Frequently Asked Questions

Behavioral Health Utilization Management

1. **How do I know if prior authorization is required for a service?**
   Meridian offers a convenient Prior Auth Check Tool for each health plan. Select the plan and follow the prompts to determine PA requirements.

   Prior Auth Check Tools:

   - Ambetter
   - Medicaid
   - Wellcare Meridian Dual Align (HMO-DSNP)
   - Wellcare
   - YouthCare

2. **How do I request prior authorization?**
   Visit our Service Authorization Program page for details on submitting a PA request via our secure provider portals or by fax.

3. **What should I do if I receive an error message when trying to submit a PA request through provider portals?**
   For Availity Portal issues, contact Availity Client Services at 1-800-282-4548 (800-AVAILITY). Providers experiencing technical issues may submit PA requests via fax. Find faxable forms for inpatient and outpatient authorization requests on our Manuals, Forms, and Resources page.

4. **How long does it take to receive a determination for my authorization request?**
   The turnaround time for an authorization is based on the review type for the request, as listed below.

Review Type	Decision Time Frame	Web/Fax/Phone Notification	Written Notification (Adverse Determinations)
Non-Urgent Pre-Service Review: Standard	Within 5 days of receipt of the request	Within 5 days of receipt of the request	Within 5 days of receipt of the request
Urgent Pre-Service Review: Expedited	Within 48 hours of receipt of the request	Within 48 hours of receipt of the request	Within 48 hours of receipt of the request
Urgent/Concurrent Review	Within 72 hours of receipt of the request	Within 72 hours of receipt of the request	Within 72 hours of receipt of the request
Retrospective Review	Within 30 days of receipt of the provider's request (N/A for members) *Meridian only reviews certain service types for Retrospective Review*	Within 30 days of receipt of the request	Within 30 days of receipt of the request

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5. **What is the process for peer-to-peer review determinations?**
   Meridian may verbally notify a provider of its decision during or after the peer-to-peer review and will issue to the submitting provider within 24 hours of the date and time of the peer-to-peer review a written decision by facsimile, provider portal, or via a web-based secure function.

6. **If a provider is still awaiting the determination notification for the previous review request, can a concurrent clinical review request for the next review be submitted on the same authorization?**
   Providers must await the determination notification from the last authorization request before requesting additional days for the same treatment stay/authorization.

7. **What is the process if a member is not meeting medical necessity criteria?**
   The Meridian BH Utilization Management (UM) peer-to-peer process steps:
   - Meridian UM will complete the medical necessity review based on clinical information received from the provider.
   - If the UM reviewer determines that medical necessity is *not* met, the UM will send the authorization to a Medical Director for an advisor notes review. The UM department will notify the provider of the outcome of the notes review.
     - If the notes review results in an adverse determination, the provider may pursue their appeal rights as outlined in the denial letter faxed by Meridian. Appeal rights include requesting a post-determination peer-to-peer and/or pursuing a post-service appeal.
     - If the notes review results in an adverse determination, the provider may elect to complete a post-determination peer-to-peer.
       - The provider may call the number on the denial letter to request and schedule a post-determination peer-to-peer.
       - If the provider elects to complete a post-determination peer-to-peer, Meridian will notify the provider of the outcome following the discussion. If the outcome is an upheld adverse determination, the provider may pursue appeal rights as outlined in the denial letter.

8. **What are Administrative Days and how do we request them?**
   Once the facility receives notification that medical necessity criteria are no longer met for continued stay at the facility, and a denial is issued, the provider may request Administrative Days. Administrative Days provide reimbursement, at a reduced rate, when a member is no longer meeting medical necessity criteria for the current level of care and there are barriers to discharge that prevent the member from stepping down to a lower level of care (such as unavailability of beds or unique medical circumstances).

   Request Administrative Days by faxing supporting documentation to the appropriate number listed below. Label your submission "**Administrative Days Request**."
   - **Meridian Medicaid Plan** - BH Fax: 833-544-1827
   - **YouthCare** - BH Fax: 833-387-3173

   Please note that if a provider is approved for Administrative Days, they waive their appeal rights and may not appeal the medical necessity denial. Navigate to the Service Authorization web page for additional details about Administrative Days procedures and criteria.