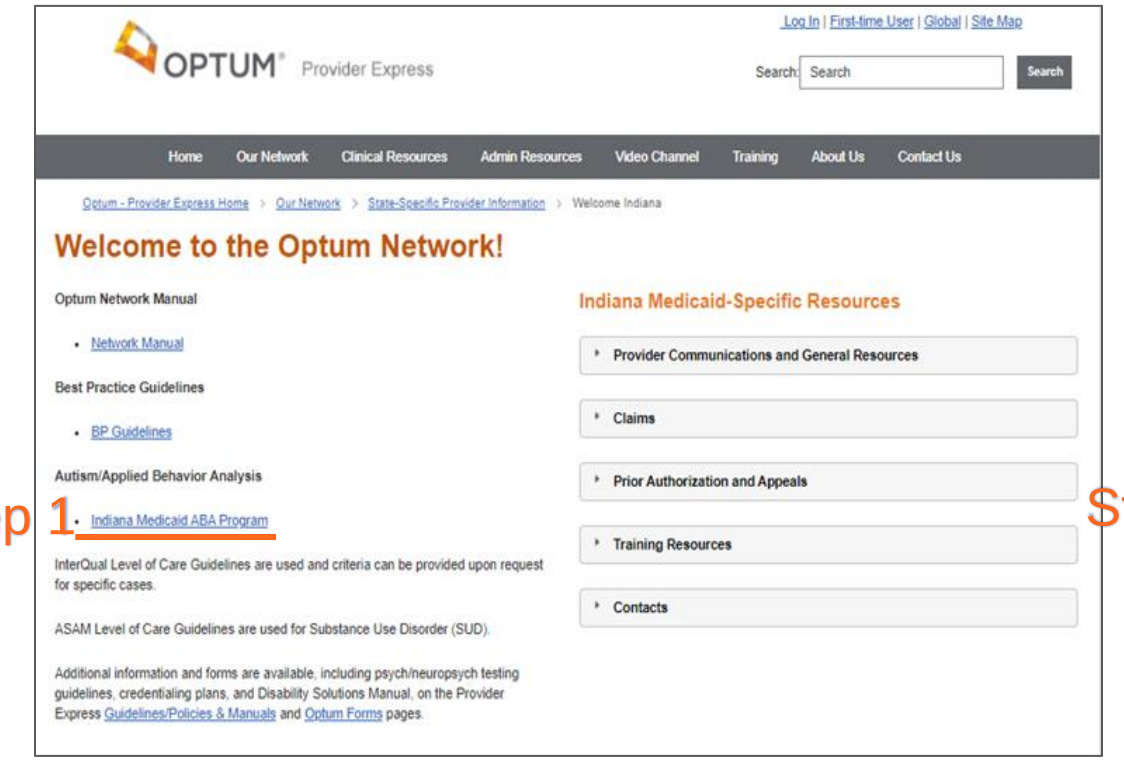
- Initiate phone authorization process by calling 877-610-9785 or the number on the back of the member's ID card
- Securely log-in to Provider Express and select "Auth Request" from the "Auths" dropdown box
- To check on status, select "Auth Inquiry"
- Use the paper Universal Prior Authorization Form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





Behavioral Health: Request Prior Authorization for ABA Therapy Services

Provider Express – Indiana Medicaid



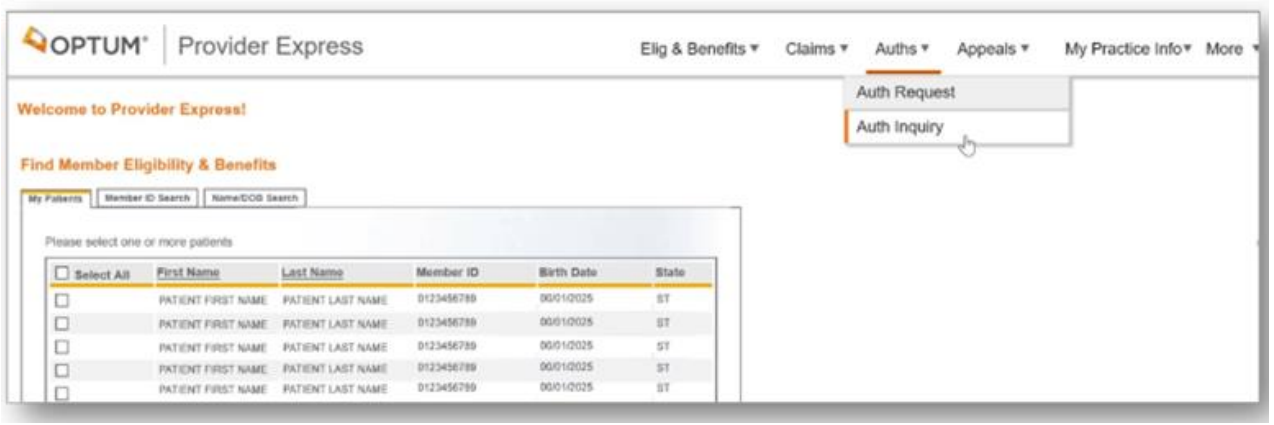
Step 1

Step 2

Behavioral Health: Escalate to a Provider Advocate

If provider submits a prior authorization request and does not receive a response within the required turnaround 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: Appeal an Authorization Decision

In the event a prior 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
- PAR
- Denial letter
- Any additional supporting documentation

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: 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),
- Moderate/deep sedation anesthesia

Dental: Determine Dental Service Prior Authorization Requirements

- For a complete listing of procedures requiring prior authorization, refer Dental Provider Manual - UnitedHealthcare Community Plan of Indiana Hoosier Care Connect (uhcprovider.com)at 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 **Provider Services** at **844-402-9118**
  Hours: 8 a.m. to 8 p.m. (EST) Monday-Friday

Dental: Request Prior Authorization

- Dental providers can submit prior authorization requests online at SKYGEN DENTAL HUB an account is required. Dental providers 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: Prior Authorization Timelines

The following authorization timelines will apply to requests for prior authorization:

UHC will make a determination and provide written notification on *expedited authorizations* within 48 hours of receipt of the request.

UHC 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 calendar 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 eyeSynergy.com provider portal an account is required
- For medically necessary contact lenses and fittings, providers need to submit a pricing request form: Medically-Necessary-Form-Editable.pdf (marchvisioncare.com)

Vision: Request a March Vision Care Prior Authorization

- Obtain confirmation by logging in to eyeSynergy.com and searching for the member, verify eligibility and benefits, and generate a confirmation number
- Confirmation number is an 11-digit identification number generated when benefits and 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
  - 2 pairs of glasses in lieu of bifocals
  - Prescription sunglasses

Vision: Request a March Vision Care Prior Authorization (cont.)

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 appeal 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 Appeal Process: Outcome

- 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

Options if the Authorization is Denied

Utilization management (UM) appeals process

1. Peer-to-peer within 14 calendar days
   Call 800-955-7615

2. Next level appeal

3. Fair hearing

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 2 business days
Retrospective review	Within 30 calendar days of receiving all pertinent clinical information	Within 30 calendar days of determination	Within 30 calendar days of determination

Medical Network Provider Advocate Team

Nneka Nelson
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nneka_m_nelson@uhc.com

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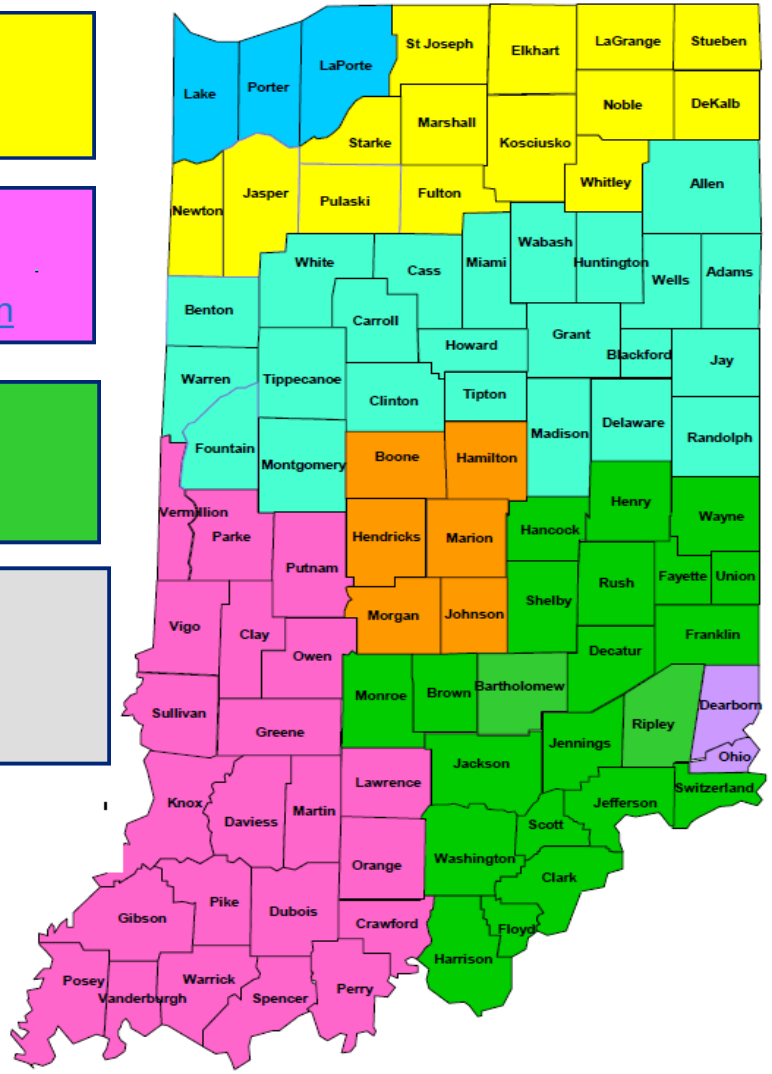
All FQHC/RHCs



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Your Dental Advocate Team

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Your March Vision Advocate

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Appendix

Provider Service Line Website Links

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

Thank you

Questions?

United Healthcare