United Healthcare

Mental Health Parity and Addiction Equity Act Disclosure
Prior Authorization Frequently Asked Questions

This document includes standard responses to questions related to Mental Health Parity (MHP) and Non-Quantitative Treatment Limitations (NQTL). This communication is not intended, nor should it be treated, as legal advice. Federal and state laws and regulations are subject to change. The content provided is for informational purposes only and is not medical advice. Decisions about medical care should be made by the doctor and patient. Please note, your plan documents govern all benefit determinations and in the case of conflict with this document your plan controls. Always refer to your Plan documents for specific benefit coverage and limitations or call the toll-free member phone number on the ID card.

The following explanations apply to both medical/surgical benefits and mental health/substance use disorder benefits unless stated otherwise.

What is prior authorization?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Prior authorization is when your Plan reviews services before you receive them to decide if they are medically necessary (See Medical Necessity FAQ for more information about what is medically necessary). Your Plan reviews the type of care, the need for that care, and the place of care.	

Why does my Plan do prior authorization?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Your Plan uses prior authorization to: • Monitor and prevent potential over-use or under-use of services • Manage high-cost and lengthy services • Decide the appropriate level of care • Decide whether the service meets medical necessity criteria • Your Plan can help with decisions about discharge planning from the hospital and/or ongoing management of your condition	

How do I get prior authorization?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Usually, your provider needs to get prior authorization before you get a service. You and your provider should talk about treatment and what your plan covers before you get a service. If we find that a service isn't covered by your Plan, you can decide if you still want to get it and pay for it yourself. If your provider is not in our network, ask them if you need to get permission or if they will do it.	

How does your provider ask for prior authorization?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Your provider can ask for prior authorization electronically or by phone using the phone number on your insurance card. This information is in your Plan documents.	

Who decides whether prior authorization is approved?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
When your provider asks for prior authorization, your Plan will check the request using medical rules and guidelines. They, we will decide if the service is covered. If we decide the service is not needed and will not be covered, we will tell you and your doctor. You will also get information about how to appeal the decision.	

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What are the qualifications of the staff who make prior authorization decisions?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Clinical, non-clinical, and administrative staff may participate in the prior authorization process. All clinical reviews are made by clinical staff (i.e., nurses, physicians, etc.). All denials are made by Medical Directors.	Clinical, non-clinical, and administrative staff may participate in the prior authorization process All clinical reviews are made by clinical staff (i.e., physicians, psychologists, nurses, licensed master's level behavioral health clinicians, etc.) All inpatient denials are made by Medical Directors. All outpatient denials are made by Medical Directors or psychologists

What information and guidelines are used to make a prior authorization decision?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Your Plan makes decisions about ongoing care using clear, fact-based medical rules known as clinical guidelines and criteria.	

What is Step Therapy and how does it affect prior authorization?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Step Therapy is when a plan requires you to first try the least invasive, most cost-effective treatment for a given condition before moving on to more invasive or more costly treatments.	
Step Therapy may be required before your health plan provides prior authorization for certain treatments or surgeries. Please see the Pharmacy FAQ for information on Pharmacy Step Therapy.	Step Therapy is not required for mental health/substance use disorder services. Please see the Pharmacy FAQ for information on Pharmacy Step Therapy.

When will my Plan respond to a prior authorization request?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
Your plan will respond to requests as soon as possible and follow timeframe rules requirements set by state and federal laws.	

What factors and sources are used to decide if prior authorization is required?

Medical/Surgical Benefits	Mental Health / Substance Use Disorder Benefits
When deciding what services need prior authorization, your Plan uses the following factors, sources of information, and evidentiary standards: Clinical appropriateness. This means services that medical experts say are right based on clear, fact-based rules and well-known guidelines. These are clinical rules from trusted sources like InterQual and ASAM or fact-based medical policies. Value. This means that the cost of the service is higher than the cost of checking to see if the service needs authorization. Your plan uses its own national data to make this calculation. Variation. This applies to outpatient services only. Variability means there is a large difference in the cost of the service among providers. Your plan uses its own national data to make this calculation. Low Value. This means that the service results in at least a minimum savings of $50 per service. Your plan uses its own national data to make this calculation. Consistency. This means that the service is approved more than 95% of the time. Your plan uses its own national data to make this calculation. Low Volume. This means that we receive fewer than 100 authorizations per year. Your plan uses its own national data to make this calculation. Experimental, investigational, or unproven services. This means that services that are experimental or unproven. Your Plan uses clinical policies to determine this. Patient Safety. This means services that are more likely to cause harm to patients. Your Plan uses the professional judgement of medical experts and clinical rules from trusted sources.	

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Level of Care. This means that we may review services to ensure they are being done at the best place. Your plan uses clinical policies and internal data to determine this.

High-Cost Drugs and Services. This means medicines and services that are more than $100,000 per patient per year. Your plan uses its own national data to make this calculation.

When the Plan performs a prior authorization, does the Plan treat mental health/substance use disorder differently than medical/surgical "as written" and "in operation?"

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
No. Your Plan found that the rules and steps used to decide if certain mental health/substance use disorder services need prior authorization are comparable to those used for medical or surgical services "as written" and "in operation." The process to review a prior authorization request is not stricter for mental health or substance use services.	

How does the Plan audit itself?

Medical/Surgical Benefits	Mental Health/Substance Use Disorder Benefits
Your Plan conducts internal audits that look at all parts of the process for making clinical decisions, from when the case is opened to when it is closed. We review the information from cases to make sure the rules are followed and that the right decisions were made.	

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