



# UnitedHealthcare Community Plan of Minnesota Provider Training – Minnesota Metro

## Community Based Behavioral Outpatient Services Prior Authorization Requirements

United  
Healthcare

# AGENDA

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# Prior Authorization Requirements



## Community Based Behavioral Outpatient Services Prior Authorization Requirements

- Beginning January 1, 2022, UnitedHealthcare Community Plan of Minnesota will require an online prior authorization process for the below outpatient community-based services
- Providers will submit authorization requests through a portal located on the [Provider Express website](#)

Service	Code
Adult Day Treatment	H2012
Children Day Treatment	H2012 UA
Day Treatment	S9480
Skills Training	H2014
DBT IOP	H2019
Therapeutic Behavioral Services	H2019





# Prior authorization process

# Prior authorization process

## How we're implementing the request process:

- Beginning January 1, 2022, providers will submit authorization requests through a portal located on the Provider Express website
- To access the request form, go to: [providerexpress.com](https://providerexpress.com) > Our Network > State-Specific Provider Information > Minnesota > Medicaid Authorization Templates > **Community Based Behavioral Outpatient Services Request Form**
- Authorizations will be required for both initial and continued stay requests



# Access the Request Form on the Minnesota Page on Provider Express

[Optum - Provider Express Home](#) > [Our Network](#) > [State-Specific Provider Information](#) > Welcome Minnesota

## Welcome to the Optum Network!

### Optum Network Manual

- [Network Manual](#)

### Special Regulatory Attachment

- [MN Specific Regulatory Attachments](#)





### Clinical Criteria


- [Standard Clinical Criteria](#)

### Best Practice Guidelines

- [BP Guidelines](#)

### Coordination of Care (COC)

- [COC Flyer](#)  
- [COC Checklist](#)  

- MnFIRE Assistance Program (MAP)
- General Information
- Provider Announcements
- ▾ Authorization Forms
  - [Community Based Behavioral Outpatient Services Request Form](#) 
  - [Provider Training Deck- Requesting Community Based Behavioral Outpatient Services](#)
  - [TMS & ECT Authorization Request Form \(NEW\)](#)



# Prior authorization process

## The submission process

- Complete the online request form
- Once submitted, you will receive a confirmation page display. A decision will be made within 2 - 10 business days of the online submission date
- If you have checked the UnitedHealthcare Provider Portal and have not received a decision within the above timeframe you can contact our team directly





# Prior authorization process

## The review process

- Submission information will be reviewed against our current Adverse Benefit Determination (ABD) information.
  - If the service(s) requested has an ABD on file, the provider will be directed to the appeals process.
- If services are deemed medically necessary, the care provider will receive written authorization for those services
- If additional information is needed to make an authorization determination, a licensed Care Advocate may outreach the requesting provider if clarification is needed
- If medical necessity is in question or the case would benefit from a Psychologist or Medical Director input, the Care Advocate may refer to a peer reviewer
- Live Peer Reviews are not required; providers may request the determination be made based on the information given to the Care Advocate and/or in the online submission



# Prior authorization process

## The review process continued

- An authorization will be created based on the request or final determination
  - If a requested service is determined to not meet guidelines, a letter will be sent including appeals rights
- Once the authorized units are used, additional units can be requested by completing another online submission
- Services will be authorized based on Supplemental Clinical Criteria:  
Minnesota Metro found on Provider Express > Guidelines/Policies & Manuals > State/Contract Specific Criteria
- This also indicates when other clinical criteria may apply



# Prior authorization process

## Information needed in submitted documentation:

Medical Necessity Reviews will be based on Supplemental Clinical Criteria: Minnesota Metro found on Provider Express > Guidelines/Policies & Manuals > State/Contract Specific Criteria or other clinical criteria as outlined

Current member clinical presentation will be reviewed, including:

- ✓ Onset and initial need for the service
- ✓ Diagnosis including supporting symptoms and behaviors
- ✓ Risk issues including suicidal or homicidal concerns and substance abuse
- ✓ Risk plan, if appropriate
- ✓ Most recent Higher Level of Care Admission, including ER visit
- ✓ Pertinent history of hospitalizations
- ✓ Medications including coordination of care with all providers
- ✓ Functional impairments and abilities
- ✓ Individual Treatment Plan



# Prior authorization process

## Examples of clinical information being assessed:

(The below questions are only examples and the intent is not to ask every question)

Functional Abilities Over Time				
Functional Areas	Start of Current Service	Progress (Abilities-Centric)	Goal	Intervention Plan
<ul style="list-style-type: none"> <li>Work/School</li> <li>Social/Play</li> <li>Family/Relationships</li> <li>Activities of Daily Living</li> <li>Medical/Physical</li> <li>Other</li> </ul>	<ul style="list-style-type: none"> <li>What strengths/abilities were present when they started treatment?</li> <li>What gaps/roadblocks/barriers were interfering with their potential functioning?</li> <li>Were they having any problems in the area of &lt;functional area&gt;? How often did these occur?</li> <li>Were there concerns from others around them?</li> <li>What did the member identify as their abilities and/or concerns?</li> <li>What are the member's medical/behavioral comorbidities?</li> </ul>	<ul style="list-style-type: none"> <li>How have their abilities improved or changed?</li> <li>How much has this increased or decreased?</li> <li>How has the progress been? Any set-Backs?</li> <li>How are they doing now?</li> <li>Does the member feel like they have made progress?</li> <li>What has helped them to make this progress?</li> <li>What types of interventions have worked well?</li> <li>Are they taking any medications that help?</li> <li>How do they utilize their support system/community supports?</li> <li>What types of skills are they learning?</li> </ul>	<ul style="list-style-type: none"> <li>What do you see as the outcome of this service?</li> <li>What abilities does the member want to build and strengthen?</li> <li>What do you anticipate the progress will be going forward?</li> <li>How long do you anticipate this will take?</li> <li>What would you and the member need to see to know the member is ready for a reduction in intensity?</li> </ul>	<ul style="list-style-type: none"> <li>What services are being utilized to meet the member's goal?</li> <li>What are the specific skills/interventions being taught/implemented?</li> <li>How is the member engaging in meaningful activities within the community outside of the home?</li> </ul>



# Prior authorization process

## Length of process

- A decision will be made within 2-10 business days of the online submission date
- Authorization specifics:
  - If services are deemed medically necessary, start date of authorization will be date of the portal submission or requested start date if in immediate future
  - If requested service is found to not meet medical necessity, the service the member is currently receiving will be denied from the requested start date forward
  - Please ensure that your contact information is updated to ensure correct processing of authorization
  - Authorization information can be viewed via the Prior Authorization and Notification tile on UHCprovider.com

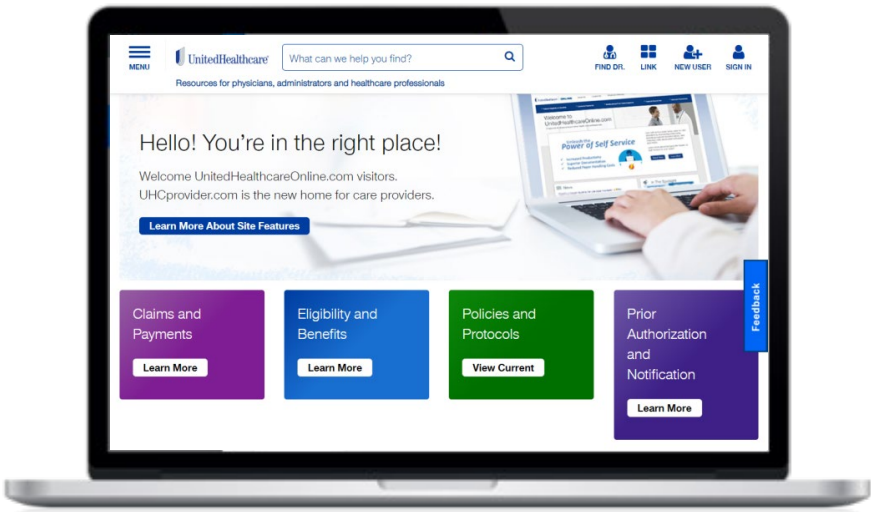




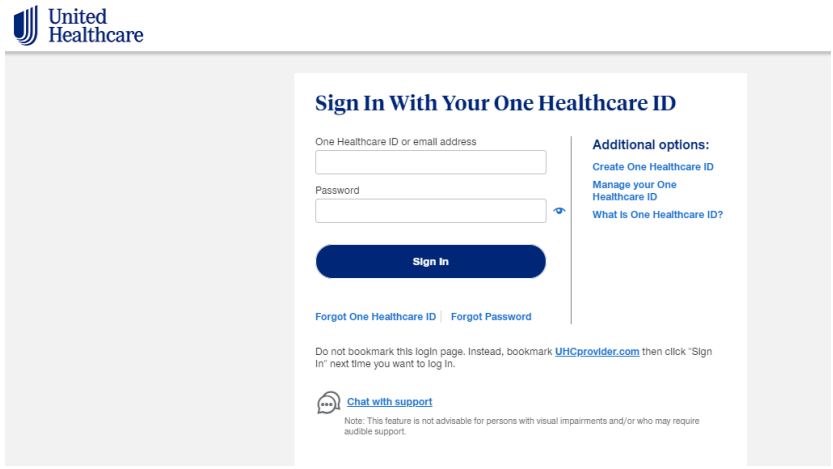
# Accessing your prior authorizations

# Accessing your prior authorizations

UnitedHealthcare Provider Website > UHCprovider.com > Prior Authorization and Notification Tool



UHCprovider.com



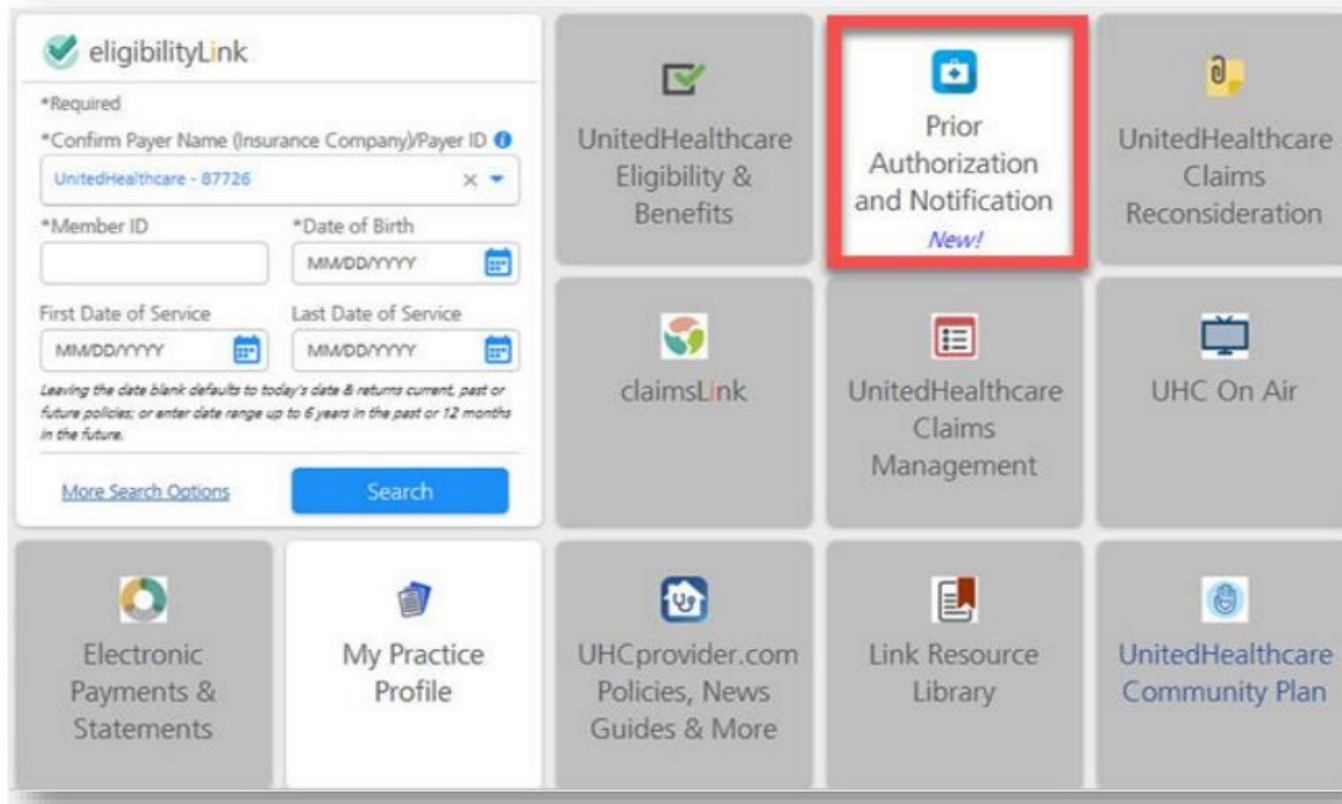
Log-in



# Accessing your prior authorizations

## DASHBOARD

- Click the Prior Authorization and Notification tile



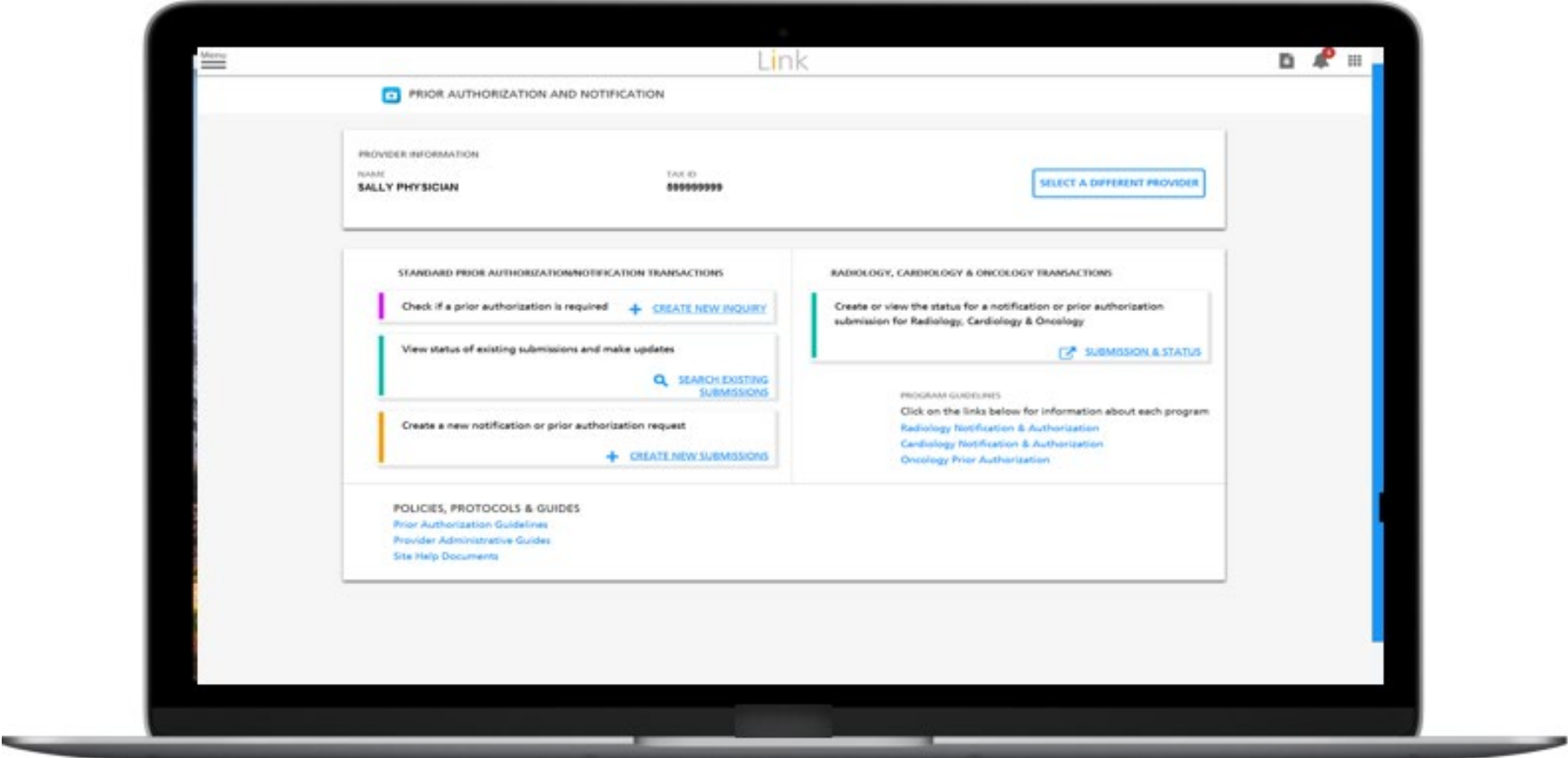
The screenshot shows the eligibilityLink dashboard. On the left is a search form with fields for Payer Name (filled with 'UnitedHealthcare - 87726'), Member ID, Date of Birth, First Date of Service, and Last Date of Service. Below the form is a 'Search' button. The main area contains a grid of tiles: 'UnitedHealthcare Eligibility & Benefits', 'Prior Authorization and Notification' (highlighted with a red border and a 'New!' tag), 'UnitedHealthcare Claims Reconsideration', 'claimsLink', 'UnitedHealthcare Claims Management', 'UHC On Air', 'Electronic Payments & Statements', 'My Practice Profile', 'UHCprovider.com Policies, News Guides & More', 'Link Resource Library', and 'UnitedHealthcare Community Plan'.





# Accessing your prior authorizations

## Search Existing Submissions



# Accessing your prior authorizations

- Select a **Search Method**
- Enter the required information and click **Search**

PROVIDER INFORMATION  
NAME: CHILDRENS HOSP  
ADDRESS: [REDACTED]  
TAX ID: 977977977  
SELECT A DIFFERENT PROVIDER

\* Required fields

SEARCH BY NOTIFICATION/PRIOR AUTHORIZATION NUMBER

SEARCH BY REQUESTING PROVIDER

SEARCH BY MEMBER ID AND NAME

SEARCH BY MEMBER NAME, DOB AND STATE

BROWSE UPDATES WITHIN LAST 7 DAYS

06/19/2017  
mm/dd/yyyy

07/03/2017  
mm/dd/yyyy

PHYSICIAN/PROVIDER ADDRESS

SERVICE SETTING: All

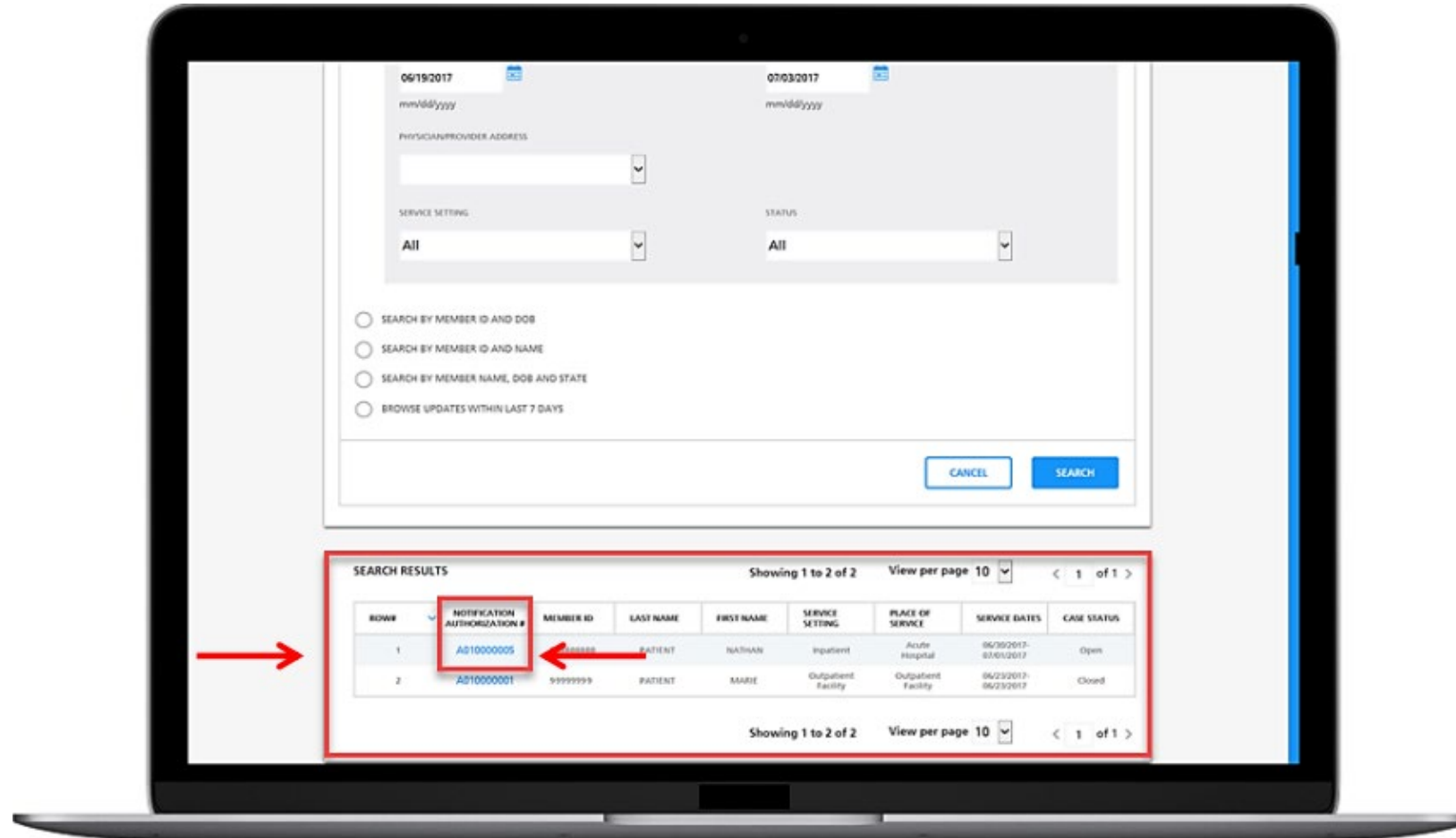
STATUS: All

CANCEL SEARCH



# Accessing your prior authorizations

- View the **Search Results** at the bottom of the screen
- Click on the desired **Notification/Authorization #** to view the details



# Accessing your prior authorizations

Service Details and Procedure Details are where services codes and number of units will be displayed

The screenshot shows a web form with several sections. A red box highlights the 'SERVICE DETAILS' section, which includes 'PLACE OF SERVICE\*' (Outpatient Facility) and 'SERVICE DETAILS\*'. Below this is a link to 'Add another diagnosis code'. Another red box highlights the 'PROCEDURE DETAILS' section, which includes a link to 'Add another procedure code'. A third red box highlights the 'CLINICAL NOTES' section, which contains instructions to enter clinical information. Two red arrows point to the left side of the form, one pointing to the 'Add another diagnosis code' link and the other to the 'CLINICAL NOTES' section.

▼ SERVICE DETAILS

PLACE OF SERVICE\* SERVICE DETAILS\*

Outpatient Facility

➕ Add another diagnosis code

▼ PROCEDURE DETAILS

➕ Add another procedure code

▼ REVIEW PRIORITY

Expedited Review

➕ By checking this box and indicating that you are requesting an Expedited Review, you acknowledge that you have read and are adhering to the regulations pertaining to requesting an Expedited Review.  
Medicare: 42 CFR Section 422.570  
Medicaid: CFR Section 438.210  
All other membership: Health Care Reform - PPACA and DOL 29 CFR 2590.715.2710 AND 29 cfr 2560.503

▼ CLINICAL NOTES

Enter clinical information in the section below. You will also have the ability to attach clinical documentation on the confirmation page once you submit your request.



# Prior Authorization and Notification Tool Resources



## Live training session

- **UHCprovider.com** > Menu > Resource Library > Training > [Prior Authorization and Notification Overview](#)

## UHC On Air

- **UHCprovider.com** > Menu > Resource Library > [UHC On Air](#)

## Other training resources

- **UHCprovider.com** > Menu > Prior Authorization and Notification > [Prior Authorization and Notification Tool](#) > Quick Reference Guides, Videos and Training Tools





# Thank you!

**Questions?**

**Email STEM at [stem.ca.admin@optum.com](mailto:stem.ca.admin@optum.com)**

**Contact your provider advocate**