Optum

Quick Reference Guide

Authorization required for Arizona Medicaid IOP services – billing codes S9480 and 0015

Overview

Beginning June 15, 2026, authorization is required before you deliver Intensive Outpatient (IOP) services to adult members covered by either Arizona's Medicaid Program or Arizona Health Care Cost Containment System (AHCCCS) for the following treatments:

- Mental health (Billing code: S9480)
- Substance use disorder (Billing code: H0015)
- IOP service billing codes that align with industry standards for IOP services and are deemed appropriate by Arizona's AHCCCS

How to submit your prior authorization request

For these IOP services, you must submit your authorization request online via the UnitedHealthcare Provider Portal. Do **not** submit through Optum's Provider Express secure portal, as this will result in delays and denials. You may also request authorization by phone.

When to submit requests

- Submit a prior authorization request for dates of service **on or after June 15, 2026**
- **Do not** submit a prior authorization request for dates of service **before June 15, 2026:** Members currently enrolled in an IOP program will automatically be authorized to complete their treatment.

Where to submit authorizations

1. **Online: Submit through the UnitedHealthcare Provider Portal**
   - Go to **UHCprovider.com** and click Sign In at the top-right corner
   - Enter your One Healthcare ID. You use the same One Healthcare ID to access both the Provider Express secure portal **and** the UnitedHealthcare Provider Portal.
     - Don't have a One Healthcare ID? Visit UHCprovider.com/access to get started.
   - From the left-hand tabs, select **Prior Authorizations & Notifications.** Then, click "Create a new request."
   - Select the appropriate prior authorization type from the dropdown
   - Enter the required information and click Continue

   For help submitting prior authorizations, view the Quick Start Guide**.**

2. **Phone:** To submit via phone, please call the number on the back of the member's ID card

Key details about limited prior authorizations

- Prior authorization will be implemented on a trial basis for a minimum of 6 months. After that, we'll conduct ongoing reviews as needed to determine if authorization is needed and to ensure medical necessity criteria are met.
- Limited authorizations will have varying units and end dates to stagger the need for a concurrent prior authorization
- Please note the end date/approved units of the limited authorization. You'll need to submit a new prior authorization ahead of time, based on which ends first (units or date).
- If you don't submit a prior authorization request, or if the request is denied, any services provided on or after June 15, 2026 are not eligible for reimbursement

What to submit with prior authorization requests

- **Treating physician's notes:** Include recommended level of care
- **Recommended treatment frequency:** List expected days/week and hours/day
- **Medication information:** Include Medications for Opioid Use Disorder (MOUD) and Medications for Alcohol Use Disorder (MAUD)
- **Initial clinical assessment:** Include substance use or behavioral health condition symptoms and functional impairments necessary for that level of care
- **Service plan goals:** Include documentation of current progress toward goals
- **Discharge/step down plan:** Include projected discharge date, and post-discharge treatment needs and services

How we make prior authorization/coverage decisions

For more information, please review the following:

- Optum Behavioral Health Clinical Criteria and Guidelines, which includes, among other things, details on the following adult services:
  - Level of Care Utilization System (LOCUS) for adult mental health services
  - American Society of Addiction Management (ASAM) for adult Substance Use Disorder (SUD) services.

Questions?

Please email us at: arizona_bh_pr@optum.com.

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