UnitedHealthcare Community Plan of Minnesota Provider Training – Minnesota Metro

Community Based Behavioral Outpatient Services Prior Authorization Requirements

BH4009 03/2022

AGENDA

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Prior Authorization Requirements

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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

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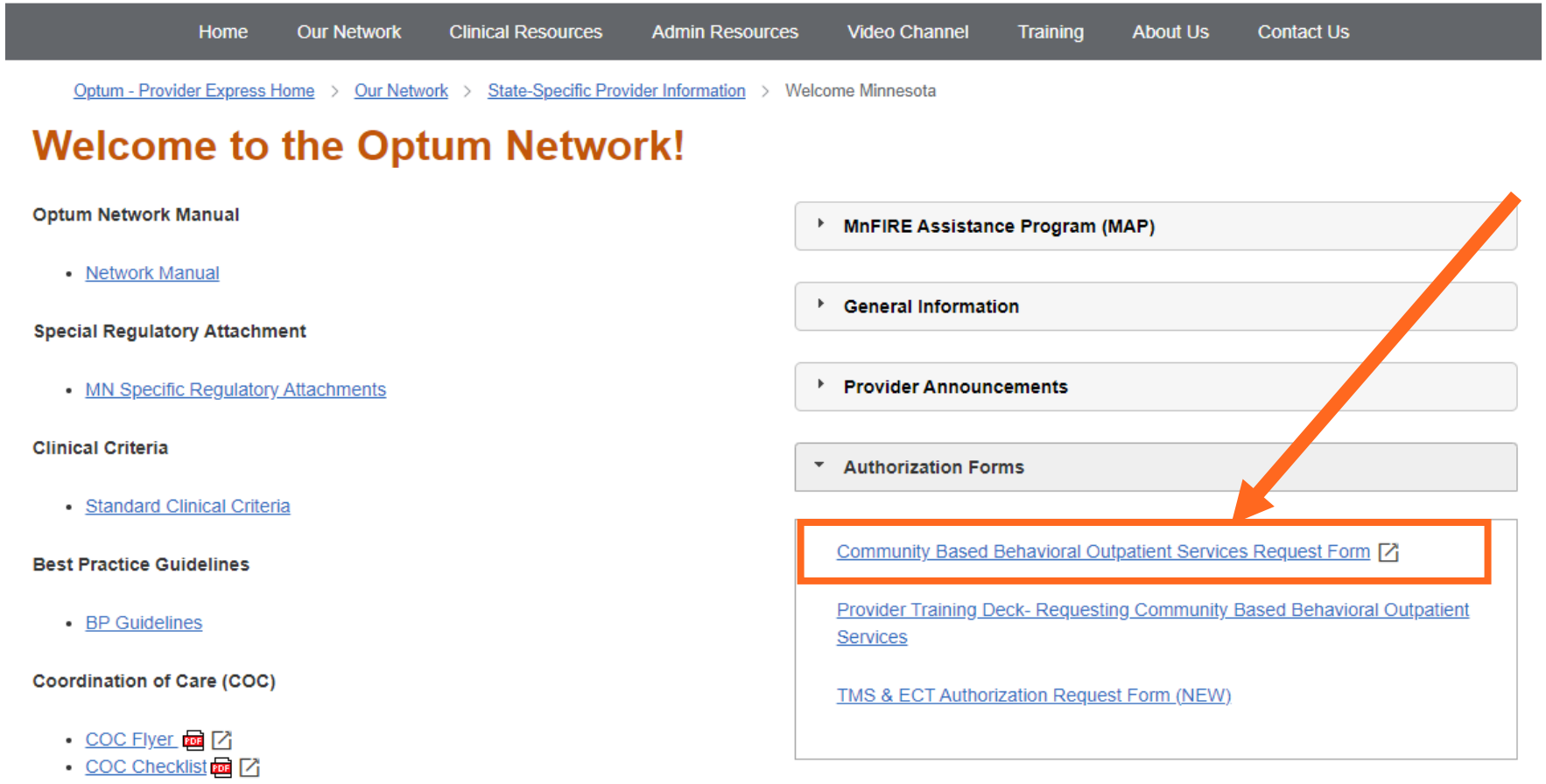
Prior authorization process

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 > 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



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**
• Work/School • Social/Play • Family/Relationships • Activities of Daily Living • Medical/Physical • Other	• What strengths/abilities were present when they started treatment? • What gaps/roadblocks/ barriers were interfering with their potential functioning? • Were they having any problems in the area of <functional area>? How often did these occur? • Were there concerns from others around them? • What did the member identify as their abilities and/or concerns? • What are the member's medical/behavioral comorbidities?	• How have their abilities improved or changed? • How much has this increased or decreased? • How has the progress been? Any set-Backs? • How are they doing now? • Does the member feel like they have made progress? • What has helped them to make this progress? • What types of interventions have worked well? • Are they taking any medications that help? • How do they utilize their support system/community supports? • What types of skills are they learning?	• What do you see as the outcome of this service? • What abilities does the member want to build and strengthen? • What do you anticipate the progress will be going forward? • How long do you anticipate this will take? • What would you and the member need to see to know the member is ready for a reduction in intensity?	• What services are being utilized to meet the member's goal? • What are the specific skills/interventions being taught/implemented? • How is the member engaging in meaningful activities within the community outside of the home?

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

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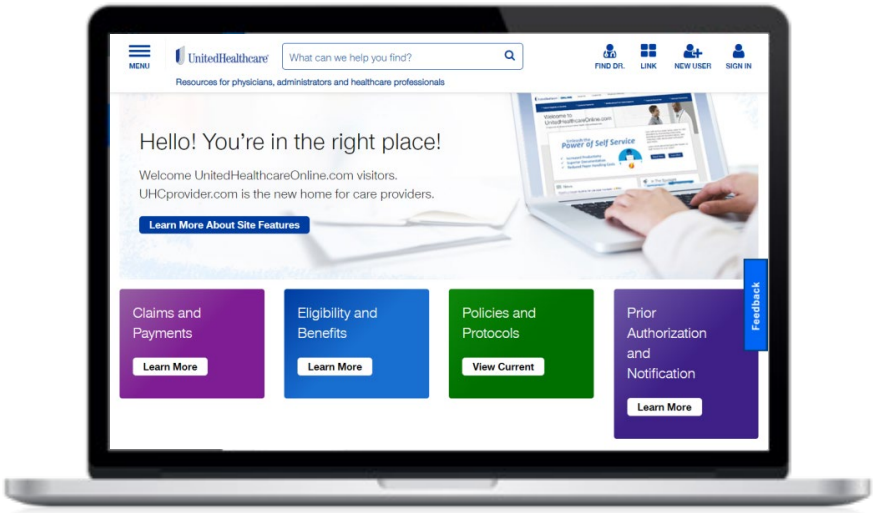
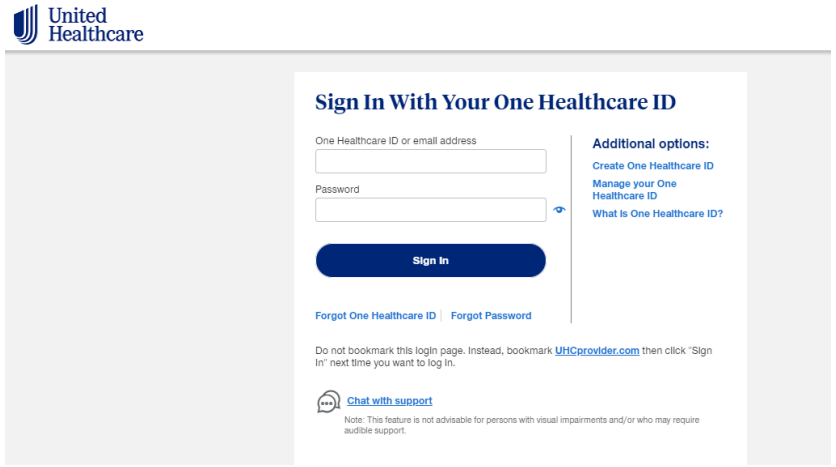
Accessing your prior authorizations

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



UHCprovider.com

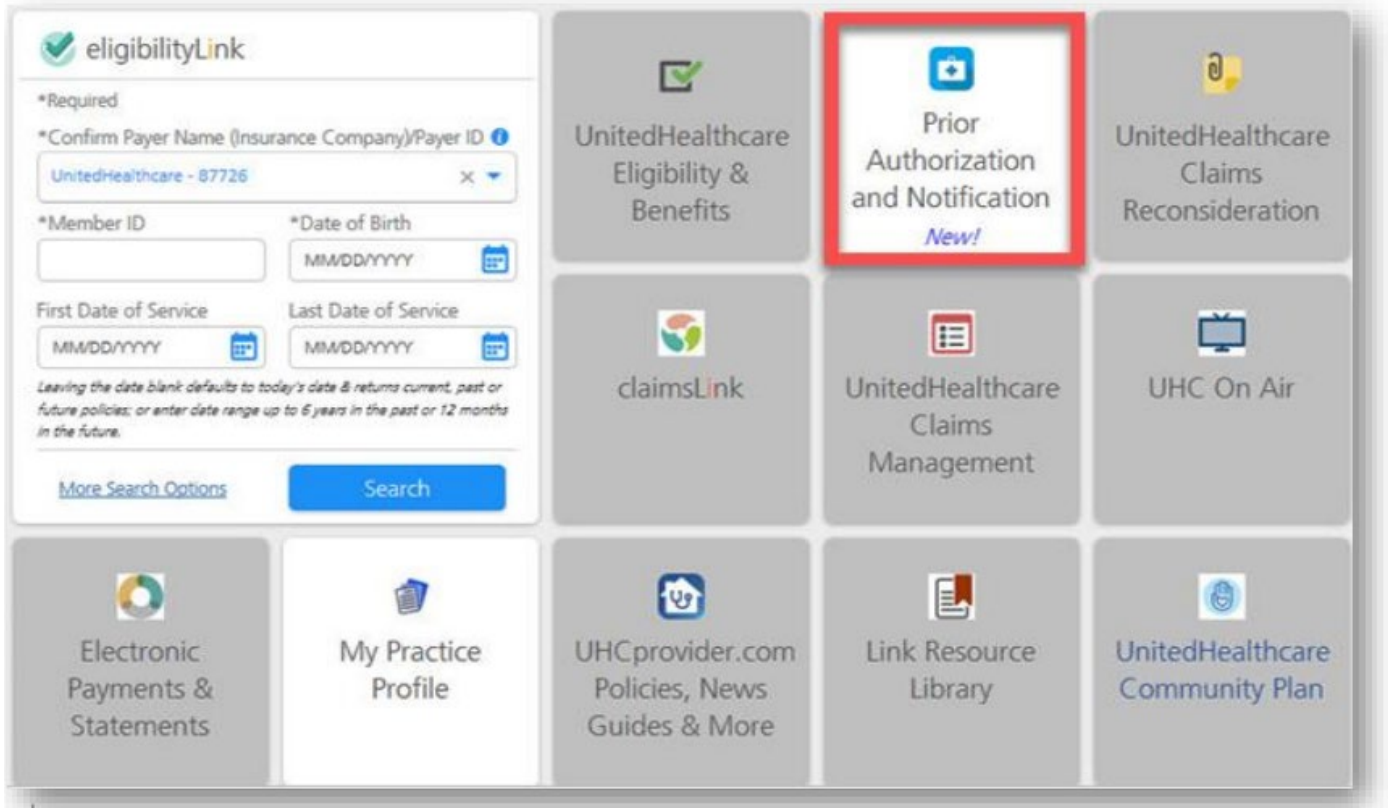


Log-in

Accessing your prior authorizations

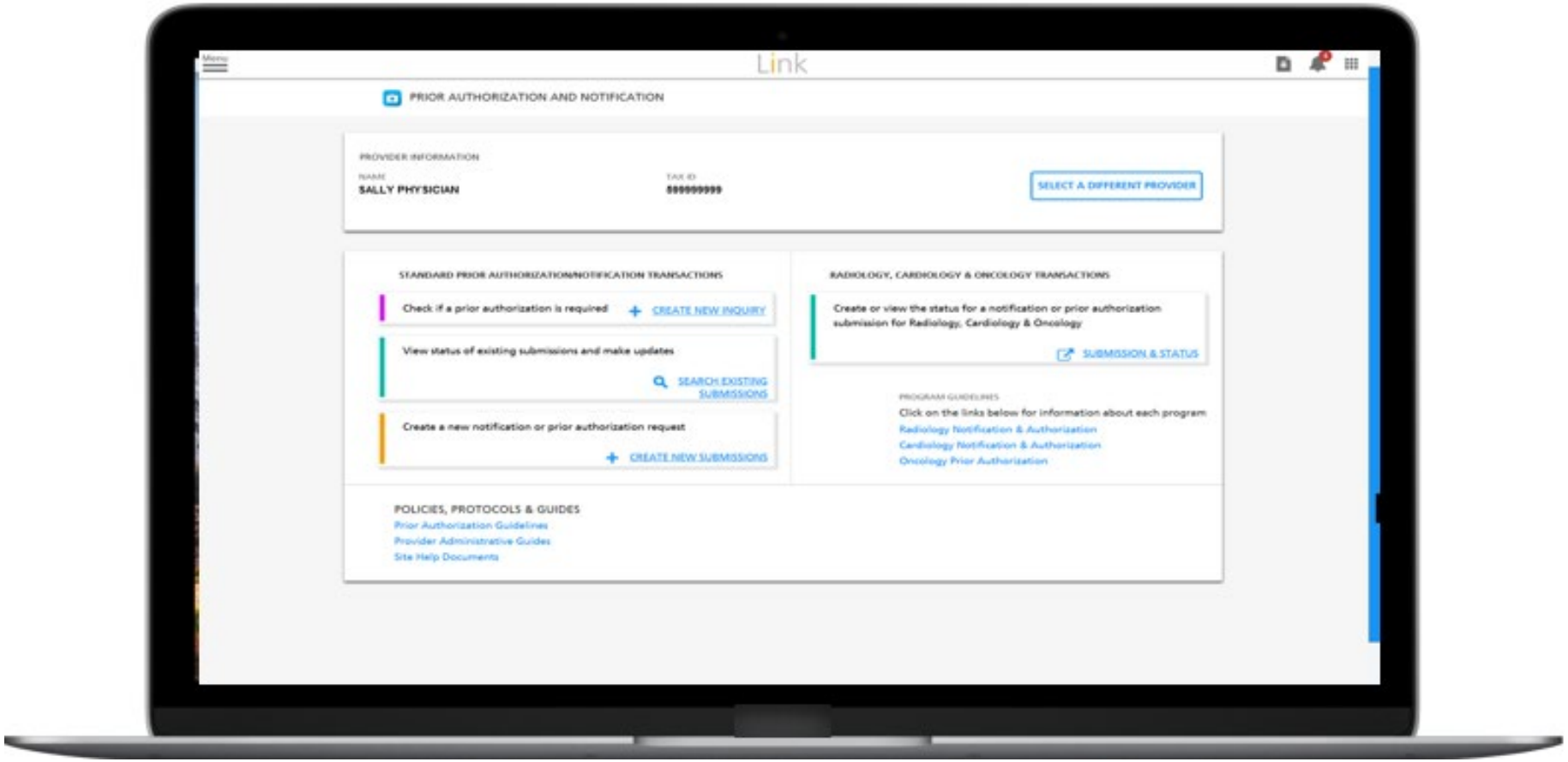
DASHBOARD

- **Click the Prior Authorization and Notification tile**



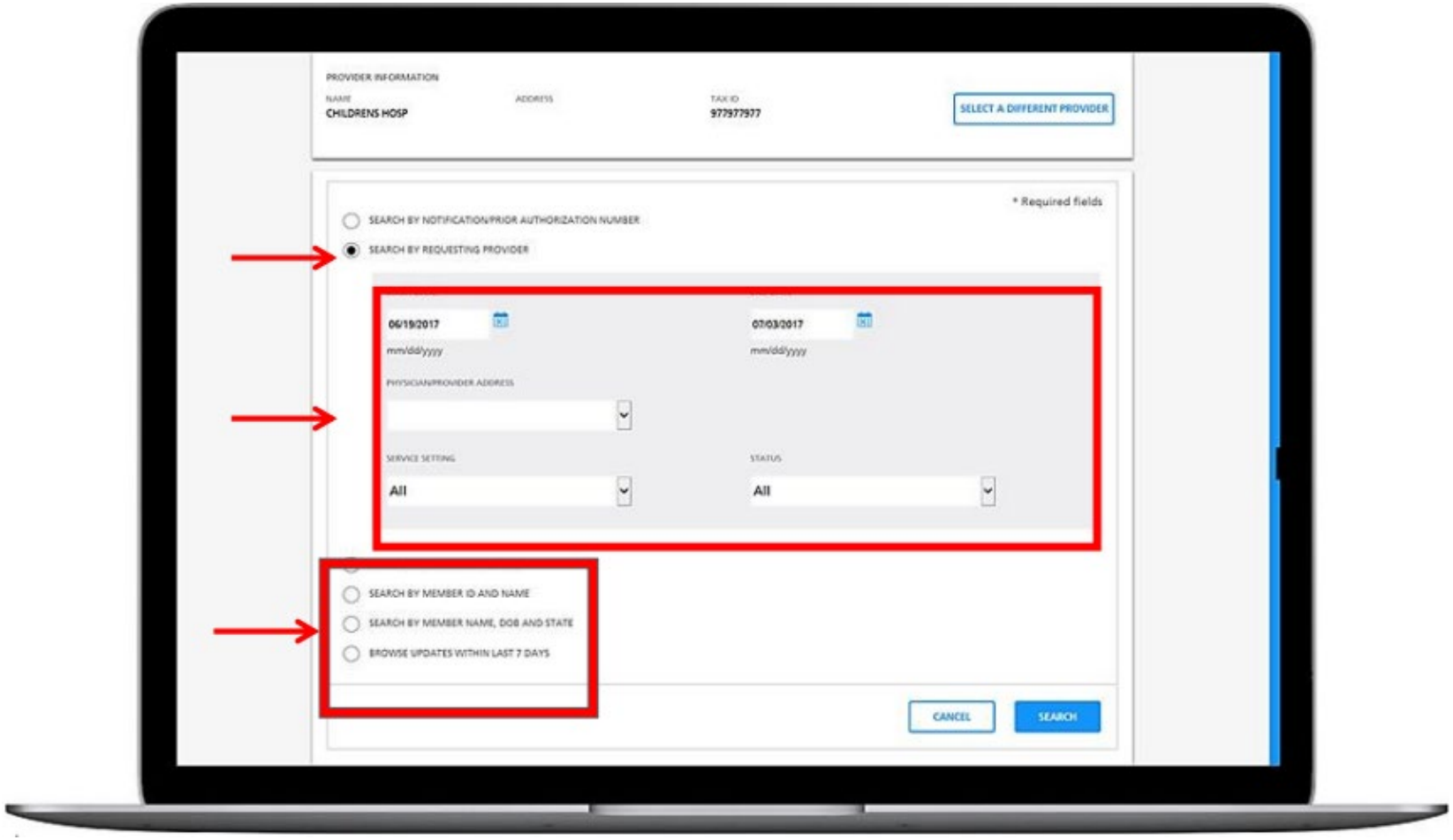
Accessing your prior authorizations

Search Existing Submissions



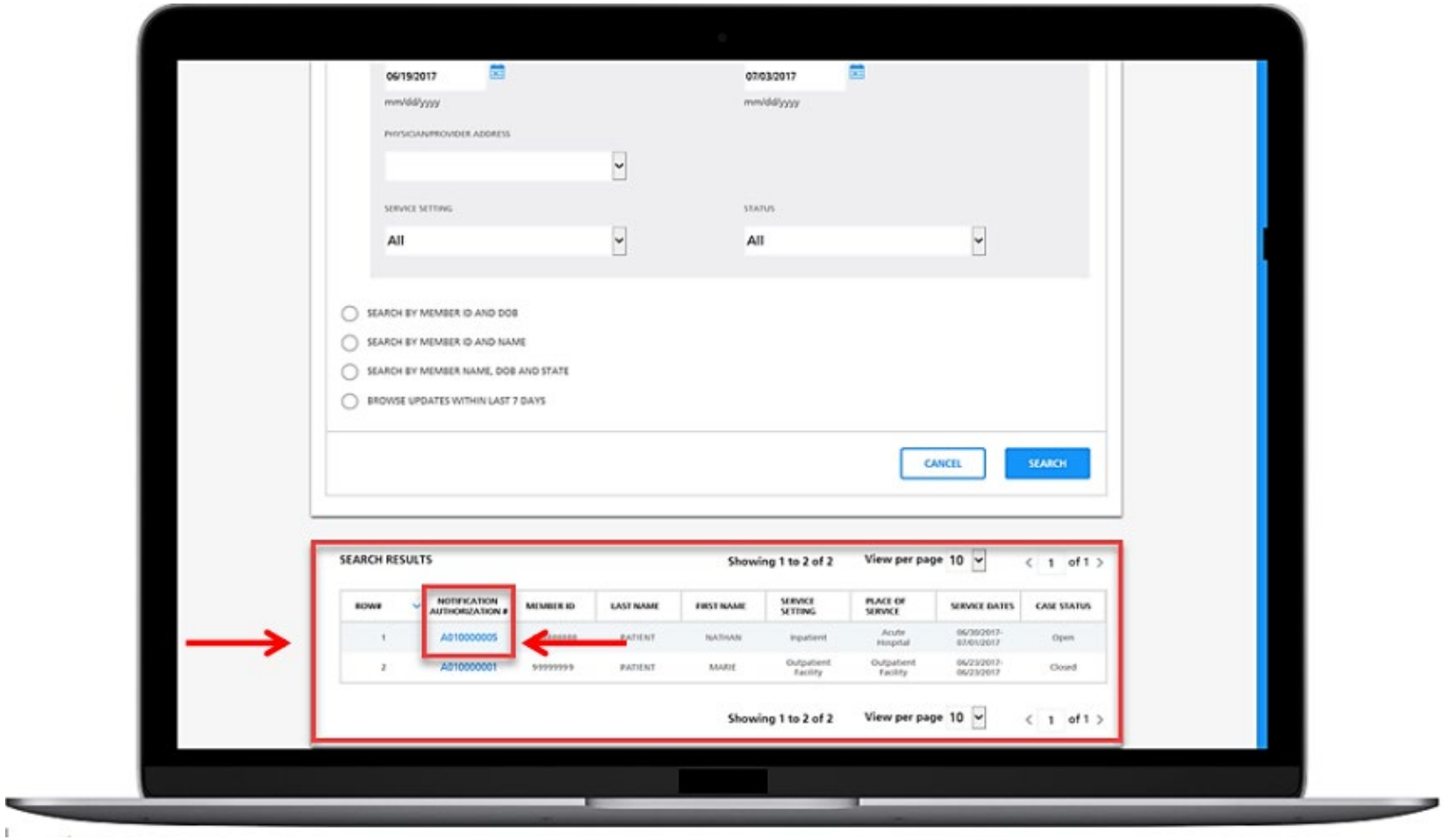
Accessing your prior authorizations

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



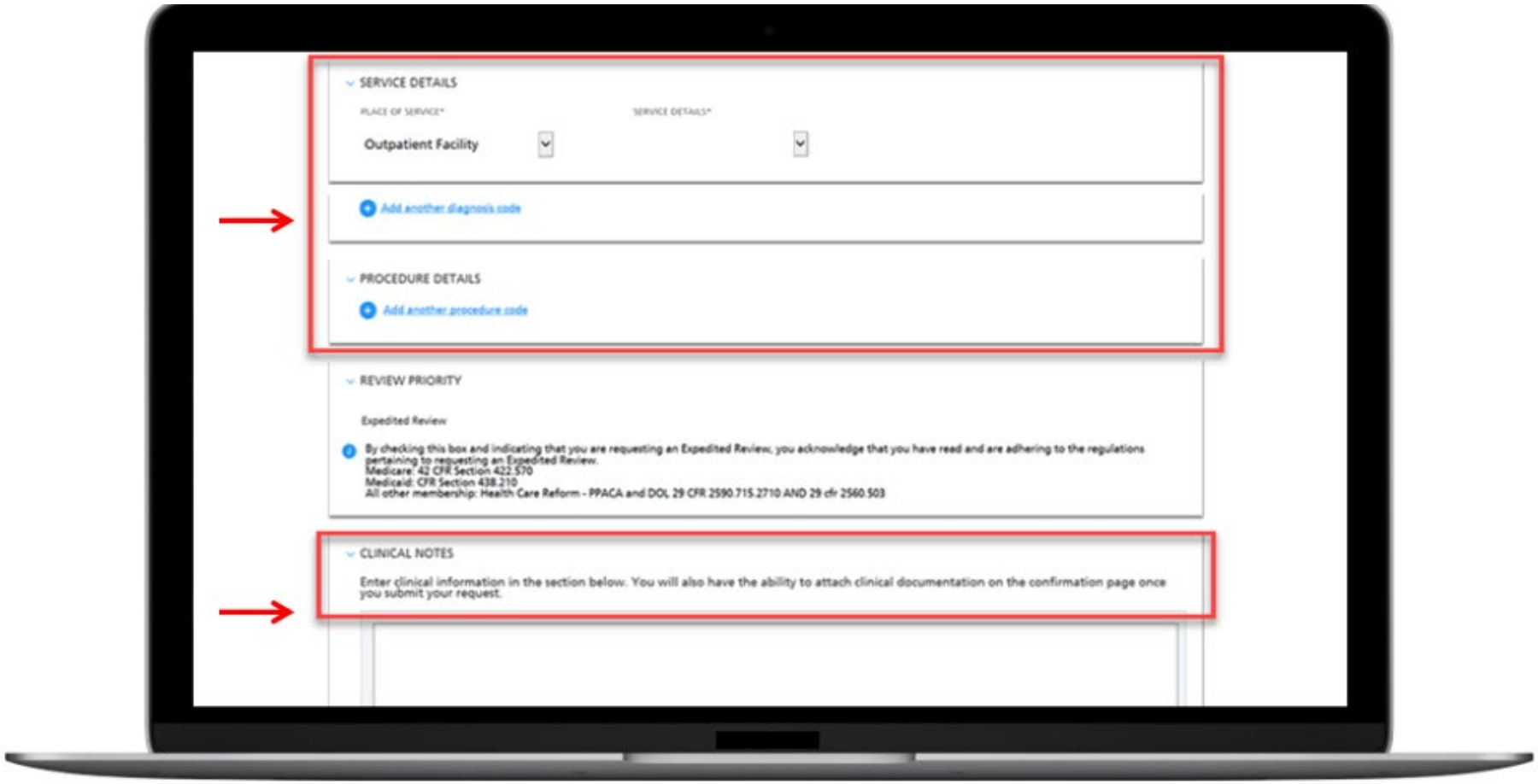
Accessing your prior authorizations

- 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



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

Contact your provider advocate

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