

**Optum**



UnitedHealthcare  
Community Plan

# Nebraska Provider Training

For Nebraska Community Mental Health  
Rehabilitative Services Prior Authorization



# AGENDA



Prior Authorization Requirements



Prior Authorization Process



Accessing your Authorizations

# Prior Authorization Requirements

## The authorization requirements

- Beginning June 7, 2021, UnitedHealthcare Community Plan of Nebraska will begin the online prior authorization process for the following community-based services
- Level of Care Guidelines: [providerexpress.com](https://providerexpress.com) > Our Network > State-Specific Provider Information > Nebraska > Clinical Criteria Guidelines > Nebraska Clinical Criteria Guidelines



Service	Code
Community Treatment Aide	H0036
Assertive Community Treatment	H0040
Community Support Services	H2015 HE, H2015 HF
Day Rehabilitation	H2017, H2018
Youth Day Treatment	H2027
Long-Acting Injectables	J0400, J0401, J1630, J1631, J2315, J2426, J2426TH, J2680, J2794, J3490
Sex Offender Risk Assessment (SORA)	H2000 HA

# Prior authorization process

# Requirements

## How we're implementing the request process

Beginning June 7, 2021, 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 > Nebraska > Authorization Templates

Authorizations will be required for both initial and continued stay requests

# The Nebraska page on Provider Express

**Optum** | Provider Express

[Log In](#) | [First-time User](#) | [Global](#) | [Site Map](#)

Search:

Home | Our Network | Clinical Resources | Admin Resources | Video Channel | Training | About Us | Contact Us

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

## Welcome to the Optum Network!

**Optum Network Manual**

- [Network Manual](#)

**Clinical Criteria**

- [Standard Clinical Criteria](#)

**Best Practice Guidelines**

- [BP Guidelines](#)

**Coordination of Care (COC)**

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

[Nebraska – Medically Frail Attestation Form](#)

**General Information**

**Provider Announcements**

**Medicaid Authorization Templates**

- [Nebraska Certification of Need for Services](#)
- [Nebraska Crisis Stabilization Admission Notification](#)
- [Nebraska LAI Buy and Bill Authorization Request](#)
- [Nebraska Medicaid ABA Treatment Request Form](#)
- [Nebraska Medicaid Critical Incident Report](#)
- [Nebraska MRO Authorization Request](#)
- [Medicaid Rehab Option & Peer Support Services, Treatment Review & Authorization Request](#)
- [NE Community Health Service Request Form](#)

# Prior authorization process

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## The submission process

- Complete the online request form
- Once submitted, you will receive an email confirmation message to the email address entered in the “Request Recovery Email” field on the submission form
- You can check the status of your request using the Recovery Email. If request reflects “complete”, authorization information can be found in UnitedHealthcare Provider Portal



# Prior authorization process

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## The review process

- Submission information will be reviewed against our current non-coverage determinations.
  - If the service(s) requested has an non-coverage determinations ABD on file, the provider will be directed to the appeals process
- If services are deemed medically necessary, the number of approved units as well as date span of the authorization can found in UnitedHealthcare Provider Portal
- Live Peer Reviews are not required; providers may request the determination be made based on the information given in the online submission

# Prior authorization process

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## The review process

- An authorization will be created based on the request or final determination
  - If a requested service is determined to not meet our Level of Care Guidelines, a letter will be sent including your appeals rights
- Once the authorized units are used, requests will be obtained by completing another online submission
- Services will be authorized based on our Level of Care Guidelines found on [providerexpress.com](https://providerexpress.com) > Our Network > State-Specific Provider Information > Nebraska > Level of Care Guidelines

# Prior authorization process

## Information needed in submitted documentation:

- Medical Necessity Reviews will be based on Nebraska Level of Care Guidelines
- 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 Service Plan (ISP)

# Prior authorization process

## Examples of clinical information being assessed:

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 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



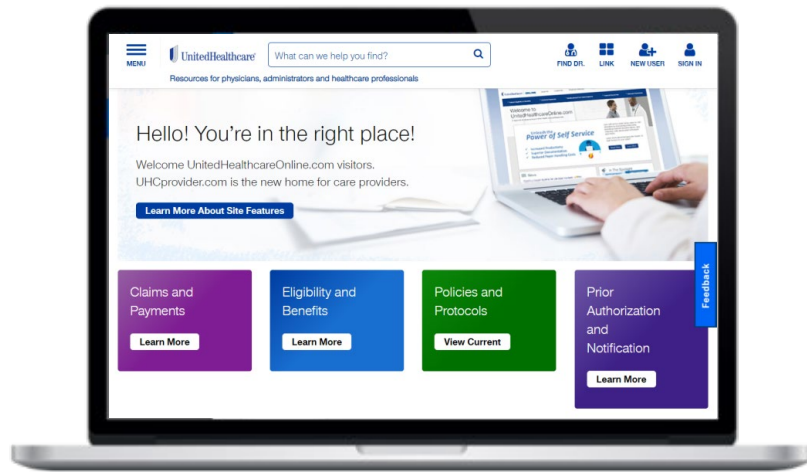
## Length of process

- A decision will be made within 2 - 14 calendar days of the online submission date
- Authorization specifics:
  - Start date of authorization will be requested start date as indicated on the request form.
  - 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.
  - Can be viewed via the Prior Authorization and Notification tile in UHCprovider.com.

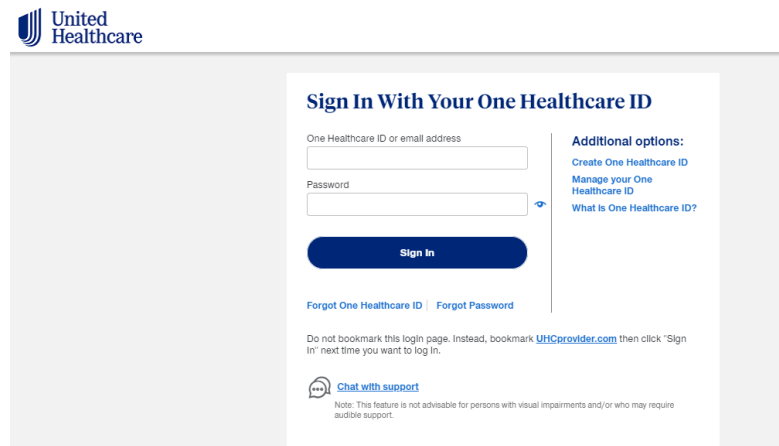
# Accessing your prior authorizations

# Accessing your prior authorizations

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



UHCprovider.com



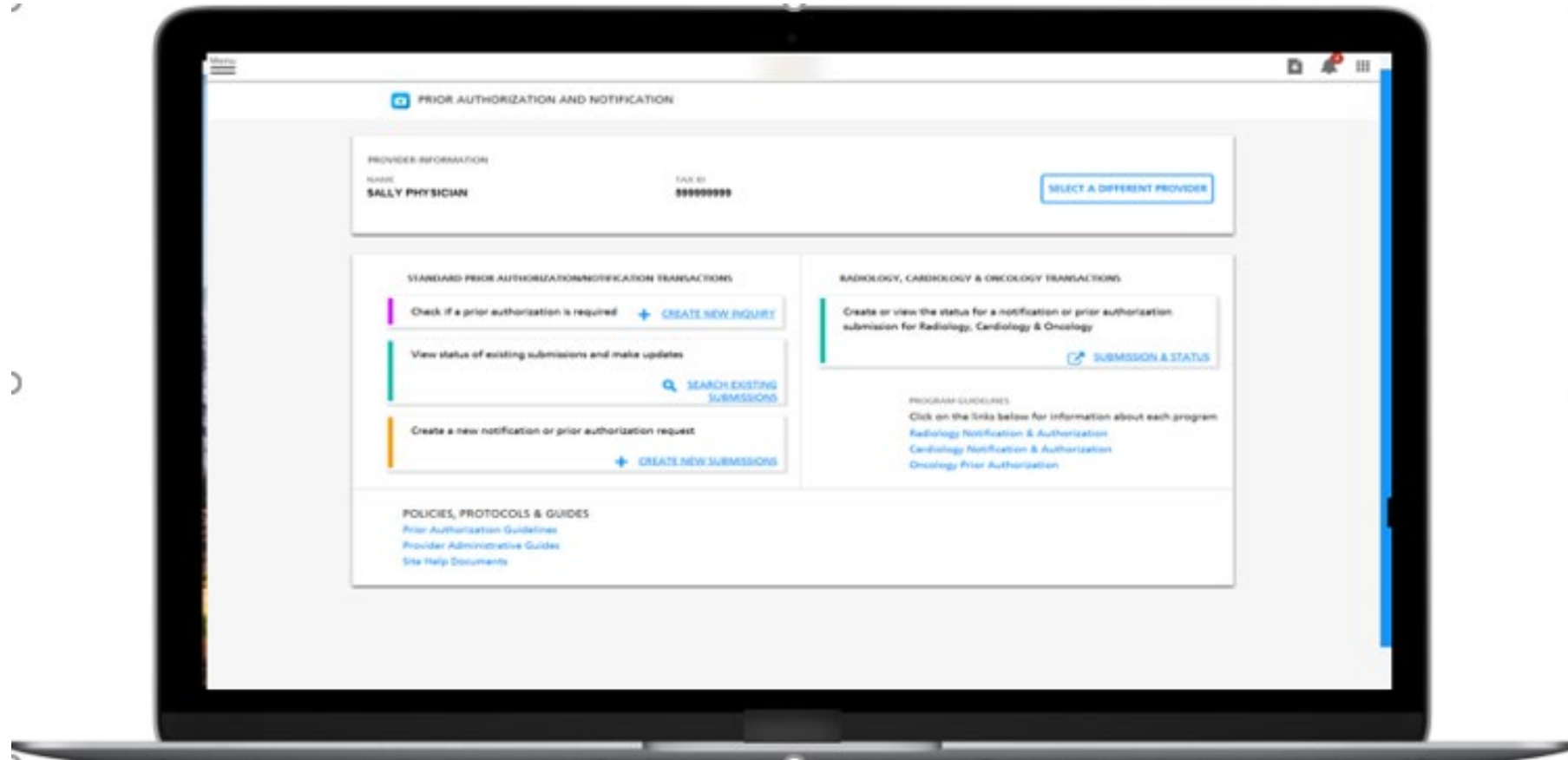
Log-in



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**

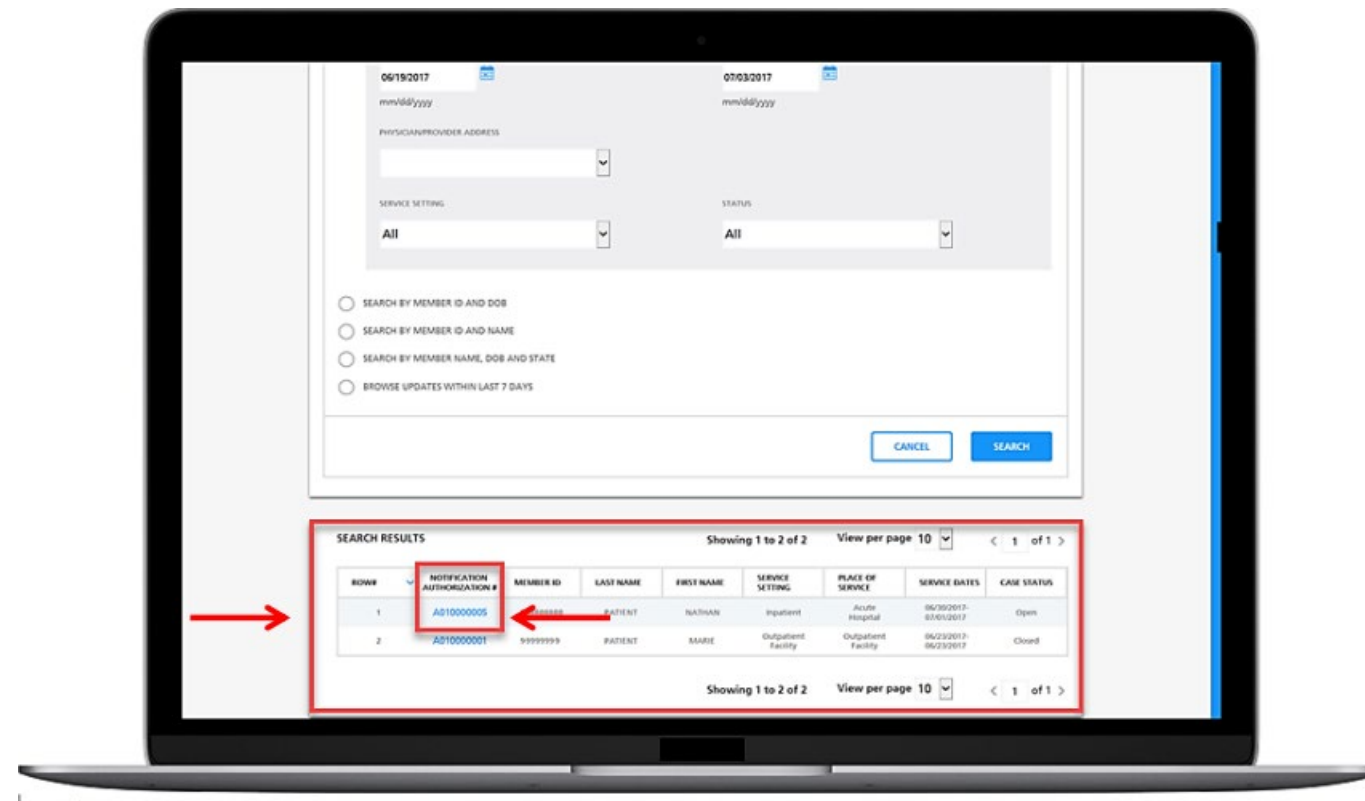
The screenshot displays a web application interface for accessing prior authorizations. The interface is divided into several sections:

- PROVIDER INFORMATION:** This section at the top shows the provider name as "CHILDRENS HOSP" and the TAX ID as "57977977". A button labeled "SELECT A DIFFERENT PROVIDER" is located to the right.
- SEARCH METHOD:** Below the provider information, there are two radio button options for search methods:
  - SEARCH BY NOTIFICATION/PRIOR AUTHORIZATION NUMBER
  - SEARCH BY REQUESTING PROVIDER
- SEARCH CRITERIA:** A red box highlights the search criteria section, which includes:
  - Two date input fields: "06/19/2017" and "07/03/2017", both with "mm/dd/yyyy" labels and calendar icons.
  - A "PHYSICIAN/PROVIDER ADDRESS" dropdown menu.
  - A "SERVICE SETTING" dropdown menu with "All" selected.
  - A "STATUS" dropdown menu with "All" selected.
- SEARCH METHODS (Bottom):** Another red box highlights a section at the bottom of the form with three radio button options:
  - SEARCH BY MEMBER ID AND NAME
  - SEARCH BY MEMBER NAME, DOB AND STATE
  - BROWSE UPDATES WITHIN LAST 7 DAYS
- Buttons:** At the bottom right, there are "CANCEL" and "SEARCH" buttons.

Red arrows on the left side of the screen point to the search method selection, the search criteria section, and the bottom search methods section.

# Accessing your prior authorizations

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



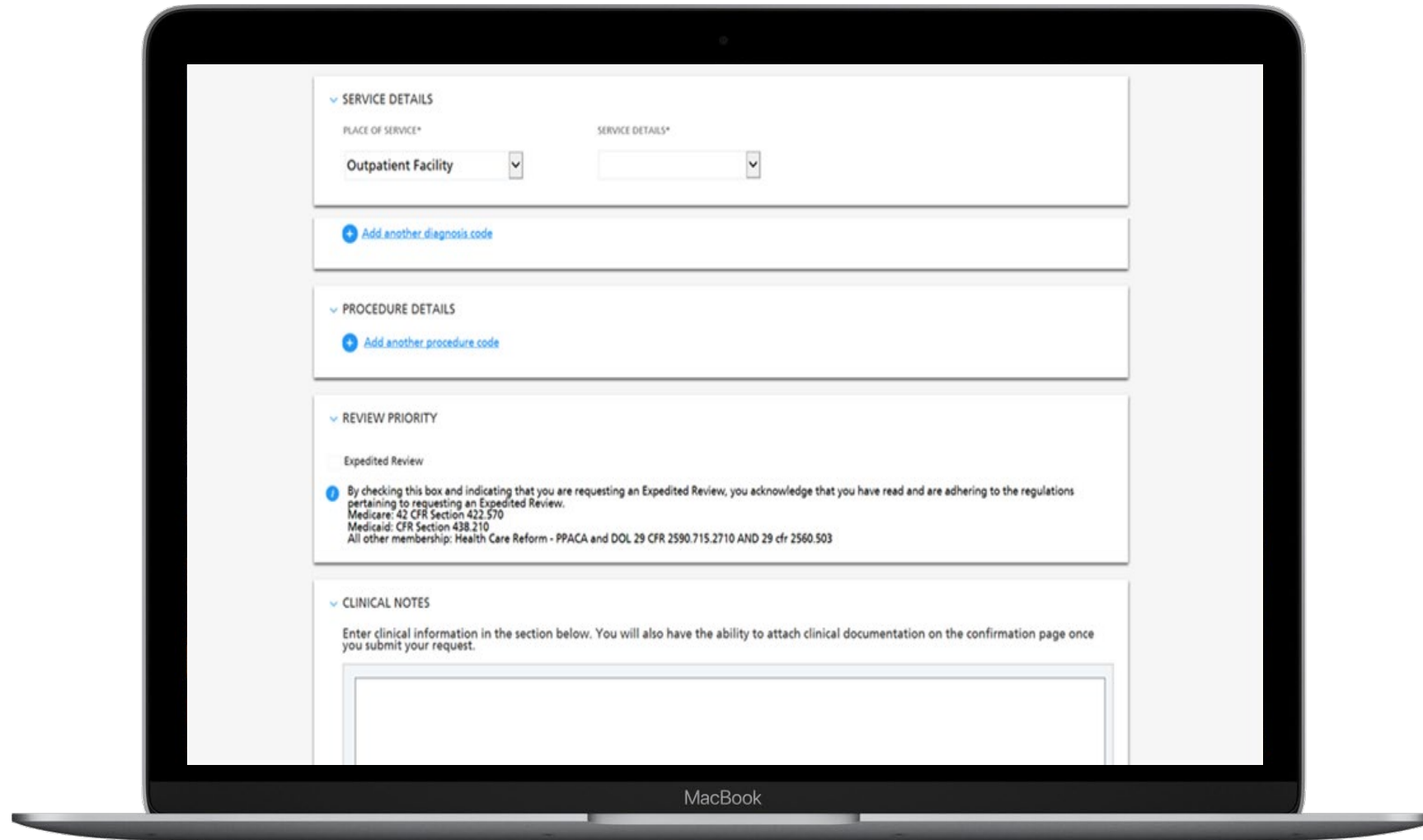
# Accessing your prior authorizations

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

The screenshot shows a laptop screen with a web form. The form is divided into several sections, each with a red box highlighting it and a red arrow pointing to it from the left. The sections are:

- SERVICE DETAILS**: This section contains two dropdown menus. The first is labeled "PLACE OF SERVICE\*" and has "Outpatient Facility" selected. The second is labeled "SERVICE DETAILS\*" and is currently empty. Below these are two buttons: "Add another diagnosis code" and "Add another procedure code".
- PROCEDURE DETAILS**: This section contains one button: "Add another procedure code".
- REVIEW PRIORITY**: This section contains a checkbox labeled "Expedited Review" and a paragraph of text: "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 422.510 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**: This section contains a text area with the instruction: "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."

# Accessing your prior authorizations



# Accessing your prior authorizations

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## 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

# Accessing your prior authorizations

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# Thank you!

Questions?

Call Provider Services at 1-866-633-4449

Email Outpatient Care Engagement at  
[stem.ca.admin@optum.com](mailto:stem.ca.admin@optum.com)

Contact your provider advocate