Behavioral Health FAQs

Authorizations & Notifications

Q: What clinical documentation does UCare expect with behavioral health prior authorization and concurrent review request?

A: UCare uses InterQual, a decision support tool, to determine medical necessity or appropriateness for many behavioral health services. Depending on the member’s product, we may also use the MN Department of Human Services (DHS) coverage criteria, Medicare National Coverage Determination (NCD), National Government Services (NGS) Local Coverage Determination (LCD). Below are examples of clinical documentation that help the behavioral health utilization review nurse, clinician, and medical director make a determination:

- A diagnostic assessment completed within the last 12 months with an Individual Treatment Plan (ITP).
- A functional assessment completed within the last 12 months (required for ARMHS, Day Treatment, DBT, and IRTS).
- Progress notes that document symptoms, functioning level and how the service is supporting the member goals and updated treatment plan.
- Civil commitment order (signed and dated) and diagnostic assessment or chemical dependency assessment to determine commitment. No other clinical documents required.
- The discharge summary from inpatient and residential level of care is requested to support transition management.
- Outpatient or residential chemical dependency treatment: full Rule 25 assessment, Rule 25 summary or comprehensive chemical dependency assessment. Must have member specific and / or collateral information.
- Inpatient hospital chemical dependency treatment: CD assessment and history & physical (if available).
- Concurrent chemical dependency outpatient, inpatient and residential: progress notes that document symptoms, functioning level and how the service is supporting the member goals and updated treatment plan.
- Concurrent inpatient mental health admission reviews: history & physical, previous 24-48 hours of practitioner, nurse, and social worker progress notes. Include discharge plan and medication administration record.
- Concurrent crisis residential reviews: intake assessment, progress notes, stabilization plan, discharge or transition plan, documentation of continued symptoms and explanation to support the need for additional days in crisis residential.

Q: How long does UCare authorize behavioral health services that require a prior authorization?

A: The length of an authorization is based on several factors: type of service, member’s condition, treatment plan, accepted community standards of care, and criteria used to make the determination.
Q: What timespan (start to end date) will UCare Behavioral Health enter for services that require a notification?

A: Below are the services and timespan:

- Outpatient chemical dependency: Six months. Notification will end early if the member begins another service that cannot be provided concurrently with outpatient chemical dependency treatment.
- Crisis residential: Ten days. The provider must fax in a concurrent review request and clinical information for additional days.
- Intensive Residential Treatment Services (IRTS): 30 days. The provider must fax in a concurrent review request and clinical information for additional days.
- Inpatient mental health admission: Five days. The provider must fax in a concurrent review request and clinical information for additional days.
- Behavioral health home: Six months (S0280-U5 only).
- Partial hospitalization: Three months. The provider must fax in a concurrent review request and clinical information for additional days.

Q: Will UCare Behavioral Health accept an authorization from DHS or another health plan?

A: We will honor authorizations from a previous payer for covered services. The authorization must still be valid when the member enrolls with UCare. The provider must fax UCare a copy of the authorization approved by DHS, the County, or previous health plan to our prior authorization fax 612-884-2033 or 1-855-260-9710. There is a different process for chemical dependency assessments and treatment after transition. Chemical dependency outpatient (with the exception of medication assisted treatment) and residential providers must always submit the most recent Rule 25 summary, progress notes and information on the member’s current level of care and previous payer approval.

Q: If a behavioral health service is not on the prior authorization grid(s), does that mean the service is not covered?

A: No. Services on the prior authorization grid(s) have been selected after review of claim data, industry trends, and risk analysis. These are not the only options available to our members. To determine if a service is covered, the provider should contact the UCare Provider Assistance Center.

Q: Can I request a review to be completed urgently or expedited?

A: UCare Behavioral Health has regulated turnaround times for expedited, standard, and retrospective reviews. Only request an expedited review if waiting the standard review timeframe (up to 14 days) would potentially jeopardize the member’s health, life, or ability to regain function. Requests related to services already rendered or paid are not urgent or expedited.

Q: I need to have an authorization adjusted, what should I do?

A: For tracking and compliance, if the adjustment is not related to a denied claim(s), we request all authorization adjustment requests to be faxed to the behavioral health prior authorization fax 612-884-2033 or 1-855-260-9710. You can use the standard prior authorization form or a fax coversheet. Please indicate the authorization number, what you would like adjusted, and the reason the adjustment is needed. Provide a call back number in case we have questions. Faxing the requests allows UCare to track adjustment requests and respond to you within a timely manner. Adjustment requests related to a denied claim(s) must follow the provider adjustment request process. See the UCare Provider Manual for details on Claim Adjustments.
Q: I received a notice of denial or termination of services, what should I do?

A: If the member or member’s responsible party disagrees with the denial or termination of services, an appeal should be filed. Directions on how to file an appeal are provided in the letter you and the member received. The Behavioral Health team does not handle appeals. Follow the directions in the letter to file a timely appeal. If your denial was related to lack of information and you now have the additional information required, please submit a new prior authorization request.

Q: Why does UCare have different threshold, authorization, and notification requirements than the MN Department of Human Services (DHS) and Medicare (CMS)?

A: UCare determines threshold, prior authorization, and notification requirements based on an independent analysis of our population, claim data, and industry trends. We are required to administer the behavioral health benefit set established by DHS, CMS, and the Affordable Care Act for the Healthcare Exchange. Threshold, authorization, and notification requirements may differ but the benefits available to our members are the same as fee for service (FFS).

Q: UCare is requesting additional information by a specific date and time. Why do I have a deadline to send in additional information?

A: UCare is required to complete expedited reviews within 72 hours, standard reviews within 14 days, and retrospective reviews within 30 days. If we do not have enough clinical information to make a determination, we must make several attempts to obtain the additional information. This must be done within the timeframes listed above. We cannot extend these timeframes. If the provider does not respond to our request for additional information by the time and date requested, it is likely an adverse determination will be made. To prevent this, please respond to our request for additional information by the date and time requested.

Q: I am requesting an authorization for psychotherapy, but not sure which code I will submit a claim for. What should I request on the authorization form?

A: We understand that the member’s treatment plan may change or amount of time needed for therapy may change. Please submit your authorization request with the total number of sessions to be provided, the timespan requested, and all codes that may be provided. As an example, if you provide individual psychotherapy, it is reasonable to request an authorization for 90832, 90834, and 90837. Claims should only be submitted for services provided.

Q: I submitted an authorization request and the Provider Portal has zero units approved and one date of service, what does this mean?

A: UCare Behavioral Health has received your request and is still in the process of making a determination. Once the review process is completed, you will receive notification via phone or fax. The member will also receive a letter via US mail. The Provider Portal will update with the authorization information after the review is completed.

Q: If a client has primary insurance should I still seek an authorization from UCare?

A: This answer depends on what type of coverage the member has with their primary insurance and the member’s coverage with UCare. In general, when a member has a commercial insurance plan, Medicare and Medical Assistance are the payer of last resort. Due to commercial insurance benefit limitations, it is always a good idea to obtain an authorization from UCare and continue to the concurrent review process for services that require a concurrent review. If the member’s commercial insurance has approved the service, you are not required to follow our authorization, notification, or concurrent review requirements. We request a copy of the discharge summary on all members for transition management.

If the member has Medicare Fee for Service (FFS) or is with another health plan, and the service you are providing is covered by Medicare, no authorization or concurrent review is required by UCare.
Q: UCare approved services at my facility and the client has been admitted to the hospital, what should I do?

A: If the member is not in your facility at midnight, they are considered as discharged. You must notify UCare. If the member returns to your facility, you must inform UCare of the readmission following the same process used for the previous admission.

Q: What is the difference between an authorization and notification?

A: A notification is to inform UCare of a service before a claim is submitted. The notification is used by our care coordinators and utilization management team. When a service requires a notification, the provider is required to have on file documentation to support the medical necessity of the service. An authorization is a review for medical necessity. UCare reviews the documentation submitted and determines if the member has the benefit, if the service is within the provider’s scope and credentials, and medical necessity has been established.

Services

Q: Does UCare cover Intensive Outpatient Programs (IOPs)?

A: IOPs is a category, not a specific service. Below are the programs that are often categorized as IOPs. UCare follows the hours per day listed to determine what type of program the member is enrolled in. The CPT or HCPC assigned to each program are subject to change. Always refer to our authorization grids to determine if an authorization or notification is required and the correct coding to use based on product. *Not all members have a benefit for these programs*

Children’s Day Treatment (H2012)
At least 1 day per week and 2 hours per day. Max of 3 hours per day and 15 hours per week.
At least 1 hour of psychotherapy, no more than 2 hours.

Adult Day Treatment (H2012)
At least 3 hours per day and max of 15 hours per week.
At least 1 hour of group psychotherapy, max of 2 hours.

Dialectical Behavior Therapy Skills Group Training (H2019)
Minimum of 2 hours weekly (up to 2.5 hours)

Partial Hospitalization Program (H0035) (G0129) (G0176-G0177) (G0410-G0411)
Under 18 years of age minimum of 4-5 hours per day
18 years and older 5-6 hours per day
Minimum of 20 hours in a 7 calendar day period

Q: Does UCare cover chemical dependency treatment for UCare’s Medicare products?

A: Yes. Providers and place of service requirements must meet Medicare coverage and coding requirements. Providers should review National Government Services Psychiatry and Psychological Services NCD L33632, MLN Matters Number SE1604, and MLN Matters Number SE0441.
Q: Does UCare cover Children’s Therapeutic Services and Supports (CTSS)?

A: Yes. UCare follows DHS’ benefits, member eligibility, and provider requirements for CTSS. Providers must be approved by DHS to provide CTSS. Please refer to our authorization grid for thresholds and authorization requirements.

Q: I am not a Medicare provider. Can I provide behavioral health services to members on UCare’s Medicare products?

A: Mental health professionals/practitioners that are Medicare ineligible may provide services authorized by the state in which they are licensed but may *not* bill UCare directly for their services. Services provided by these mental health professionals must be “incident to” a Medicare Provider of Service (Medical Doctor, Advanced Practice Nurse, Physician Assistant, Clinical Psychologist, or Clinical Social Worker). Incident to services must be part of the Medicare Provider of Service treatment or plan of care and under direct supervision. *If a provider has opted out of Medicare, they cannot provide services or submit claims for members on UCare’s Medicare products.*

The following provider types are Medicare ineligible: master level Psychologist (with the exception of performing and billing diagnostic psychological testing), Licensed Professional Clinical Counselor (LPCC), Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), Licensed Alcohol and Drug Counselors (LADC).

**Contracting & Payment**

Q: I am not a contracted UCare provider and currently providing services to a UCare member, what should I do?

A: UCare encourages our members to seek care from in-network providers. We understand this is not always possible. Out of network providers should always contact UCare Provider Assistance Center about authorization requirements, claim submission, and becoming a contracted UCare provider. UCare Provider Assistance Center can be reached at 612-676-3300 or 1-888-531-1493.

Q: How do I prevent payment of an incorrect rate on chemical dependency residential treatment claims?

A: UCare using the DHS Rate Reform Grid to determine the payment rate for chemical dependency services. Although not required on a facility claim type, it is recommended that you include the modifier(s) along with the HCPC or REV code to assist in determining the complexity and correct rate.

Q: My licensure/credentials have changed and I am not due for re-credentialing, what should I do?

A: It is important that UCare has accurate information about your licensure and credentials. Please contact UCare Provider Assistance Center 612-676-3300 or 1-888-531-1493.