Health Plan of Nevada
A UnitedHealthcare Company

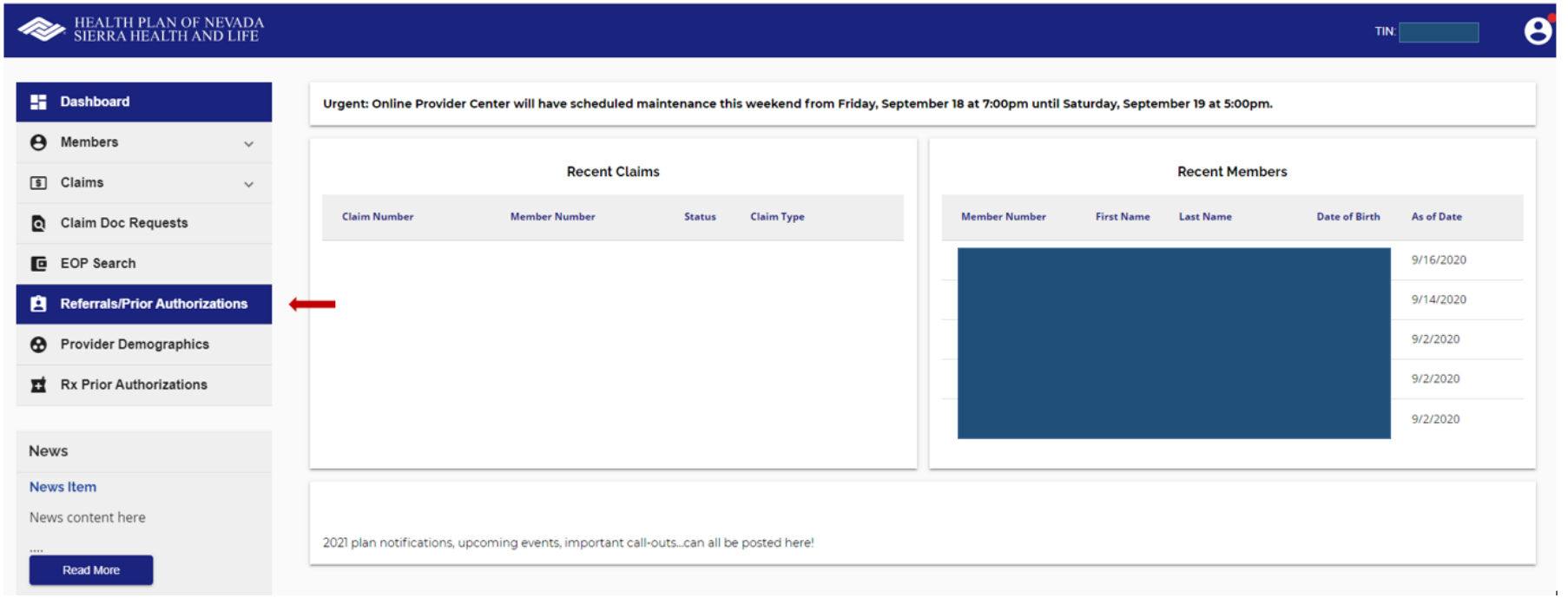
Sierra Health and Life®
A UnitedHealthcare Company

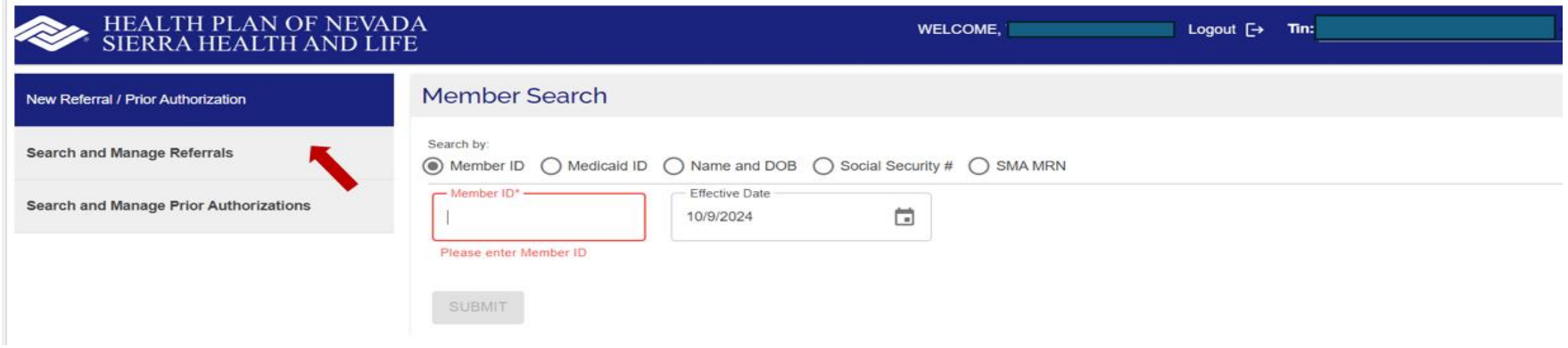
Online Provider Center Tutorial
Submitting a Prior Authorization

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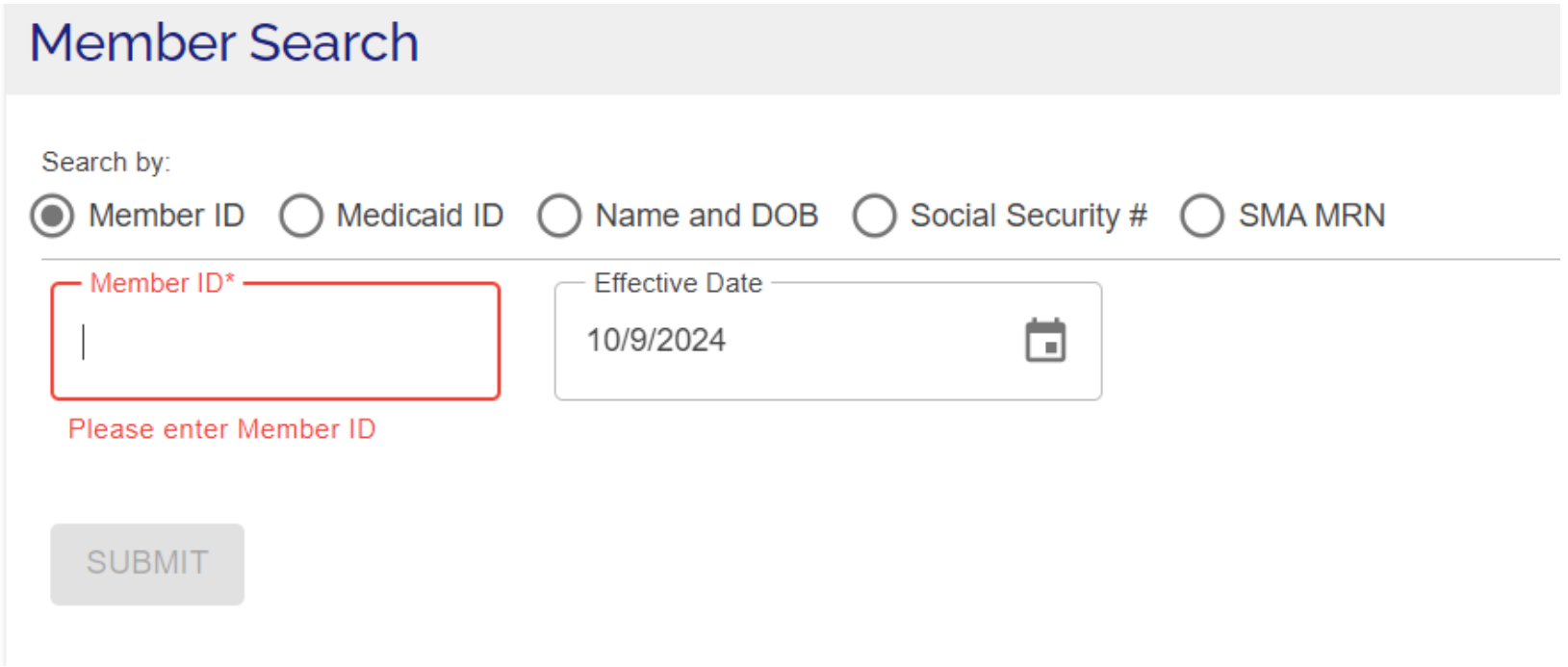
Submitting a Prior Authorization

To begin a **Prior Authorization**, select **Referral/Prior Authorization** and **New Referral/Prior Authorization**.





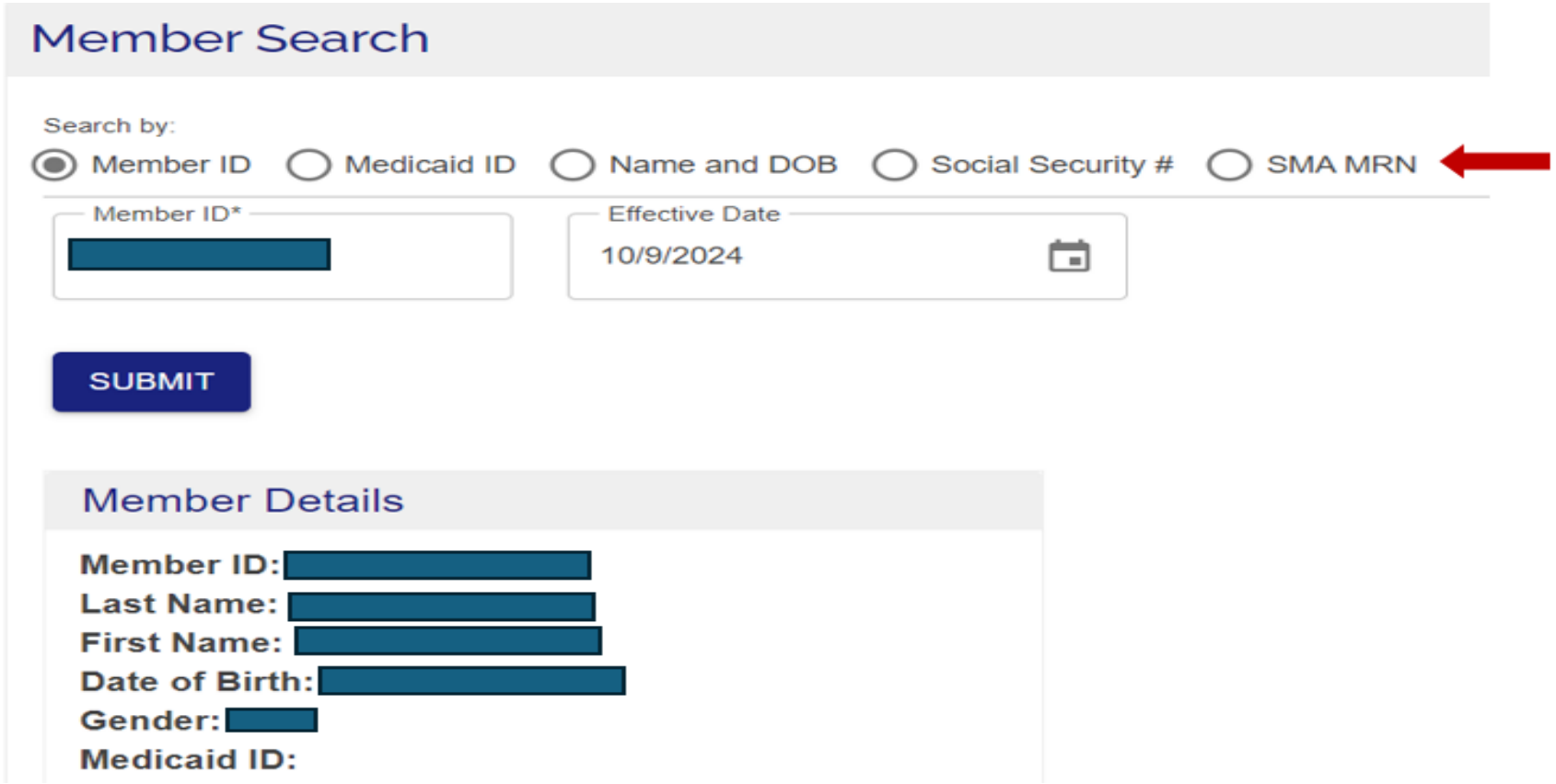
Submitting a New Prior Authorization Continued:



Enter the search criteria for the member by completing the fields that are appropriate Member ID, Medicaid ID (State assigned ID), Name and DOB, Social Security # or SMA MRN and select the **Submit** button.

Submitting a New Prior Authorization Continued:

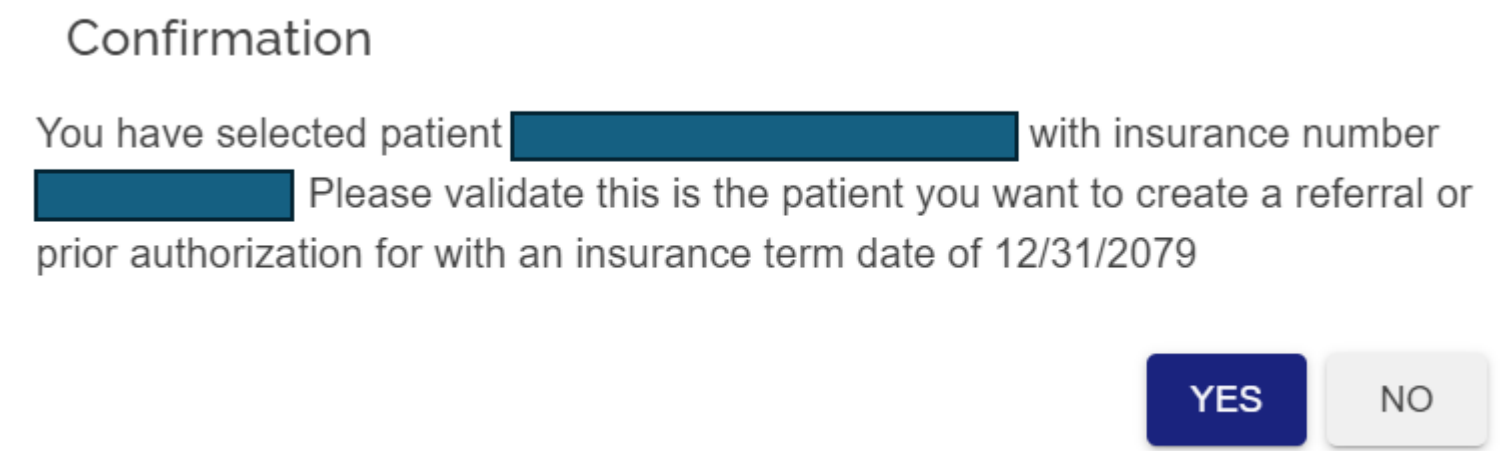
Verify the information on the screen
If the information is correct, choose **Select Member Details box**
If the information is ***not correct***, replace the search criteria & try again.



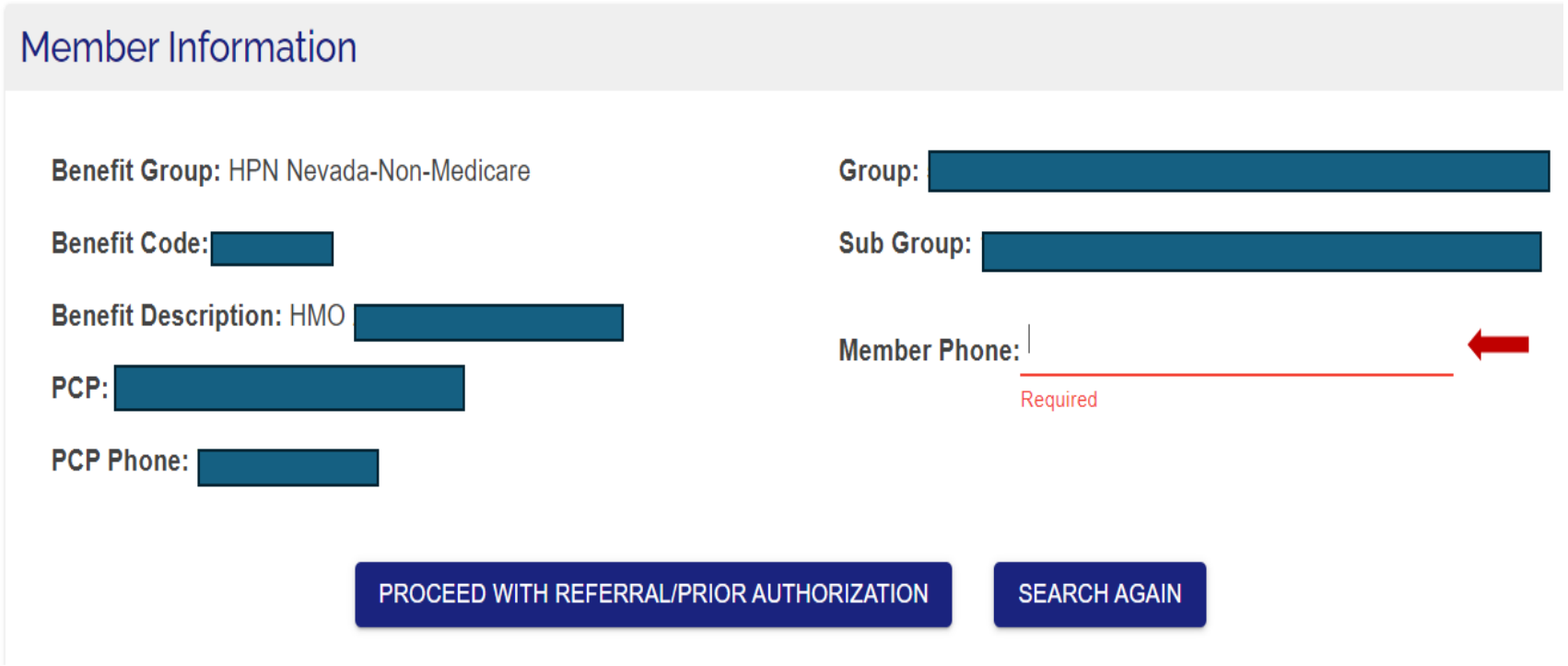
Submitting a New Prior Authorization Continued:

Our security feature allows you to confirm that this is the correct member
If the information is correct, select the **Yes** option
If the information is not correct, select the **No** option and perform another search

A term date that generates from our claims system will display & should be reviewed to decide if there is enough time for services to be provided for the Prior Auth submission. If not, the user must select **No**.



Submitting a New Prior Authorization Continued:



If the information is correct, you can now **Enter the Member's Phone Number** (to include area code) and **Proceed with Referral/Prior Authorization**

Submitting a New Prior Authorization Continued:

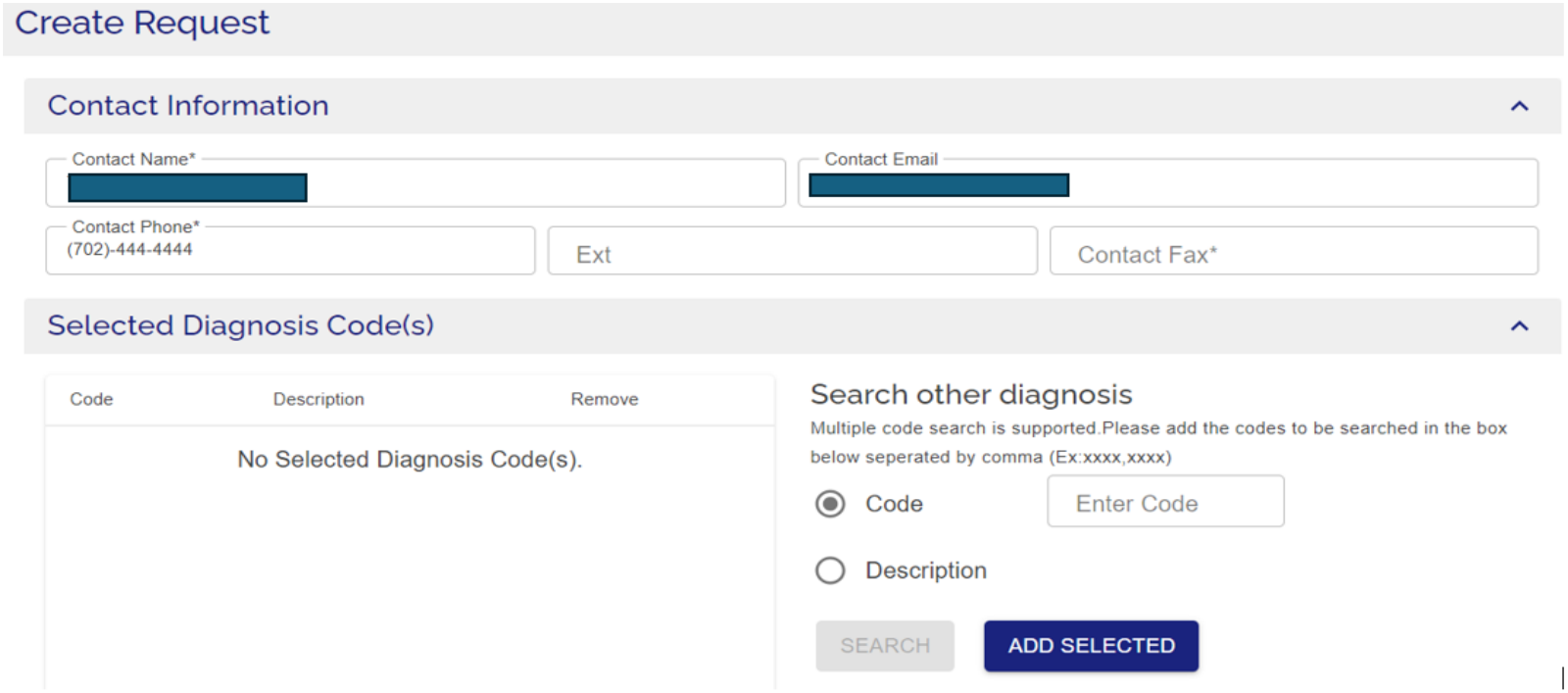
<u>Contact Information; Name, Phone, Fax, Email address (optional) and Ext (optional)</u>. These fields identify important information about the sender of the prior auth.

This section also identifies the applicable **diagnosis codes** and even though one diagnosis code is required, multiple ICD-10 codes can be added if applicable (separate ICD-10 codes by a comma which supports multiple code searches at one time).

- Enter the member's diagnosis code, select **Search** and choose **Add Selected** for the applicable codes to load on the left for processing.

or

- Enter a diagnosis description, select **Search** and choose **Add Selected** for the applicable codes to load on the left for processing.

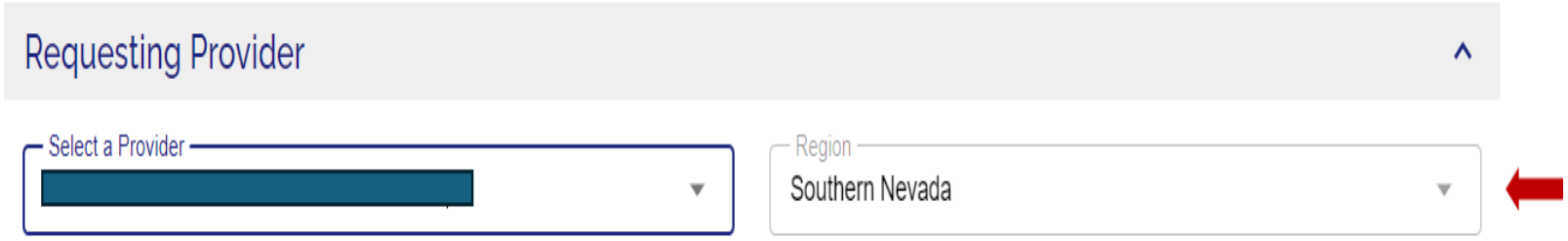


Submitting a New Prior Authorization Continued:

Requesting Provider Information

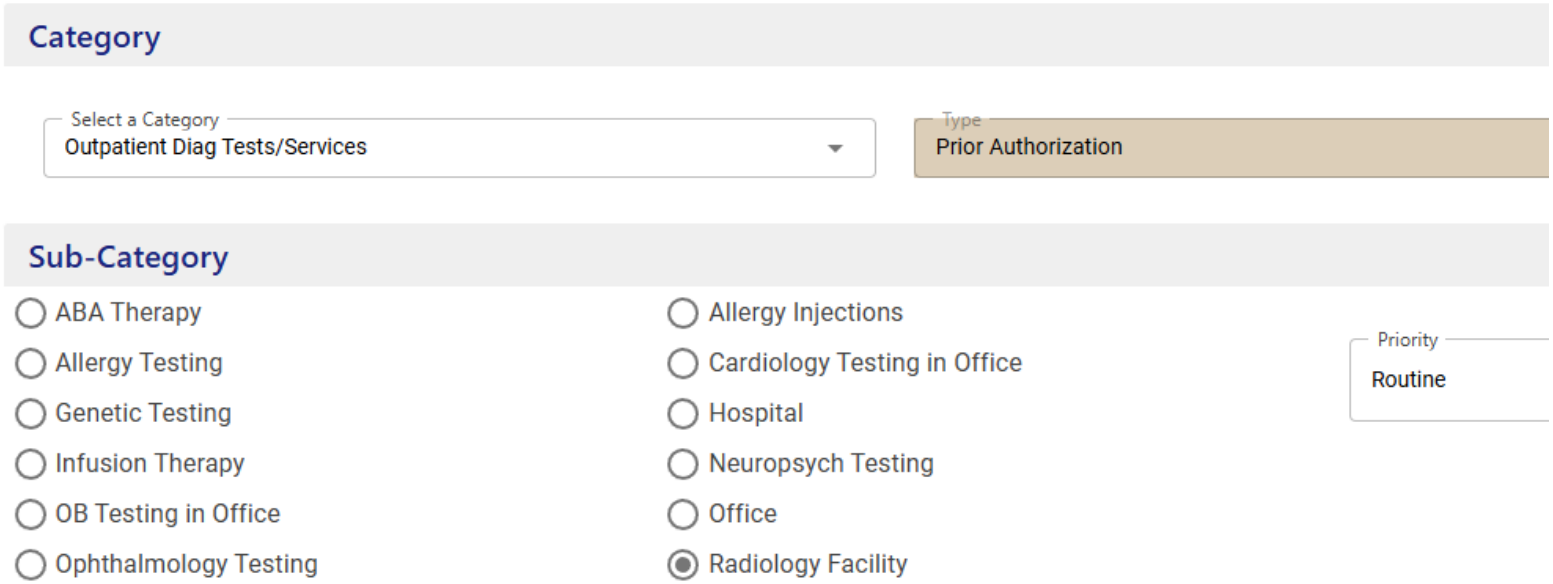
The organization submitting the request is the **Requesting Provider**. To log into the Online Provider Center, you are required to enter a username and password associated with a tax identification number (TIN). All of the providers/groups associated with the tax identification number are shown in the drop-down box area of the **Requesting Provider**.

Region - This field auto-populates based on the selected provider's contract which defines the provider's service region.



Submitting a New Prior Authorization Continued:

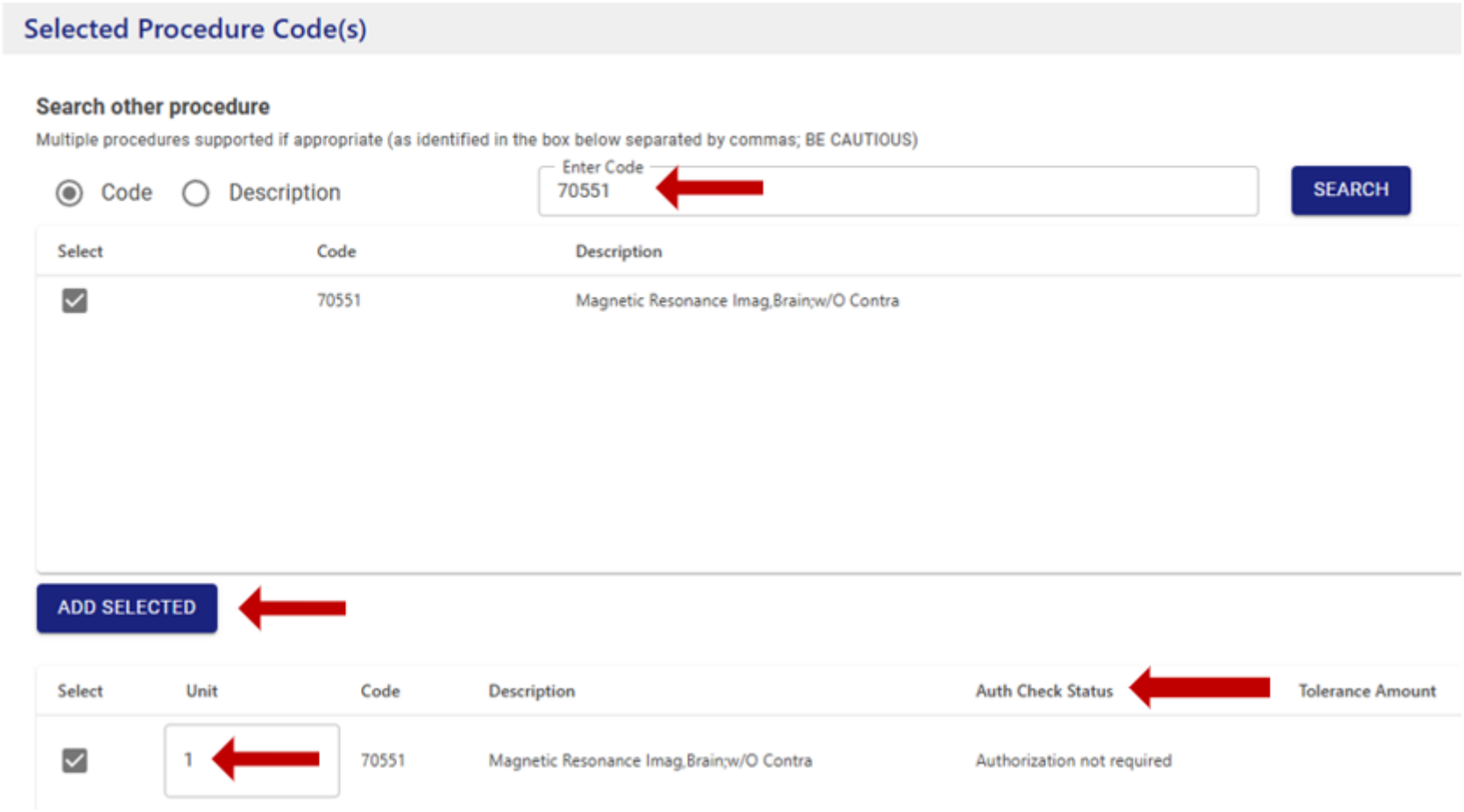
Category - This field identifies the prior authorization services being requested from the drop-down menu. The screen will refresh to show the corresponding Sub-Categories.
Sub-Category - This section allows the user to identify what types of services are requested for the prior authorization. The user must select at least one subcategory to describe the requested service. As a Sub-Category is selected, the screen will update with the appropriate questions for that Sub-Category.
Priority - This field identifies the urgency of the prior authorization.
Servicing Provider - The contracted **Servicing Provider &/or Facility** should be identified based off the insurance coverage before submitting the on-line prior authorization.
Place of Service/Facility - The **Place of Service** auto-loads if only one option is appropriate, or the user can select from the drop down. **Requested Date of Service** from the calendar is optional; if scheduled date is unknown, let the system default to the date indicated. Only future date are supported retro date entries are not allowed intentionally.
Asterisk (*) indicates required information



Submitting a New Prior Authorization Continued:

Select Procedure Code (s)

Select the appropriate **CPT code(s)** by searching with the code or description and selecting **Search**. Multiple CPT codes can be entered at once by placing a comma (,) between the codes. The user must check the box next to the code(s) that apply and choose **Add Selected**. If **Add Selected** is missed the code(s) will not load correctly. Adjust **Units** as required for request.



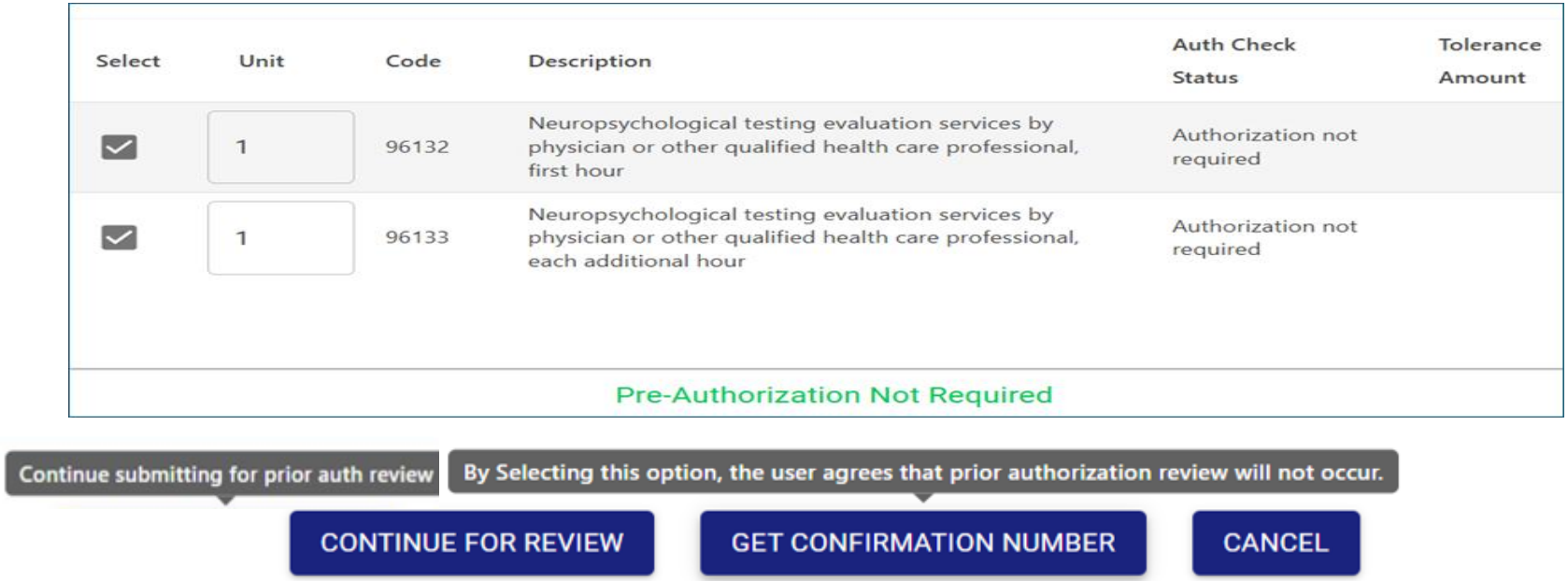
Submitting a New Prior Authorization Continued:

A new feature has been added to the Online Provider Center (OPC) which displays the prior authorization requirement for both Medical and Behavioral Health services. The new feature identifies whether prior authorization is required for the code based on the provider contract, place of service, requested services and other elements inherent to claims payment. During the submission process, the user will receive a view of the prior authorization requirements for each of the codes submitted on a case. The response will fall into these categories.

Prior Authorization Required
Prior Authorization Required $1500 Tolerance
No Prior Authorization Required
Non-Covered Service Code

The screen will then provide the user with three options.
The first option is *Continue for Review*, the second is *Get Confirmation Number*, and last is *Cancel* the request.

Example Response



Submitting a New Prior Authorization Continued:

If *Get Confirmation Number* is selected the user will not be presented with any follow up questions and the case will create a reference number that begins with the letter, “C”. The system will create a case with the entered elements, similar to all other cases that are submitted. The case will automatically flow to a voided status. If it was submitted as a Confirmation in error, the user builds a new case. The confirmation case will not be adjusted to a pending status nor be reviewed by the UM team.

Of note, the *Get Confirmation Number* feature will be turned on for all submission requests, so even if the user sees a message on the code that says, “Prior Authorization Required” if the option, “*Get Confirmation Number*” is selected, the case will be cancelled and will not be reviewed by the prior authorization department. No claims are processed against a cancelled case. **Any services that require prior authorization may result in a denied claim if the *Get Confirmation Number* is selected and a claim is subsequently submitted.

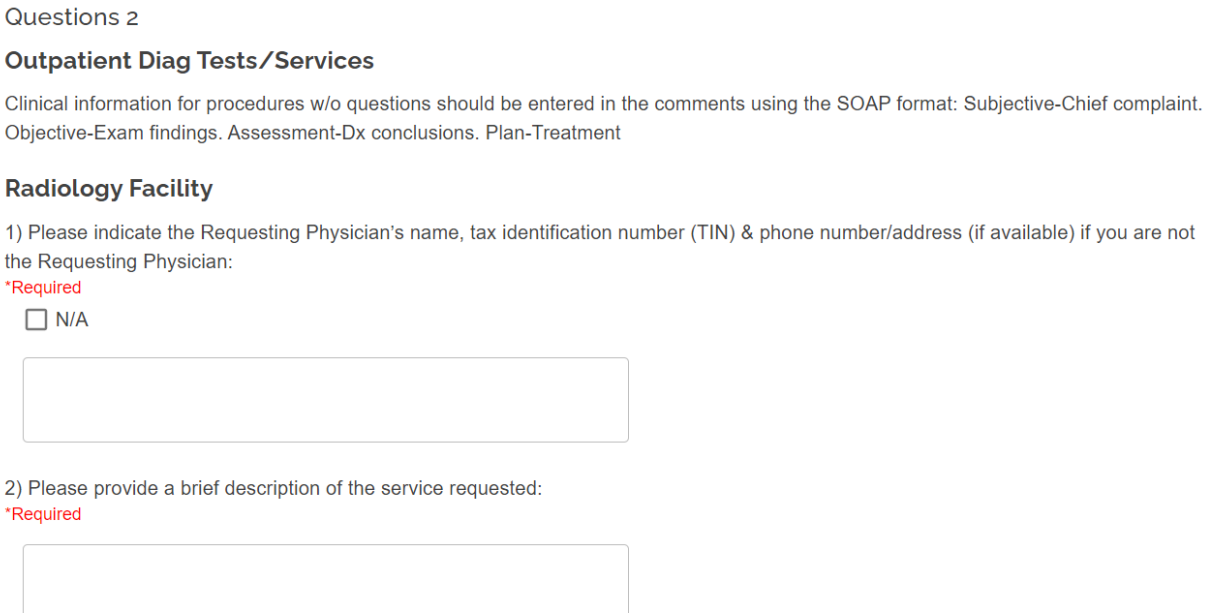
Every submission will require the user to acknowledge a disclaimer prior to completing the submission process. This is true for all submission types.

Disclaimer:
All prior authorization services must be completed within the authorization's approved time frame. Approval of a prior authorization is based solely on a determination of medical necessity and does not guarantee payment. Payment for all services is subject to verification of eligibility and benefits, including, but not limited to:
Benefits available under the member's plan
- Applicable contractual limitations
- Policy restrictions and exclusions
- Compliance with applicable managed care programs
- Any material misrepresentation or omission in the policy application.

A historical record will be retained of the response the user received during the submission process. This can be viewed in the Print Confirmation option or when reviewing the case later in the Search and Manage Prior Authorizations section.

Submitting a New Prior Authorization Continued:

Questionnaire


Questions 2

Outpatient Diag Tests/Services

Clinical information for procedures w/o questions should be entered in the comments using the SOAP format: Subjective-Chief complaint. Objective-Exam findings. Assessment-Dx conclusions. Plan-Treatment

Radiology Facility

1) Please indicate the Requesting Physician's name, tax identification number (TIN) & phone number/address (if available) if you are not the Requesting Physician:

*Required

☐ N/A

2) Please provide a brief description of the service requested:

*Required

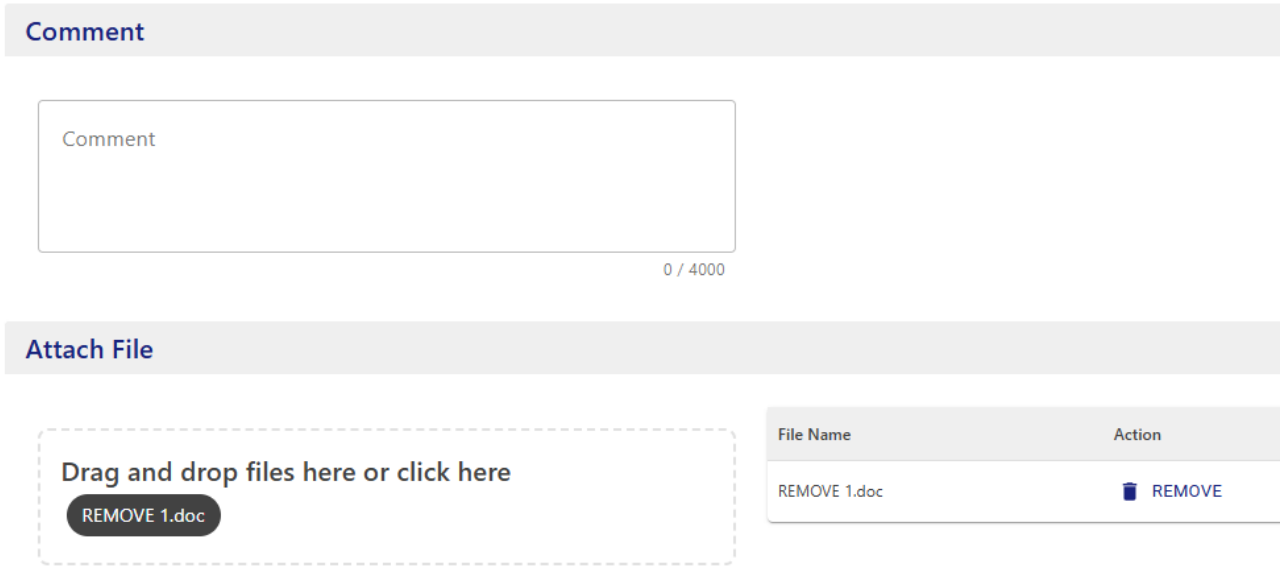
The questionnaire is a series of questions that are related to the Category and Sub-Category selected. All questions are indicated as *Required which must be answered or the user will notice a red message that appears to show which questions are unanswered.

Submitting a New Prior Authorization Continued:

Comments

The **Comment** field provides a place to enter information that needs to be communicated but does not have a specific repository. Users may choose to provide physician notes, test results, or other information from various sources. Users can copy and paste the information from any application that allows copy and paste. This is typically a word processor, such as MS Word or others. Users cannot paste graphics in the comments, but users can paste text. *Entering comments is optional.

Attach File > Electronic Medical Record Drag and drop files here or click here (*optional)

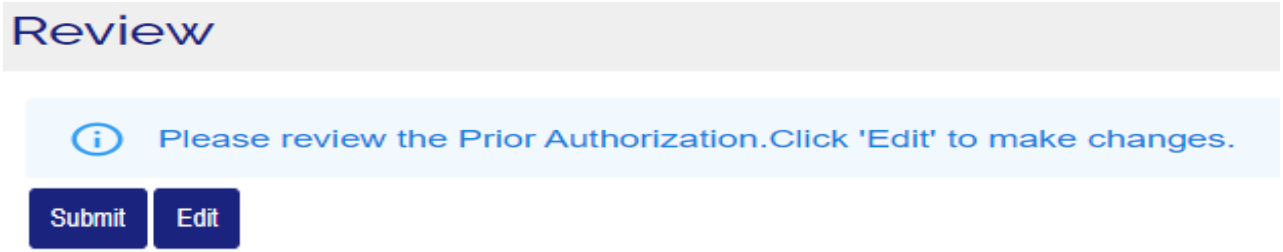


This screen will allow the user to attach ***compatible*** pertinent (electronic) patient file(s) by selecting **Drag & drop files here or click here.** If the incorrect file is loaded the **Action** of **Remove** is available. User must work with their internal technical teams to identify if the electronic medical records system is compatible with the Online Provider Center. Please include the most recent progress note and any pertinent imaging or lab results.

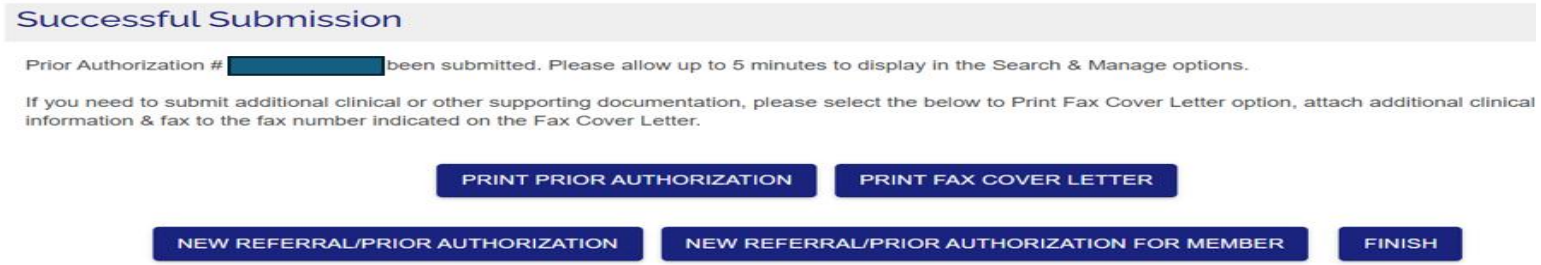
*The attachment of files is optional, if no files to attach select **Review**.

Submitting a New Prior Authorization (end)

This feature allows you to **Submit** and/or **Edit** the data you entered.
If no corrections are necessary, the user can **Submit** the prior authorization.
-OR-
If the data is incorrect, selecting **Edit** will allow the user to make the appropriate correction. Once the correction is made, select **Review** at the bottom of the page again and the user can now submit the prior authorization by choosing **Submit**.



Prior Auth or Confirmation ID #



The user now has 6 options to select from:

- Print a copy of the Prior Authorization, by selecting **Print Prior Authorization.**
- **Print Fax Cover Letter** when additional medical records are required and could not be attached during the submission.
- Begin a new Prior Authorization for a ***new member***, by selecting **New Referral/Prior Authorization**
- Continue and create a new Prior Authorization ***for the same member***, by selecting **New Referral/Prior Authorization for Member**
- Select on **Finish** to return to the main menu
- Take our Satisfaction Survey