Prior Authorization and Notification Guide For Behavioral Health Providers

All Behavioral health prior authorizations and notifications for Medicaid Mainstream, Wellness4Me and EPP members must be submitted through the online Prior Authorization and Notification ("PAAN") tool, located through the [LINK portal] on [uhcprovider.com]. *Note that the dedicated email and fax number, previously used for authorization requests, is being decommissioned.*

If you have not yet registered to use LINK, you will need to do so. Information regarding New User Registration can be found by selecting the "[New User]" link on *uhcprovider.com*.

- Once you provide your Tax Identification Number ("TIN"), the system will identify the administrator associated with that TIN. Your request will need to be approved by the administrator.

- If no one is currently assigned as an administrator, you may be assigned to that role and a service code will be mailed to you from the UnitedHealthcare Connectivity Help Desk. You may also call the Help Desk at **1-866-842-3278, option 1**.

You will find many resources on how to submit authorizations through PAAN on [uhcprovider.com]. These resources primarily target medical providers rather than behavioral health providers but are still very helpful in learning about the PAAN tool.

For **outpatient behavioral health levels of care** (PHP, IOP, ACT, PROS, CDT, IPRT, HCBS, etc.), we are also including some specific "workarounds" below to help you navigate the system. (Inpatient levels of care for behavioral health are handled the same as inpatient medical care.)

1. In "**eligibility Link**", you can confirm a member's current eligibility, as well as obtain information such as the member's primary care physician ([see #6 below]).
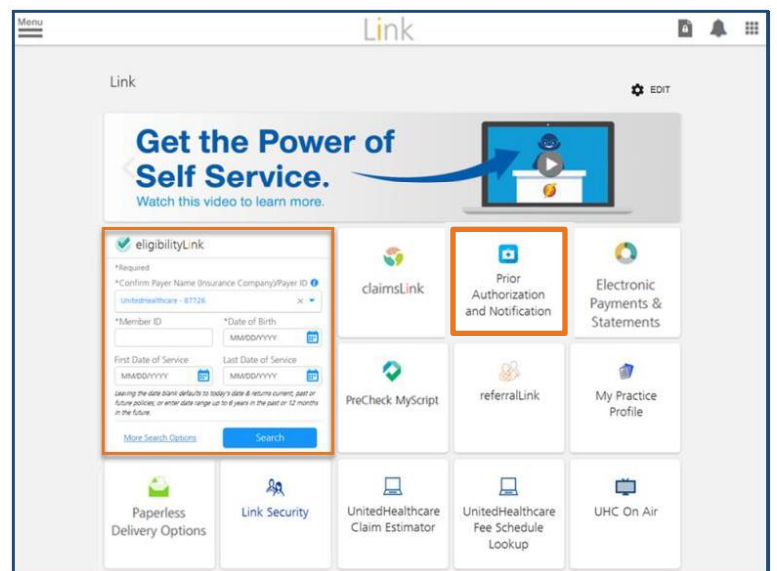
2. In "**Provider Information**", the dropdown selection list under "Provider Organization You Are Representing" is loaded from another system and cannot be altered. Each facility, association or clinic may have multiple listings. Make note of the name and numerical value you select from the dropdown list so you can use it consistently.
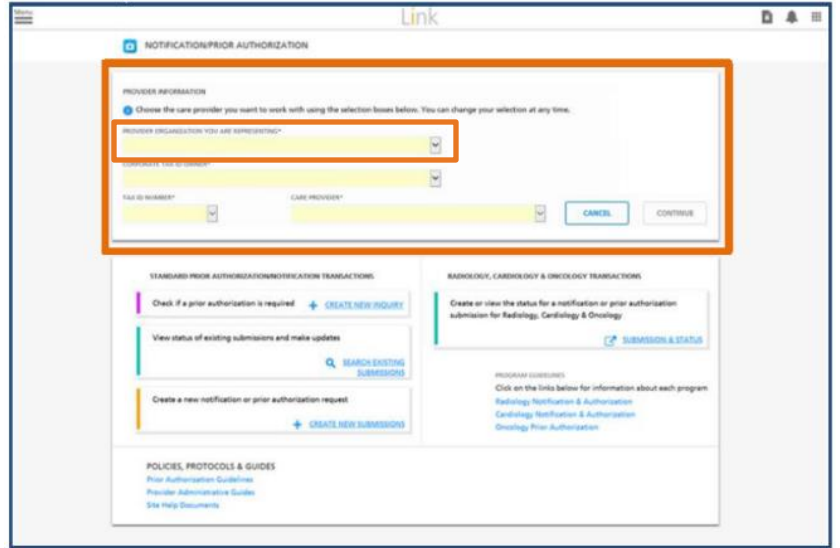
3. In the "Create a new notification or prior authorization request" section, select "**CREATE NEW SUBMISSIONS**".
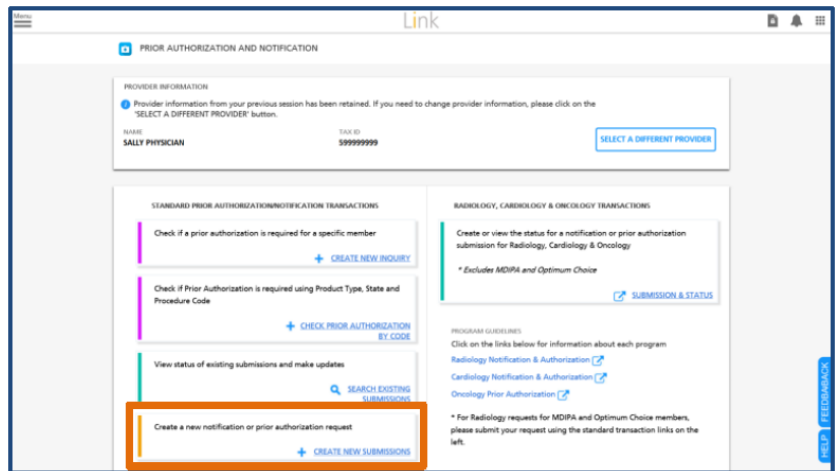
4. "**Member ID**" may be either the Medicaid Client Identification Number ("CIN") or the UnitedHealthcare subscriber ID.
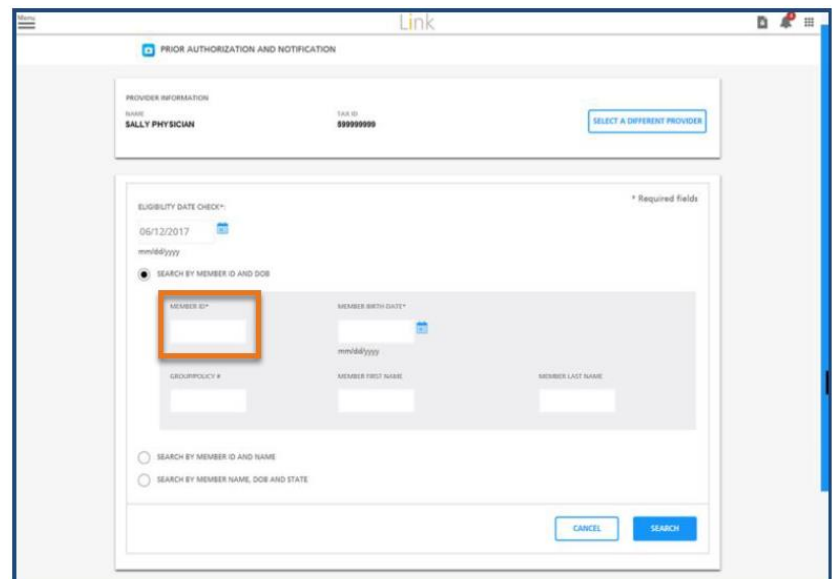
5. On the "**Notification/Prior Authorization Provider Details**" screen, the "**Place of Service**" must always be "**Outpatient**" (not "Outpatient Facility "or "Residential").

6. When completing the "**Service Details**", you must select a provider for the authorization request (this does not impact the approval of the request or claims). You may either:

- Input the member's PCP ([see #1 above])

- Use a Nurse Practitioner or MD at your facility, association or clinician. Set this individual as a "favorite" and use as your default for other authorization requests (after inputting the information for this individual and selecting the radial button, you can "Add to Favorites", as illustrated below).

7. When entering the "**Service Dates**", PAAN will only allow you to backdate 2 business days. If services are requested prior to that date, you may note this within the "Clinical Notes" section (see #11b below).

8. When entering "Diagnosis Details", you must provide at least 1 diagnosis to complete an authorization request.

Type a **Diagnosis Code/Procedure Code** or keyword, then select from the drop-down menu

Add up to a total of 10 **Diagnosis Codes** and/or 14/15 **Procedure Codes**

If member does not have an established mental health diagnosis, please enter "F99 – General Mental Health".

9. In "Service Details", select "Mental Health" or "Substance Use"
   - Expected From/To Date (From date cannot be retroactive for more than 2 business days. Earlier dates can be indicated in "Clinical Notes".)
   - In "Counts", "Standard of Measure", "Frequency" and "Total", an example would be:
     - A member is receiving 3 hours of respite each week and 1 unit is 15 minutes.
       - Count = 12 (units)
       - Standard of Measure = Units
       - Frequency = Weekly
       - Total = # of units x frequency (i.e., if requesting 26 weeks of treatment, 12 (units per week) x 26 (weeks) = 312 (Total units requested)

- All requested procedures may be entered on one authorization request (ex: PROS may include H2019 and H2018; HCBS may include S5150 and H2014)

10. You may save your most commonly utilized codes.

11. On "**Review Priority**" page:

- Disregard "**Expedited Review**" checkbox

- "**Clinical Notes**" may be used to indicate the authorization start date if more than 2 business days retroactive (i.e. "Due to limitations with PAAN, please use 3/3/2020 as the requested start date") or other information to note upon submission (i.e. "Request submitted by initial contact; clinical to be attached shortly by follow-up contact").

- "**Initial…**" and "**Follow-Up Contact Details**" should be completed as appropriate. Follow-up

Contact should be the point of contact for notification of authorization approval, denial or if more information is needed.

- Once you select "Continue", you'll have the opportunity to review the entire authorization request and ensure all information is accurate.

12. When you have confirmed the accuracy of all information, select "Submit". Once submitted, no further edits can be made.

13. When you receive the "Confirm Notification/Prior Authorization" screen:

- Record the reference number displayed on the screen

- Upload any relevant clinician information related to the authorization request. (i.e. Children's HCBS Authorization and Care Notification Forms or Initial PROS Treatment Plan, Crisis Residence Admission Notification Form, etc).