



UnitedHealthcare Community & State

Hoosier Care Connect Health Plan

Prior Authorization 201

Presented by Lynette Gatewood, Provider Engagement Manager - SNF

United
Healthcare®

Our Service Lines

❖ UnitedHealthcare



❖ Optum Behavioral Health



❖ March Vision



❖ UnitedHealthcare Dental



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!*



- Be thorough and complete with 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 clinical modification (CM).
- Anticipated date(s) of service.
- Type of service (primary and secondary) procedure code(s) and volume of service, when applicable.
- Service setting.
- Facility name and TIN/NPI, when applicable.





Prior Authorization and Notification

- 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.
- The Provider/Facility might be listed differently in our system. Use the wildcard symbol (*) to help you find the results you're looking for. (Hint: Typing in less with a wildcard will help find the results you're looking for).
- UnitedHealthcare Community Plan uses InterQual for medical care determinations.

- Peer-to-peer reviews can be requested 7 calendar days from verbal notification.
- If your request is denied you may request a Peer to Peer by calling **800-955-7615**.
- When someone gets admitted to hospital if Level of Care is Denied.
 - Rather than continuing to dispute with Prior Auth team, file the claim then dispute the claim.



- Letter will have all necessary information about the member and reason/details with the Notice of Adverse Benefit Determination.

Notice of Adverse Benefit Determination

Dear *Insert if applicable* [Parents or Guardian of:] [MEM_FIRST_NAME],

Your doctor has asked UnitedHealthcare Community Plan to approve [Requested Service] on [Date of Request]. After we reviewed the information that your doctor sent about your need for [Requested Service] on [Date of Service], we have [denied] [partially denied] that request.

For full and partial decisions insert this sentence; remove if not applicable.

The request cannot be approved.



- Letter will have all necessary information about the member and reason/details with the Notice of Adverse Benefit Determination.

We have included a list of your appeal rights with this letter.

Before you file an appeal, your doctor can ask for a “peer-to-peer” call with a physician or other appropriate reviewer. This call will help your doctor better understand our decision. You and your doctor can still file an appeal after a “peer-to-peer” call. To set up a “peer-to-peer” call, ask your doctor to call *Insert for National “peer-to-peer”*: [1-800-955-7615] *OR Insert for Healthy First Steps “peer-to-peer”*: [1-800-599-5985] within 7 calendar days of the date of your denial.

Your doctor will get a copy of this letter. You can talk to your doctor about other medical choices. You or your doctor can ask to see:

- Any medical records and any other documents we used to make our decision.
- A copy of the benefit provision, guideline, or policy we used to make the decision.

You or your doctor can call UnitedHealthcare Community Plan Member Services Helpline at **1-800-832-4643**, TTY **711**, to ask for these free of charge.



- Letter is sent to Provider only

*****FOR COB DENIALS***** UnitedHealthcare® Community Plan determined that the member listed above has primary coverage through [\[Insert Name Of Primary Insurance Company\]](#). UnitedHealthcare Community Plan is always the last payor if there is other insurance. UnitedHealthcare Community Plan coverage is the “payor of last resort” when a primary insurer is present. A member may have primary medical coverage through another carrier. The member should present the other insurance card and their UnitedHealthcare Community Plan card at the time of service.

***** FOR TIMELY NOTICE DENIAL ***** UnitedHealthcare® Community Plan requires timely notification following an emergency admission. Our records indicate that your facility did not notify UnitedHealthcare Community Plan of this admission within the required timeframe per your provider agreement. Accordingly, this admission is denied for lack of timely notification.

***** ELIGIBILITY ***** UnitedHealthcare® Community Plan has been notified that member’s eligibility with the plan has terminated as of [\[insert term date\]](#). The member is no longer covered by UnitedHealthcare Community [Plan](#), therefore services are not covered by UnitedHealthcare Community Plan after that date of service.

***** NO PRIOR AUTH ***** UnitedHealthcare® Community Plan requires that [\[insert service type\]](#) services must obtain prior authorization by the health plan before being rendered. Our records indicate that your facility did not request prior authorization from UnitedHealthcare Community Plan. Accordingly, this admission is denied for not obtaining prior authorization.

If you disagree with this decision or have [questions](#) please refer to the UnitedHealthcare Community Plan’s care provider manual on the <https://www.uhcprovider.com> website.



- Retroactive Authorization request:
 - Authorization will be issued when due to eligibility issues.
- Medical Claim Review
 - Example: Provider obtains authorization for a particular code then upon entering the surgical site the provider must perform an additional or different service than originally approved.
 - The claim would be filed then reviewed by Medical Claim Review team after an appeal is filed.



- Submission of needed clinical information with authorization
 - UHC often doesn't receive complete clinical information with an authorization to make a medical necessity determination.
 - Submitting prior authorization via [UHCprovider.com](https://www.uhcprovider.com) provider portal will decrease the denial rate.
 - Decreases the number of requests for additional information.
 - Complete online request in its entirety leaving no fields blank
 - More timely and quicker decision.



- Submit timely routine prior authorization so determination is received in advance of service.
 - Problem: UHC does not receive routine prior authorization requests for services scheduled well in advance of the service date.
 - Identify what services or items requires prior authorization.
 - Submitting prior authorization with the Prior Authorization and Notification tool or fax are quicker.
 - Increases timely decision.
 - Submit authorization request for services or procedures as soon as they are scheduled.
 - For example, if a surgery is scheduled two months in advance, go ahead and submit request for authorization to ensure determination is timely.



UnitedHealthcare
Resources for physicians, administrators and healthcare professionals

What can we help you find?

Members [Find Dr.](#) [New User & User Access](#) [Sign In](#)

Welcome to the Home for Care Provider Resources

For UnitedHealthcare Community Plan of Indiana

UnitedHealthcare Community Plan of Indiana Homepage

- [Bulletins and Newsletters](#)
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- [Eligibility and Benefits](#)
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- [Policies and Clinical Guidelines](#)
- [Prior Authorization and Notification](#)
- [Provider Forms and References | UnitedHealthcare Community Plan of Indiana](#)

UnitedHealthcare Community Plan of Indiana Homepage

We know you don't have time to spare, so we put all the UnitedHealthcare Community Plan resources you need in one place. Use the navigation on the left to quickly find what you're looking for. Be sure to check back frequently for updates.

Prior Authorization and Notification Resources

[Learn More](#)

Current Policies and Clinical Guidelines

[Learn More](#)

Provider Administrative Manual and Guides

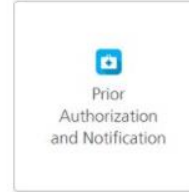
[Learn More](#)



Prior Authorization and Notification | UnitedHealthcare Community Plan of Indiana

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 on Link.



[Go to Prior Authorization and Notification Tool](#)

Current Prior Authorization Plan Requirements

- [UnitedHealthcare Community Plan Prior Authorization Indiana Hoosier Care Connect - Effective September 1, 2021](#) 

Prior Authorization Fax Forms 

Previous Prior Authorization Plan Requirements 

UnitedHealthcare Community Plan of Indiana

- [UnitedHealthcare Community Plan Prior Authorization Indiana Hoosier Care Connect - Effective June 1, 2021](#) 



- Review UnitedHealthcare clinical policies at UHCprovider.com/INcommunityplan

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[Learn More](#)

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[Learn More](#)

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- Example: 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 04.01.2021

Effective Date: 04.01.2021 – This policy addresses bariatric surgical procedures, including gastric bypass, gastric banding, sleeve gastrectomy, biliopancreatic bypass, and biliopancreatic diversion with duodenal switch.



- Indiana Medicaid Bariatric Surgery Medical Policy

<https://www.in.gov/medicaid/providers/files/surgical-services.pdf>.

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.



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

UnitedHealthcare
Community Plan

UnitedHealthcare® Community Plan
Medical Policy

Bariatric Surgery (for Indiana Only)

Policy Number: CS007IN.01
Effective Date: April 1, 2021

[Instructions for Use](#)

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Related Policies

- [Minimally Invasive Procedures for Gastroesophageal Reflux Disease \(GERD\) and Achalasia](#)
- [Obstructive Sleep Apnea Treatment](#)



Provider Reference Appendix



Provider Service Line Website Links

- United Health Community Plan (Medical): UHCprovider.com/INcommunityplan
- UHC Dental: uhcdentalproviders.com
- March Vision: marchvisioncare.com
- Optum Behavioral Health: [Provider Express – IN Medicaid](#)





Meet Your Advocate Teams

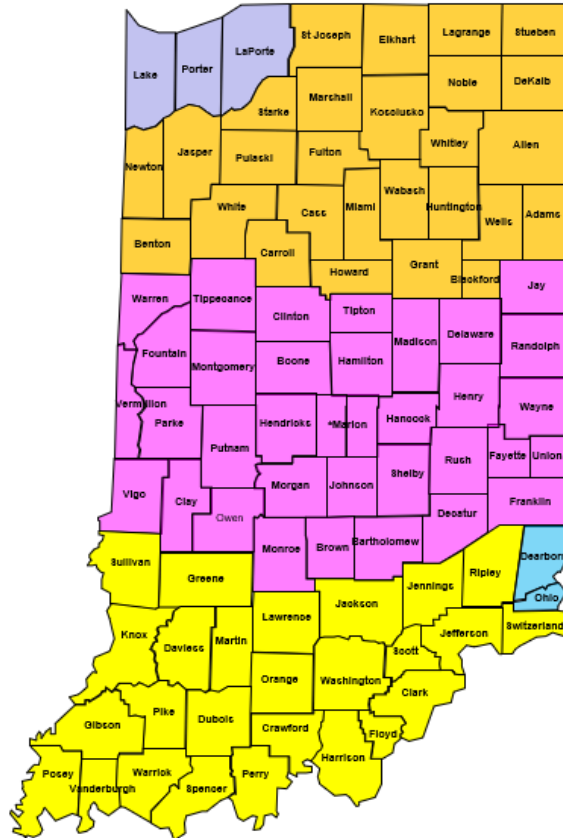
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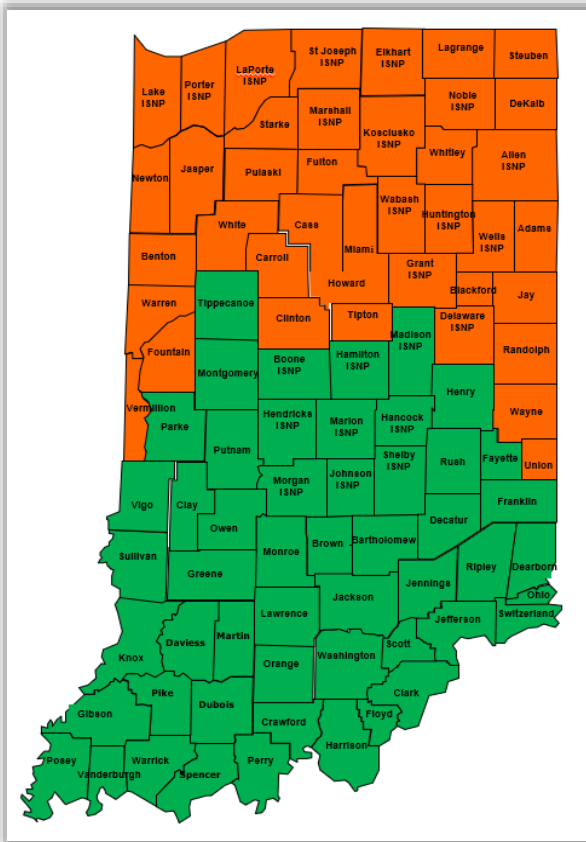
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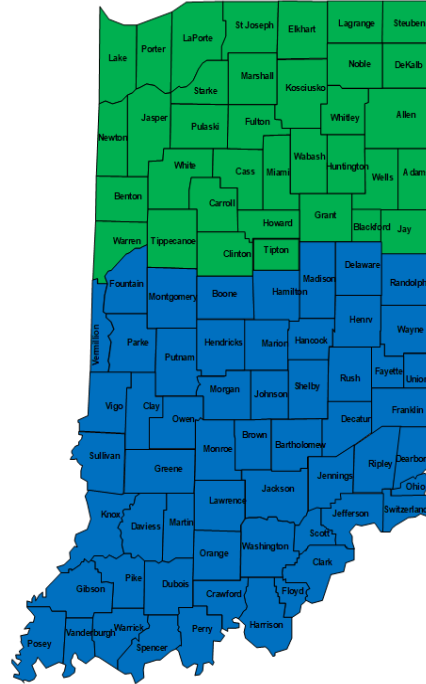
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Questions and Answers

Thanks for Attending Today's Session





Thank you

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PCA-1-21-02948-C&S-PRES_09232021

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