March 11, 2016

Behavioral Health Retro Authorization Process After a Claim Has Been Denied for No Authorization on File

A June 2015 UCare Provider Bulletin outlined changes to mental health and chemical dependency forms. As part of our ongoing efforts to improve the timeliness and accuracy of payment, UCare is further clarifying the retro authorization process for behavioral health providers.

Effective April 15, 2016, UCare will only accept the adjustment/recoupment request form for retro authorization requests. The adjustment/recoupment request form must be used when providers are seeking to receive payment on services that have already been rendered and billed to UCare and were denied by UCare for no notification and/or authorization being on file.

If a claim is denied because a notification or authorization was not obtained prior to services being rendered or the number of available units were insufficient, providers will be required to follow the claim adjustment process. The adjustment/recoupment request form must be submitted along with clinical information to support the medical necessity of the provided services. All information should be faxed to the number on the form.

The goal of requiring the standard adjustment/recoupment request form is to streamline the review and processing of these claims for providers and UCare. Requests submitted on the claim adjustment/recoupment form are reviewed by UCare's Behavioral Health clinicians and Claims department in one request. These requests are typically completed within 30 days. The current retro authorization process requires multiple steps between UCare and the provider. The new process and form will allow UCare to more quickly review and re-process denied claims so providers can receive more timely payments.

Important reminders:

- Authorization requests for services listed on UCare's Mental Health & Chemical Dependency Authorization and Notification grids should be submitted 14 days prior to the start of the service for non-urgent conditions.
- Services that are ongoing (concurrent) should continue to follow the prior authorization process.
- Requests for authorization or notification of services that have been rendered but not yet billed to UCare should be submitted on UCare's standard authorization form. Please include all dates of service provided. UCare continues to have a 30-day turnaround time for retro authorization requests that have *not* had a denied claim.
- In order to determine medical necessity for prior authorization, retro authorization or claim adjustments, clinical information is required. The clinical information submitted must support the medical necessity of the service requested/provided.
- Providers will *not* receive an authorization or denial letter when the claim adjustment is approved or denied. The only communication from UCare to the provider will be the Explanation of Payment (EOP).
- For more information on UCare's claim submission and adjustment process, please review Chapter 6 of UCare's Provider Manual.
- To check the status of an adjustment request, please call UCare's Provider Assistance Center at 612-676-3300 or 1-888-531-1493 toll free.