OPTUM Care® | Network of Connecticut

OptumCare Network of Connecticut
Prior authorization, referral information and FAQs

Updated February 2019

Prior authorizations and referrals for OCNCT UnitedHealthcare Medicare Advantage members

For Medicare Advantage members who are managed through OptumCare Network of Connecticut (OCNCT), the Independent Physician Association (IPA) will follow the UnitedHealthcare (UHC) and Anthem prior authorization policies.[1] This is for members who have an OCNCT PCP and have one of the following plans and/or group numbers on their cards.

Plan Name	PBP Plan#	Group#
UHC Medicare Complete Plan 1	030	27151
UHC Medicare Complete Plan 2	031	27153
UHC Medicare Complete Plan 3	033	27100 or 27150
UHC Medicare Complete Essential	032	27155 or 27156

Plan Name	PBP Plan#
Anthem MediBlue Plus	CT H5854-007-000
Anthem MediBlue Dual	CT H5858-008-000
Anthem MediBlue Plus	CT H5854-009-000
Anthem MediBlue Select	CT H5854-010-000

Key points

Referrals are not required by plans; however, OCNCT still requires that contracted partners enter referrals for utilization management and administration purposes.

- Prior authorizations and referrals should be done prior to scheduling the appointment.
- All clinical referrals should have prior authorization, such as the following:
  - o Specialists[2]
  - o Rx injectable only
  - o Outpatient services
    - ▪ Skilled nursing facility
    - ▪ Home health
    - ▪ Dialysis
    - ▪ Infusion
  - o Inpatient services
  - o Durable medical equipment
  - o Physical health
    - ▪ Physical therapy
    - ▪ Speech therapy
    - ▪ Occupational therapy
  - o Chiropractic services
- UHC/Anthem will manage the prior authorization for Part D drugs.
- An active order for a referral is good for one initial consult and three follow-up visits in a 90-day period.
- The specialist or PCP can order subsequent visits, if clinically necessary.
- If the PCP requires more visits, a new referral must be entered for these. OR, if the PCP wants the referral to be extended beyond 90 days, a new order must be entered.
- All prior authorizations/referrals must have the necessary clinical information.

You can process prior authorizations and referrals either online or by fax. *For clinically urgent (life-threatening) referrals/prior authorizations you may also call.*

NAMMNet Express (NE) is available through the OptumCare provider gateway: **https://www.optumcare-mso.com/logon/LogonPoint/custom.html.**[3] This will take you to the NE application.

1-855-268-2904. Prior authorization fax forms are available on the provider resources website: **https://professionals.optumcare.com/resources-clinicians.html.**

1-888-556-7048. Prompt #3 for *clinically urgent (life-threatening) referrals only.*

Please note: Prior authorization/referral responses will be returned to providers via the method they were submitted; for example, if faxed, a fax will be sent back for referral authorization.

Hours of operation

Provider help line, 1-888-556-7048

- Press "1" for UnitedHealthcare members
- Press "2" for Anthem BlueCross BlueShield members
  - Press "1" for claims information
  - Press "2" for existing prior authorization information
  - Press "3" for new prior authorization information
- Monday through Saturday 8 a.m.–4 p.m. EST
- Sunday and after daytime hours: voicemail

Member help line, 1-888-832-0963

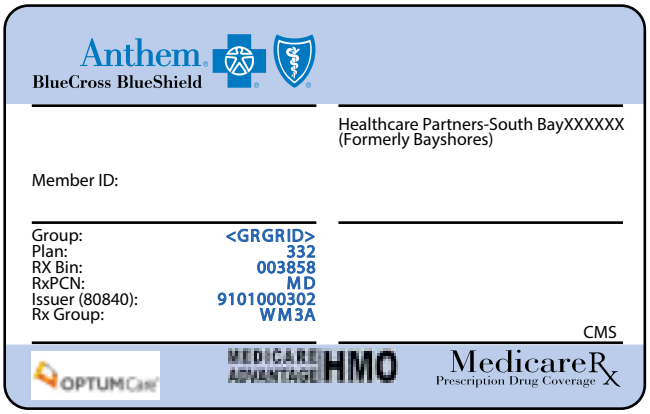
- Hours of operation: Monday through Saturday, 8 a.m.–4 p.m. EST
- Sunday and after daytime hours: voicemail

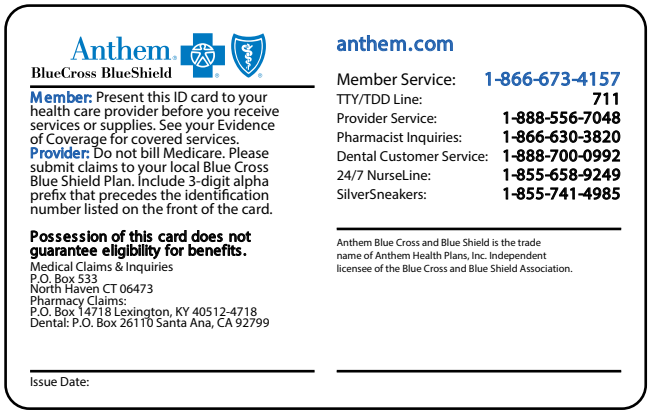
Frequently asked questions

Do the ID cards for these members reflect the new plan?

Below are images of the UHC plan card. UHC patients with an OCNCT PCP will have one of the following group numbers on their card: 27151, 27153, 27100, 27150, 27155, 27156.

Below are images of the Anthem plan card.





What are the UHC and Anthem Medicare Advantage plan prior authorization requirements that OCNCT is following?

Please access the following links to learn more about the UHC MA prior authorization requirements that OCNCT's utilization management team is following:

- **UnitedHealthcare Medicare prior authorization requirements effective January 1, 2019**
- **UnitedHealthcare Cardiology**
- **UnitedHealthcare Radiology**
- **Anthem Medicare Advantage 2019 Precertification Requirements**

Does the referral order need to be linked to a problem?

Yes, the order must be linked to a specific problem, not health maintenance.

Does the patient need to be seen within a year before the referral order can be entered?

Yes. The patient must be seen by the PCP within a year for that problem before a referral can be entered.

How long does a referral for a UHC Medicare Advantage plan take to approve?

Routine: A routine referral in the gated plan can take up to 14 days to approve.

Urgent: Use ONLY if the order is a medically necessary STAT (life-threatening) referral where the patient needs to be seen within 24 hours, or an ASAP referral where the patient needs to be seen within three days. Please call **1-888-556-7048.**

How long are referrals active?

An active referral is good for one initial consult with three follow-up visits within a 90-day period.

Ideally, specialists should order/prior authorize subsequent visits, if clinically necessary. If the PCP requires more visits, a new order must be submitted for these. OR, if the PCP wants the referral to extend beyond 90 days, a new order must be entered.

Physical therapy initial consult referral requests are good for one initial visit.

If you are a PCP, make sure that you put in an office visit/consult code and not procedure codes for specialist referrals.

If a specialist office calls and doesn't understand the plan requirements, please have them call the provider help line at **1-888-556-7048.**

I am a specialist, can I prior authorize tests or procedures that I may need to perform during a patient visit, ahead of the patient's appointment?

Yes, you may request tests or procedures prior to the patient's appointment and submit the necessary clinical documentation, which will be reviewed by our utilization management team.

If an urgent clinical need arises during a consult, you may request an urgent prior authorization through NAMMNet Express or via phone.

May I back-date a referral or prior authorization?

No, an authorization needs to be obtained and approved prior to the patient being seen by the specialist/facility. Claims will be denied if an authorization is not obtained.

What happens if a service is not covered by the plan?

You will be notified if the service is not covered.

How are prior authorizations for state-mandated preventive care screenings handled?

Screenings such as mammograms, colonoscopies and other state-mandated preventative care screenings are auto-approved. But you are still required to enter a referral to determine if the member is being referred to a network provider or facility.

What if a patient isn't in group number 27151, 27153, 27100, 27150, 27155 or 27156, or is in another UnitedHealthcare MA plan?

For all other UnitedHealthcare Medicare Advantage plans, the practice should follow all of their regular processes and applications for UnitedHealthcare. Contact your provider advocate if you need assistance.

The UHC Self-Service Tool can be accessed at **uhcprovider.com.**

What if the patient doesn't have an OptumCare logo on their Anthem card?

For all other Anthem plans, the practice should follow the regular Anthem process.

[1] For all other UnitedHealthcare product plans, please refer to your current policy and procedures for preauthorization. Please refer to appropriate phone numbers and/or websites to submit preauthorizations.
[2] Refer to **optumcare.com/state/ct.html** for a directory of eligible specialists.
[3] To request access to the provider gateway, contact the OCNCT Network Coordinator at brittany.reshotnik@optum.com.