



Prior Authorization Requirement Changes

For Virginia Community Mental Health Rehabilitative Services

Today's Speaker



Alexandra Thorn, LCSW
National Outpatient Director

Today's agenda

1

New changes and requirements

2

Prior authorization process

3

Accessing your prior authorizations

New changes and requirements



Why we're implementing the changes

- Create a streamlined process for the providers and UHC Community Plan
- Better identify members whose treatment would benefit from a clinical review of the case

New changes and requirements



The new requirements

- Beginning August 26, 2019, UnitedHealthcare Community Plan of Virginia will begin the online prior authorization process for the following CMHR services
- Faxed authorization requests no longer be accepted
- Level of Care Guidelines: providerexpress.com > Our Network > State-Specific Provider Information > Virginia

Service	Code
Mental Health Case Management	H0023
Mental Health Peer Support	H0024/H0025
Crisis Stabilization	H2019
Crisis Intervention	H0036
Intensive Community Treatment	H0039
Day Treatment/Partial Hospitalization	H0035 HB
Therapeutic Day Treatment for Children	H0035 HA/UG/U7
Psychosocial Rehabilitation	H2017
Mental Health Skill Building	H0046
Intensive In Home	H2012

Prior authorization process

New changes and requirements




How we're implementing the changes

- Beginning August 26, 2019, providers will begin submitting new 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 > Virginia
- Authorizations will now be required for both initial and continued stay Intensive Community Treatment requests

Existing authorizations submitted through the fax process prior to the change will remain valid until the limits of that authorization have been reached.

The Virginia Page on Provider Express



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Search:

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

Home > Our Network > State-Specific Provider Information > Welcome VA

Welcome to the Optum Network!

Virginia Provider Resources

Optum Network Manual

- [Network Manual](#)



Level of Care Guidelines

- [LOC Guidelines](#)

Best Practice Guidelines

- [BP Guidelines](#)

Virginia Medicaid Provider Resources

[CCC+ Provider Orientation](#) (Dec. 2017)
[Medallion 4.0 Provider Orientation – Medical and Family Access to Medical Insurance Security](#)
[Notice Regarding Changes to the Authorization Process for Virginia Community Mental Health Rehabilitative \(CMHR\) Services](#)  
[VA UnitedHealthcare Community Plan, a CCC Plus Plan \(Manual Addendum\)](#)

[Site Audit Tools](#)

Authorization Request Form

Virginia Community Mental Health Rehabilitative Services (CMHRS) Request Form

Professionals completing this Request form should consider the following information:

- Prior authorization must be obtained for coverage of CMHRS services as required by the member's benefit plan. Applicable codes include:
 - Mental Health Skill Building – H0046
 - Mental Health Case Management – H0023
 - Mental Health Peer Supports
 - Individual – H0024
 - Group – H0025
 - Crisis Intervention – H0036
 - Crisis Stabilization – H2019
 - Intensive Community Treatment – H0039
 - Intensive In Home for Children and Adolescents – H2012
 - Day Treatment/Partial Hospitalization – Adults – H0035 HB
 - Therapeutic Day Treatment for Children
 - School Day – H0035 HA
 - After School – H0035 HAUJ
 - Summer – H0035 HAU7
 - Psychosocial Rehabilitation – H2017
- Only one of the above services can be requested per submission. If multiple CMHRS services for the same member please complete a new request for each service.
- EPSDT Behavioral Therapy (H2033) can be requested from the following site: <https://optumpeacoms.secure.force.com/ABA/treatment/>
- Authorization requests for all other services should be requested through the number on the back of the member's card.
- Authorization is contingent upon the member's eligibility, terms of the benefit plan, state regulations, Virginia Medicaid Level of Care Guidelines, and Optum policies/procedures.
- Please confirm member coverage and availability for this service prior to completing this form. If online access for coverage is not available for you please call the number on the back of the member's card.
- Only complete submissions will be considered and official request for services.

[Submit] [Cancel]

Member Information: ▶ Request Information

Member First Name <input type="text"/>	Member Last Name <input type="text"/>
Member's DOB <input type="text" value="MM/DD/YYYY"/>	Member Medicaid ID # <input type="text"/>

Provider Information:

Provider Facility/Group Name <input type="text"/>	Tax ID <input type="text"/>	
Address 1 <input type="text"/>	Address 2 <input type="text"/>	
Address City <input type="text"/>	Address State <input type="text" value="None"/>	
Address Zip <input type="text"/>	Treating Provider <input type="text"/>	
Direct Phone # of Treating Provider (if further information needed) <input type="text"/>	Phone # Extension <input type="text"/>	

License level: Available Master's Level Bachelor's Level Less than Bachelor's Level ▶ Chosen

Authorization Information:

Requested Service

Start Date Requested

Type of Request

Number of Units Requested per Month

Clinical Information:

Current Primary DSM-5 Diagnosis Code <input type="text"/>	Current Primary DSM-5 Diagnosis Description <input type="text"/>
Secondary DSM-5 Diagnosis Code <input type="text"/>	Secondary DSM-5 Diagnosis Description <input type="text"/>
Tertiary DSM-5 Diagnosis Code <input type="text"/>	Tertiary DSM-5 Diagnosis Description <input type="text"/>

When did member initially begin receiving this service?

Level of Functional Impairment

Status of Home to Self or Others

Services Being Received: Available Medication Management Services with Psychiatrist or PCP Individual and Family Therapy Day Treatment (Adult or Child) ▶ Chosen

Is Coordination of Care occurring with the above providers?

Is member making progress in best of functioning and (if goals and objectives)?

Please Upload Required Documents:

File Description	Select File
Competency Needs Assessment	Browse
Individual Service Plan	Browse
Freedom of Choice Form	Browse
All attachments in one file	Browse

Save Documents

Saved Documents

Acknowledgement

I hereby attest that all of the information above is true and accurate to the best of my knowledge.

Case Information

Attending Individual's Name (Submitter)

Attending Individual's Email Address (Submitter)

[Submit] [Cancel]

Authorization Request Form (page 1 of 3)



Virginia Community Mental Health Rehabilitative Services (CMHRS) Request Form

Professionals completing this Request form should consider the following information:

1. Prior authorization must be obtained for coverage of CMHR services as required by the member's benefit plan. Applicable codes include:
 - Mental Health Skill Building – H0046
 - Mental Health Case Management – H0023
 - Mental Health Peer Supports
 - Individual – H0024
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 - School Day – H0035 HA
 - After School – H0035 HA/UG
 - Summer – H0035 HA/U7
 - Psychosocial Rehabilitation – H2017
2. Only one of the above services can be requested per submission. If multiple CMHR services for the same member please complete a new request for each service.
3. EPSDT Behavioral Therapy (H2033) can be requested from the following site: <https://optumpeeraccess.secure.force.com/ABA/treatment/>
4. Authorization requests for all other services should be requested through the number on the back of the member's card.
5. Authorization is contingent upon the member's eligibility, terms of the benefit plan, state regulations, Virginia Medicaid Level of Care Guidelines, and Optum policies/procedures.
6. Please confirm member coverage and availability for this service prior to completing this form. If online access for coverage is not available for you please call the number on the back of the member's card.
7. Only complete submissions will be considered and official request for services.

Authorization Request Form (page 2 of 3)

Submit Cancel

Member Information:

| = Required Information

Member First Name

Member Last Name

Member's DOB [8/9/2019]

Member Medicaid ID #

Provider Information:

Provider Facility/Group Name

Tax ID

Address 1

Address 2

Address City

Address State

Address Zip

Treating Provider

Direct Phone # of Treating Provider If Further Information Needed

Phone # Extension

License level

Available	Chosen
Master's Level	
Bachelor's Level	
Less than Bachelor's Level	

Authorization Information:

Requested Service

Start Date Requested [8/9/2019]

Number of Units Requested per Month

Type of Request

Authorization Request Form (page 3 of 3)

Clinical Information:

Current Primary DSM-5 Diagnosis Code

Current Primary DSM-5 Diagnosis Description

Secondary DSM-5 Diagnosis Code

Secondary DSM-5 Diagnosis Description

Tertiary DSM-5 Diagnosis Code

Tertiary DSM-5 Diagnosis Description

When did member initially begin receiving this service? [8/9/2018]

Level of Functional Impairment

Risk of Harm to Self or Others

Other Services Being Received:

- Crisis Stabilization
- Case Management
- Residential Treatment
- None

Is Coordination of Care occurring with the above providers?

Is member making progress in level of functioning and ISP goals and objectives?

*Please Upload Required Documents:

File Description	Select File
Comprehensive Needs Assessment	<input type="text"/> <input type="button" value="Browse..."/>
Individual Service Plan	<input type="text"/> <input type="button" value="Browse..."/>
Freedom of Choice Form	<input type="text"/> <input type="button" value="Browse..."/>
All attachments in one file:	<input type="text"/> <input type="button" value="Browse..."/>

Saved Documents

Acknowledgement

*I hereby attest that all of the information above is true and accurate to the best of my knowledge.

Case Information

Attesting Individual's Name (Submitter)*

Attesting Individual's Email Address (Submitter)*



The submission process

- Complete the online request form
- Based on the information provided you will receive one of two email confirmation messages to the email address entered in the “Attesting Individual’s Email Address” field on the submission form
 - Email indicating a decision will be mailed within the next 3 to 14 calendar days
 - Email indicating a licensed Care Advocate will contact you within 1-2 business days
- If you have not received a decision by mail within 14 calendar days from the submission you can contact Provider Services at 1-877-614-0484



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, a rejection email will be sent to the Attesting Individual's Email Address field on the submission form indicating such and advising to follow the appeals process
- If services are deemed medically necessary, the member and the care provider will receive written authorization for those services
- If additional information is needed to make an authorization determination, a licensed Care Advocate will outreach the requesting provider to conduct a clinical review
- 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



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 > Our Network > State-Specific Provider Information > Virginia



Information needed for reviews

- Medical Necessity Reviews will be based on Virginia 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 potential questions

Functional Abilities Over Time				
Functional Areas	Start of Current Service	Progress (Abilities-Centric)	Goal	Intervention Plan
<ul style="list-style-type: none"> • Work/School • Social/Play • Family/Relationships • Activities of Daily Living • Medical/Physical • Other 	<ul style="list-style-type: none"> • 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? 	<ul style="list-style-type: none"> • 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? 	<ul style="list-style-type: none"> • 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 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? 	<ul style="list-style-type: none"> • What services are being utilized to meet the member's goal? • What are the specific skills/interventions being taught/implemented? • How often are service providers and Integrated Health Homes Agency coordinating the member's treatment/care plan? • How is the member engaging in meaningful activities within the community outside of the home?

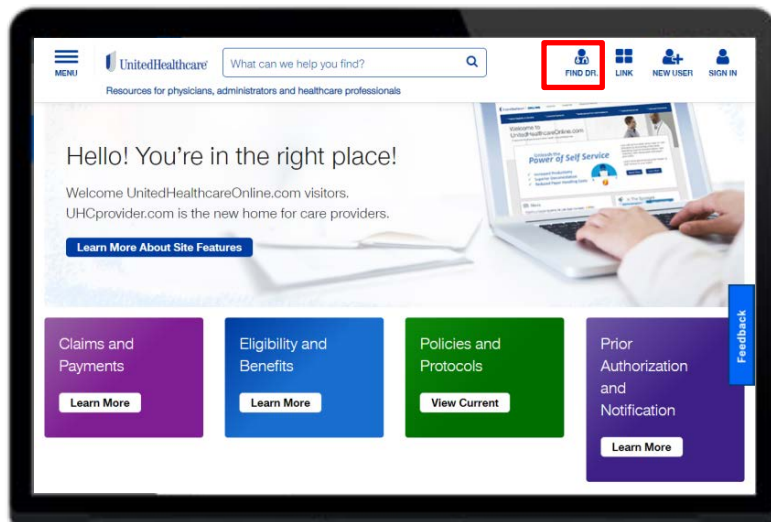


Length of process

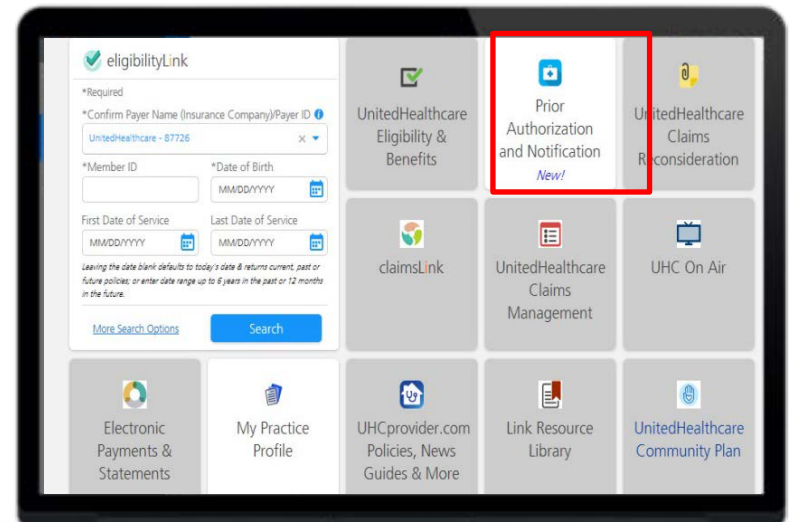
- A decision will be made within 3 - 14 calendar days of the online submission date
- Authorization specifics:
 - Start date of authorization will be the requested effective date
 - If requested service is found to not meet medical necessity, the service the member is currently receiving will be authorized for at least 10 days from date of determination
 - 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

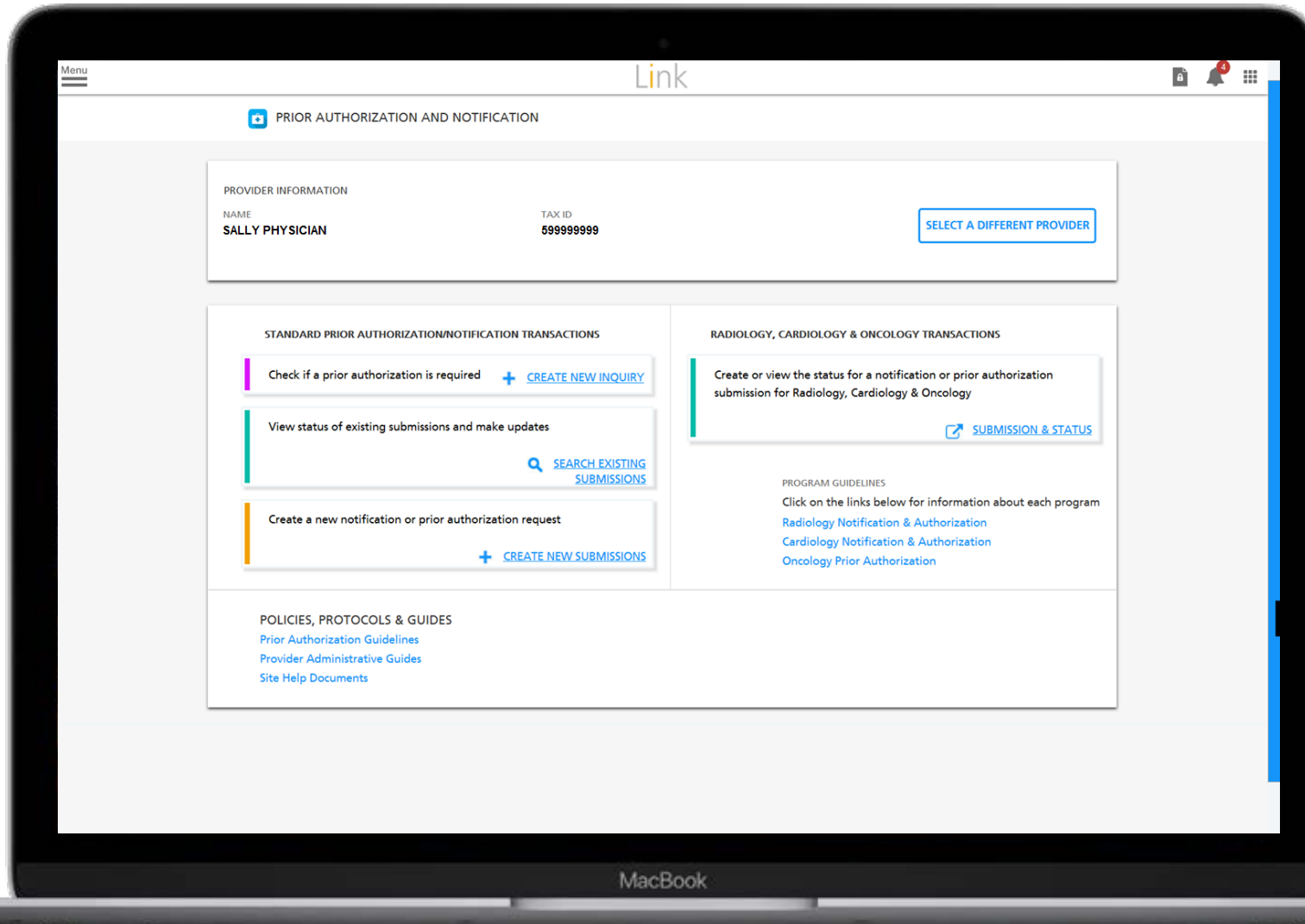


UHCprovider.com



Link dashboard

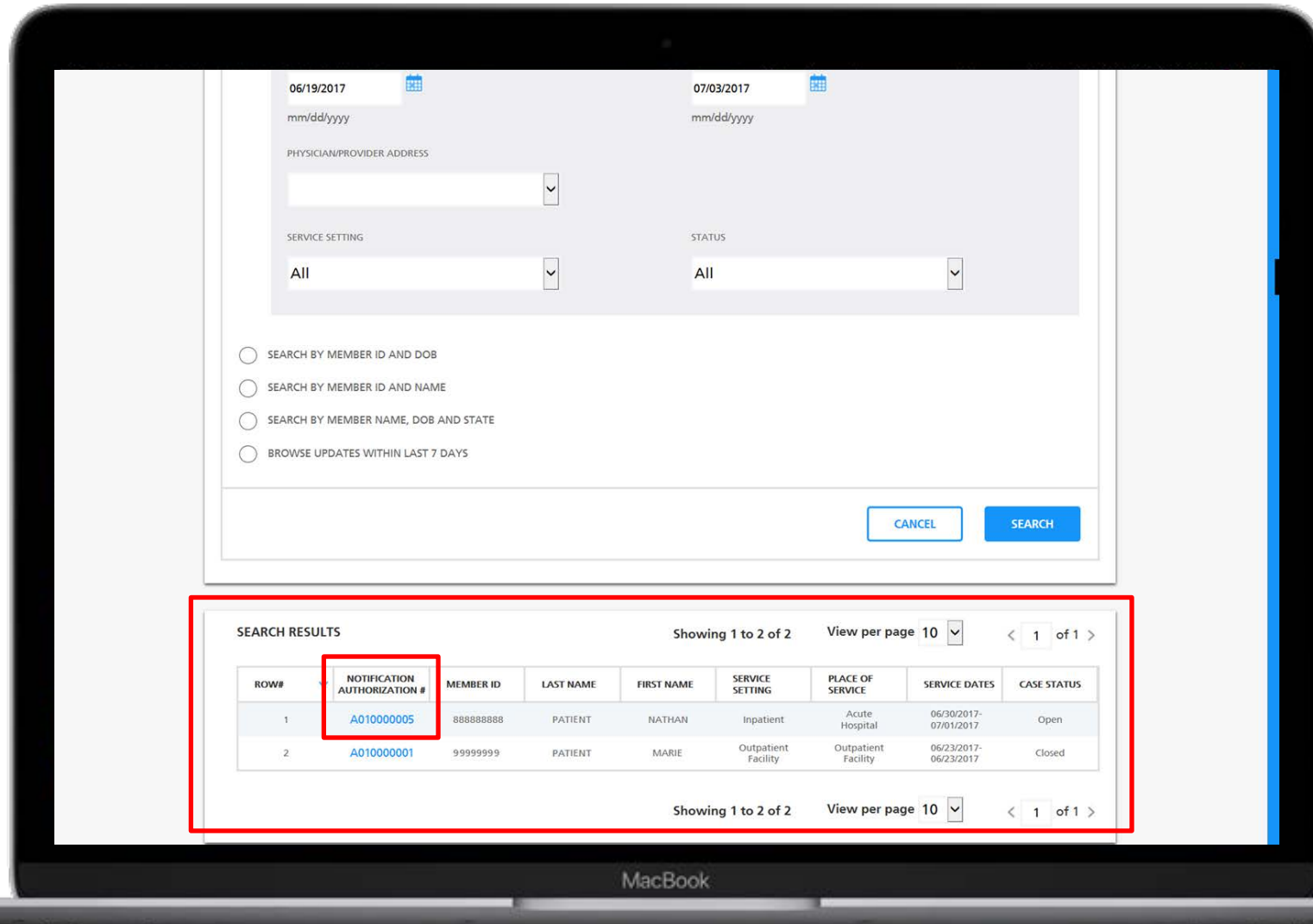
Accessing your prior authorizations



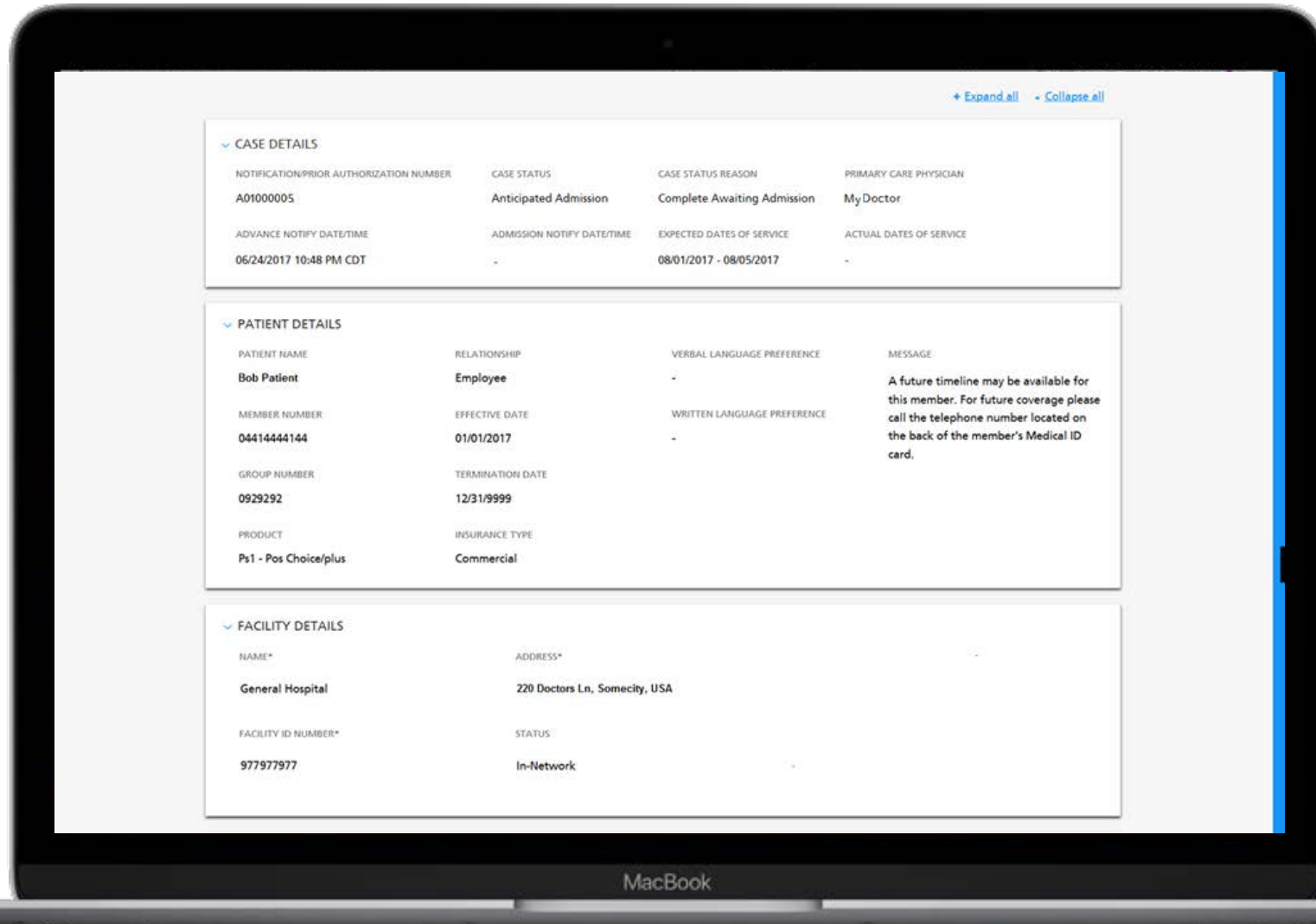
Accessing your prior authorizations

The screenshot shows a web interface on a laptop. At the top, there is a section for 'PROVIDER INFORMATION' with the following details: NAME: CHILDRENS HOSP, ADDRESS: (blank), TAX ID: 977977977. A button labeled 'SELECT A DIFFERENT PROVIDER' is located to the right of the TAX ID. Below this is a search section with a '* Required fields' label. There are four radio button options for search criteria: 'SEARCH BY NOTIFICATION/PRIOR AUTHORIZATION NUMBER', 'SEARCH BY REQUESTING PROVIDER' (which is selected), 'SEARCH BY MEMBER ID AND DOB', and 'SEARCH BY MEMBER ID AND NAME'. The 'SEARCH BY REQUESTING PROVIDER' section contains several fields: 'START DATE*' with a value of '06/19/2017' and a calendar icon; 'END DATE*' with a value of '07/03/2017' and a calendar icon; 'PHYSICIAN/PROVIDER ADDRESS' with a dropdown menu; 'SERVICE SETTING' with a dropdown menu set to 'All'; and 'STATUS' with a dropdown menu set to 'All'. At the bottom of the search section are 'CANCEL' and 'SEARCH' buttons. The laptop's 'MacBook' logo is visible at the bottom center.

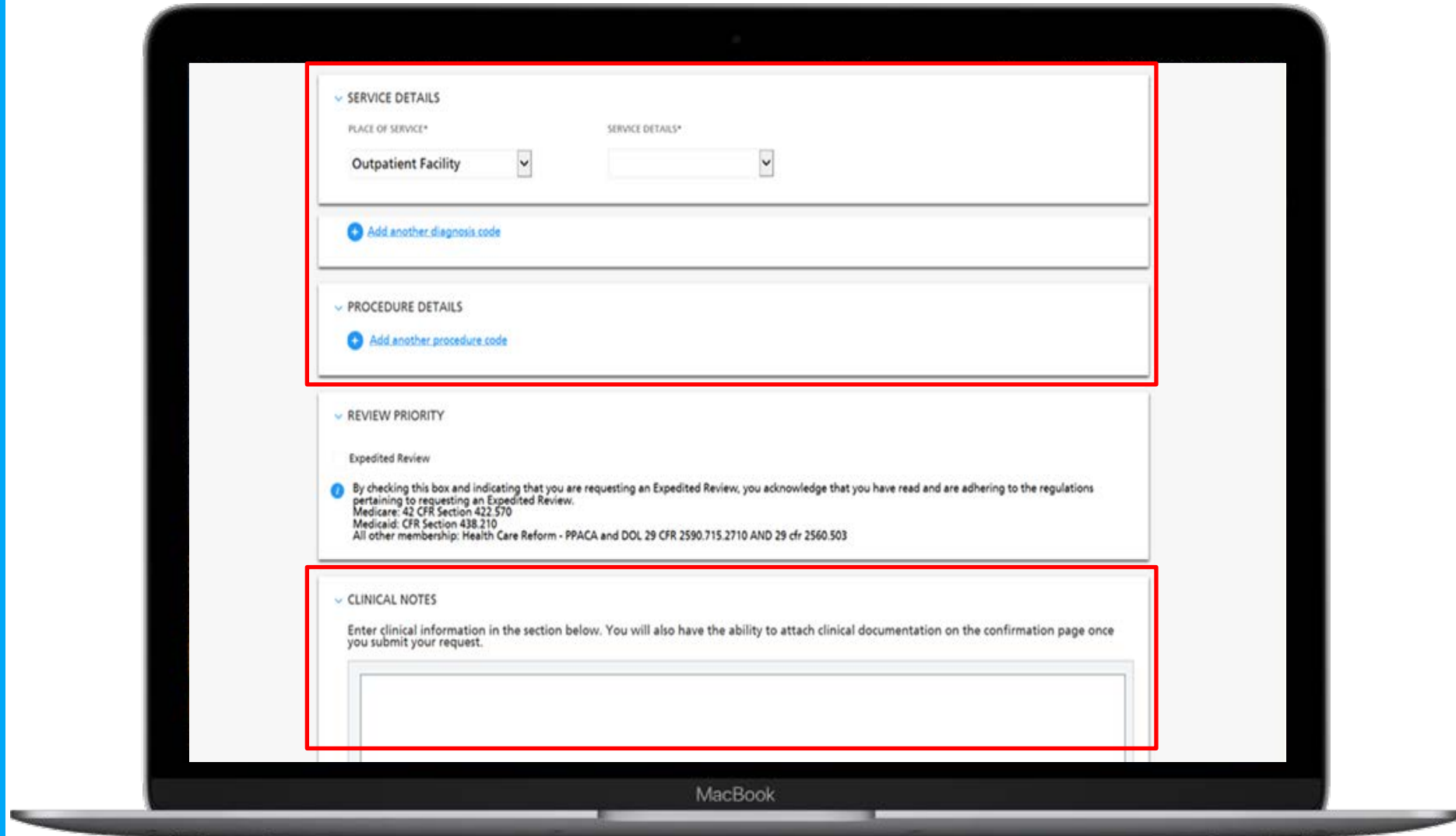
Accessing your prior authorizations



Accessing your prior authorizations



Accessing your prior authorizations





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?

Call Provider Services at 1-888-650-3462 or contact your provider advocate.