Optum | UnitedHealthcare Community Plan

Behavioral Provider Training

United Healthcare Community Plan Medicaid

June xx, 2022

Our United Culture

Our mission is to help people live healthier lives
Our role is to make health care work for everyone

Integrity.	Honor commitments Never compromise ethics
Compassion.	Walk in the shoes of people we serve and those with whom we work
Relationships.	Build trust through collaboration
Innovation.	Invent the future, learn from the past
Performance.	Demonstrate excellence in everything we do

Introduction to Optum

United Behavioral Health (UBH) was officially formed on February 2, 1997, via the merger of U.S. Behavioral Health, Inc. (USBH) and United Behavioral Systems, Inc. (UBS).

United Behavioral Health, operating under the brand Optum, is a wholly owned subsidiary of UnitedHealth Group. Optum is a health services business. You will see both UBH and Optum in our communications to you.

Optum was contracted with UnitedHealthcare Community Plan to administer the behavioral health portion of the Missouri HealthNet program beginning on May 1st, 2017. This includes both mental health and substance use disorders. (**and foster care if awarded**)

Behavioral Health Services

Covered Behavioral Services*

*list not inclusive of all services: refer to fee schedule for all covered OP services. Refer to contract payment appendix for all covered facility services.

Facility Services:

- Psychiatric hospitalization
- SA detox
- IOP
- PHP
- Crisis Observation
- PRTF

Outpatient Services:

- Medication management
- Outpatient therapy (individual, family, group)
- Initial diagnostic interviews
- Child-parent psychotherapy
- Electroconvulsive therapy
- Telemental health
- Crisis Services/intervention
- 90837/extended OP
- TMS
- HBAI

Access to Care – Standards

Routine Outpatient	Members shall be seen by an appropriate provider within 30 calendar days of the request for an appointment
Urgent (defined as: If not addressed in a timely way could escalate to an emergency.)	Shall be seen within 24 hours
Life Threatening Emergencies (defined as: imminent risk of harm or death to self or others due to a medical or psychiatric condition)	Referral within one hour generally and within two hours in designated rural areas
Post Inpatient Discharge	All Members must be seen within 7 days post discharge If you are unable to see the Member during this time – refer to another in-network provider to satisfy this deadline

Authorization

Non- emergent situations	Emergent situations
Prior authorization can be obtained by a member, family member, or a provider. When calling UHC, be prepared to provide demographic information, codes billed, and a brief description of the presenting problem. UHC will explain the services available under their benefit plan.	• Conditions that warrant an emergency admission are situations in which there is a clear and immediate risk to the safety of the member or another person as a direct result of mental illness or substance abuse. • Contact UHC for prior authorization of admission as soon as member is safe. Demographic information, full clinical detail, and facility identifying information/level of care will be required

Authorization Phone Number: 866-815-5334

Outpatient codes that require authorization

*Always verify authorization requirements prior to rendering services

Description	Code
TMS	90867
TMS	90868
TMS	90869
ALCOHOL AND/OR DRUG SERVICES	H0019
REHABILITATION PROGRAM per Half Day	H2001

Prior Authorization Process

Request via Phone	Request via Portal
• Provider calls **866-815-5334 (daytime) or 844-295-2411 (evenings/weekends)** • Provider selects the Mental Health/Substance use option • Provider services representative confirms eligibility/benefit questions • Call is transferred to Behavioral Health Care Advocate to complete the prior authorization	• Provider logs in to Home (providerexpress.com) • Provider follows the steps for ReviewOnline, but is directed to STAR once training is completed • Provider enters authorization request on the portal and receives the STAR SYSTEM Authorization (SSA) if the clinical in with in the expected range for the clinical cohort • If any information is outside of the expected range, then the Facility reviewer is vectored to a Care Advocate for a clinical conversation via the Chat functionality in the STAR platform • Behavioral Health Care Advocate can call the provider to complete authorization process if the chat is interrupted. • Both the Concurrent Review and Discharge processes can be completed in STAR via the Facility's Census page

Utilization Management Statement

Utilization Management decision-making is based only on the appropriateness of care as defined by:

- CASII
- Psychological and Neuropsychological Testing Guidelines
- LOCUS/CALOCUS
- American Society of Addiction Medicine Criteria

United Healthcare does not reward Medical Directors or licensed clinical staff for issuing denials of coverage or service.

Alert Program- **AI**gorithms for **E**ffective **R**eporting and **T**reatment

Member Identification	Outreach	Potential Outcome
Claims data Service combinations Frequency and/or duration that is higher than expected	**Licensed Care Advocate reach out telephonically to treating provider to:** Review eligibility for the service(s) Review the treatment plan/plan of care Review the case against applicable medical necessity guidelines	Close case (member is eligible, treatment plan/plan of care is appropriate, care is medically necessary) Modification to plan (e.g., current care is not evidence-based but there is agreement to correct) Referral to Peer Review (e.g., member appears ineligible for service; treatment does not appear to be evidence-based; duration/frequency of care does not appear to be medically necessary)

Outpatient Management

Reduce Administrative Burden	In-Scope Services	Management Strategy
We have removed precertification requirements for in-scope services (90837 included)	Individual/Group/Family Outpatient Therapy.	Two types: Algorithms for Effective Reporting and Treatment (ALERT) Practice Management

Practice Management Program

As an alternative to requiring precertification for routine and community-based outpatient services, we will provide oversight of service provision through our Practice Management Program.

Program Components

- Regular and comprehensive analysis of claims data by provider/provider group
  - Service/diagnostic/age distribution
  - Proper application of eligibility criteria
  - Appropriate frequency of service/duration of service
- Outreach to provider group when appropriate to discuss any potential concerns that arise from the claims analysis
- Potential outcomes from discussion
  - No additional action necessary
  - Program audit including record review
  - Corrective Action Plan (CAP)
  - Targeted precertification as part of CAP

Discharge Planning

Planning begins with the onset of care and should be documented and reviewed over the course of care

- Discharge treatment planning focuses on achieving and maintaining a desirable level of functioning after the completion of the current episode of care
- Discharge instructions should be specific, clearly documented and provided to the member prior to discharge. For discharge from an acute inpatient program, the member's follow-up appointment should be scheduled prior to discharge and should occur within seven days of the date of discharge
- Throughout the treatment and discharge planning process, it is essential that members be educated regarding the importance of enlisting community support services, communicating treatment recommendations to all treating professionals, and adhering to follow-up care
- Having a follow-up appointment and prescriptions at the time of discharge helps increase the member's successful transition

Behavioral-Medical Integration

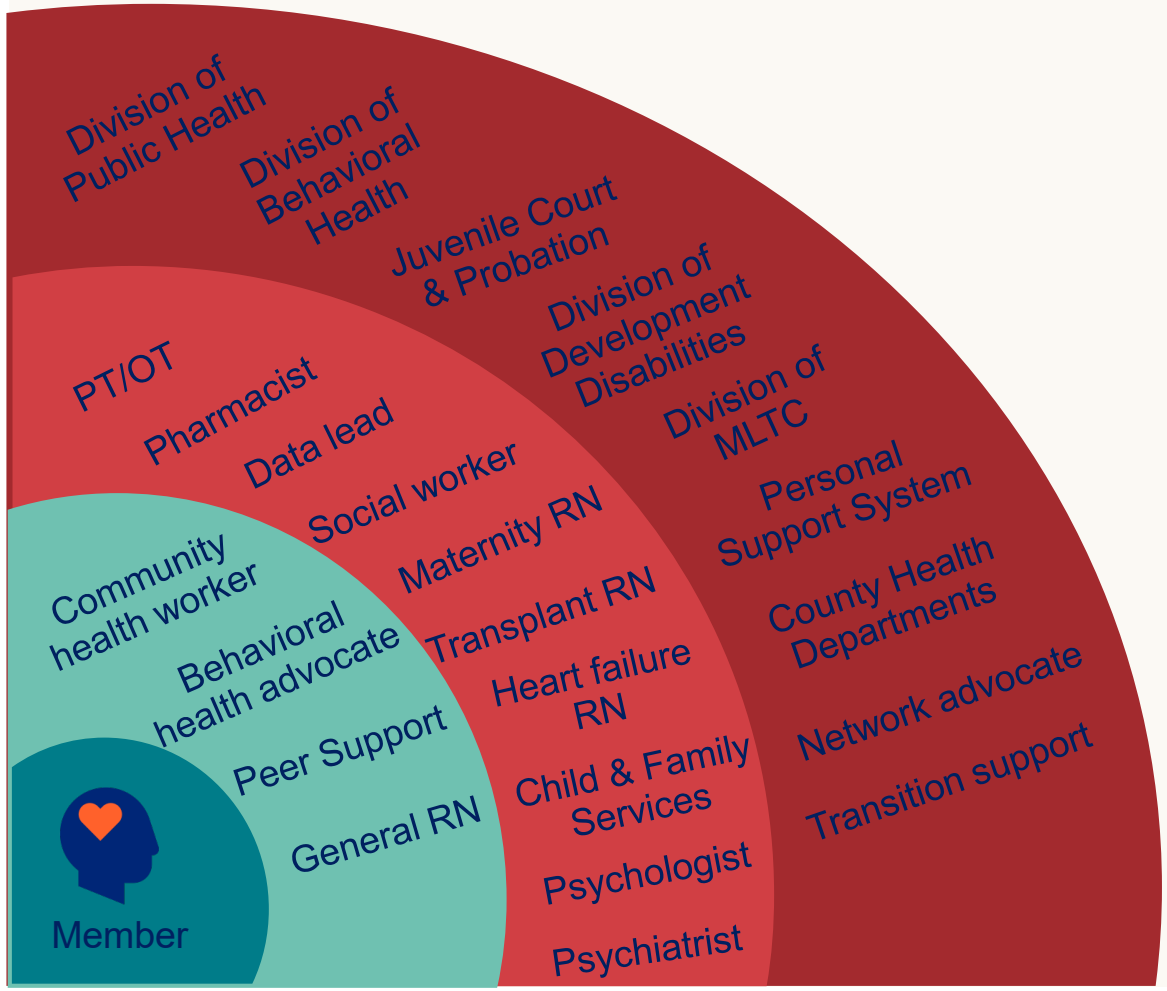
Our Goal: **Achieve medical and behavioral health care integration for all members**

- Behavioral providers are asked to refer members with known or suspected and untreated physical health problems or disorders to their Primary Care Physician for examination and treatment
- Primary Care Physicians are asked to identify and refer members with known or suspected and untreated mental health or substance use disorders for behavioral health examination and treatment

Our Goal: **Achieve integration of treatment for mental health and substance use disorder conditions**

- Our care management program assists members with complex medical and/or behavioral health needs in the coordination of their care
- All members are expected to be treated from a holistic standpoint; this is especially true for high-risk, high-service utilizers and other members with complex needs

Whole Person Care Team



Medicaid Members can be referred to the Whole Person Care team. The care team will report to one leader and will be supported by program specialists who can “flex” to quickly address the needs of the member

Whole-person care focuses on how the physical, behavioral, and social needs of a person are inter-connected to maintain good mental and physical health

Care is focused on supporting the physician to member relationship.

Role of the Recovery & Resiliency Team

- Our Recovery & Resiliency (R & R) team will consist of certified peer support specialists and a recovery & resiliency manager. This team can coordinate with our Whole Person Care team to coordinate needed services.
- This team will work with individuals and families to develop wellness, whole-person care and recovery action plans of care, including community/social determinants connections
- Family and other peers will act as conduits to R & R Services (peer support, development of a crisis/recovery plan, life planning activities, community connection, treatment options and more) and to other services as appropriate (legal, shelter, basic needs, etc.)
- Members of the R & R team will provide a consultancy role to other physical and mental health providers

Role of the Care Manager

- Medicaid Members can be referred or assigned to a Care Manager.
- The care manager helps members with Serious and Persistent Mental Illness (SPMI), complex behavioral health, and co-morbid medical conditions connect with needed services and resources
- Care managers collaborate and partner with individuals in the development of a comprehensive plan of care which coordinates the following:
  - Therapeutic services (therapy, medication management)
  - Community and psychosocial supports (education/support regarding illness, coordination with support system, other supportive services)
  - Coordination of care between physical and behavioral health providers and clinicians
  - Recovery and Resiliency Services (peer support, development of a crisis/recovery plan, life planning activities)
  - Other services as appropriate (legal, shelter, basic needs, etc.)

Billing and Claims

Claims Submission

- Providers must submit claims using the current 1500 Claim Form or UB-04 with appropriate coding including, but not limited to ICD-10, CPT, and HCPCS coding
- Timely Filing for general contracts is 90 days.
- All claim submissions must include:
  - Member name, Medicaid identification number and date of birth
  - Provider's Federal Tax I.D. number
  - National Provider Identifier (NPI) (unique NPI's for rostered clinicians)
  - Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at www.cms.gov
  - When a provider is contracted as a group or facility, the payment is made to the group/facility and not to the individual clinician

Claims Submission

Submitting claims electronically:

Providerexpress.com: Secure portal to view eligibility, submit prior authorization request and submit claims for Medicaid members. **(Preferred)**

Accepting all major clearinghouses including: Web MD ENVOY, Medavant, and ENSHealth.

Submitting paper claims:

UnitedHealthcare Community Plan, PO Box 5240, Kingston NY 12402-5240

Claims Submission

IMPORTANT

Use Payer ID number 86050 for all UnitedHealthcare Community Plan claims

- **When am I going to see payments?** Clean claims will be paid within 30 days of receipt. Corrected claims within 45 days of receipt.

Claims Submission Tips

- **To ensure clean claims:**
  - Include your NPI # on all claims
  - Include a complete diagnosis (to the highest specificity) on all claims

- **Balance Billing**
  - The Member cannot be balance billed for behavioral services covered under the contractual agreement

- **To Confirm Member Eligibility**
  - Verify Member eligibility through DHS website or Missouri Medicaid Eligibility NMES Line: 1-800-642-6092 prior to performing services

Claims Submission Tips

With EPS, you receive electronic funds transfer (EFT) for claim payments, plus your EOBs are delivered online:

- Lessens administrative costs and simplifies bookkeeping
- Reduces reimbursement turnaround time
- Funds are available as soon as they are posted to your account

To receive direct deposit and electronic statements through EPS you need to enroll at myservices.optumhealthpaymentservices.com > How to Enroll. Here's what you'll need:

- Bank account information for direct deposit
- Either a voided check or a bank letter to verify bank account information
- A copy of your practice's W-9 form

If you're already signed up for EPS with UnitedHealthcare Commercial or UnitedHealthcare Medicare Solutions, you will automatically receive direct deposit and electronic statements through EPS for UnitedHealthcare Community Plan.

Note: For more information, please call 877-620-6194

Claims Submission Quick Reference

Prior Authorization	UnitedHealthcare at 866-815-5334
Paper Claim Submission	Mail paper claims to: UnitedHealthcare Community Plan PO Box 5240 Kingston, NY 12402-5240
Electronic Claim Submission	www.providerexpress.com (secure section) or EDI clearing house of your choice Payor ID 86050
Claims Status	Provider Service Center at 866-815-5334 **providerexpress.com**
Claims Appeals	UnitedHealthcare Community Plan of Missouri Attention: Grievance and Appeals P.O. Box 31364 Salt Lake City, UT 84131-0364
Eligibility Verification	View eligibility online at DHS Website, Missouri Medicaid Eligibility NMES line: 1-800-642-6092 or providerexpress.com
Provider Service Center	866-815-5334
Update Practice Information	**providerexpress.com** or via 877-614-0484

Appeals and Complaints

Appeals

Non-Urgent (Standard Appeal)	Urgent (Expedited Appeal)
•Must be requested within 90 days from receipt of the Notice of Action letter	•Must be requested as soon as possible after the Adverse Determination
•When an appeal is requested, Optum will make an appeal determination and notify the provider, facility, Member or authorized Member representative in writing within 45 calendar days of receipt of request	•Optum will make a reasonable effort to contact you prior to making a determination on the appeal. If Optum is unsuccessful in reaching you, an urgent appeal determination will be made based on the information available to Optum at that time •Notification will occur as expeditiously as the member's health condition requires, within two (2) business days, unless the appeal is pertaining to an appeal relating to an ongoing emergency or denial of continued hospitalization, which we will complete investigation and resolution of no later than one (1) business day after receiving the request

Appeal requests can be made verbally or in writing. Verbal requests must be followed with a written and signed letter of appeal.

Services While in Appeal

- You may continue to provide service following an adverse determination if the following are met:
  - The Member is informed of the adverse determination
  - The Member is informed that the care will become the financial responsibility of the Member from the date of the adverse determination forward
  - The Member agrees in writing to these continued terms of care and acceptance of financial responsibility
  - You charge no more than the United contracted fee for such services, although a lower fee may be charged

If, after the adverse benefit determination and in advance of receiving continued services, the Member does not consent in writing to continue to receive such care and we uphold the determination regarding the cessation of coverage for such care, you cannot collect reimbursement from the Member pursuant to the terms of your Agreement

Complaints

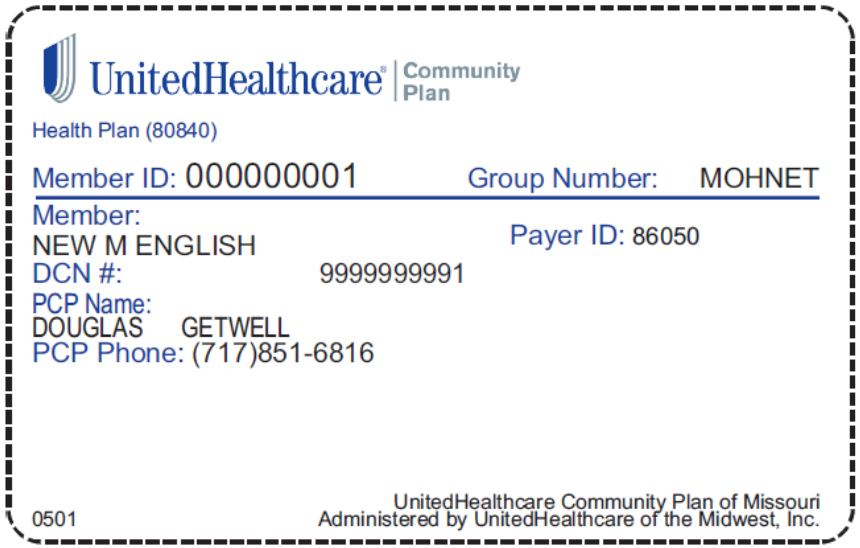
- We strive for the best customer service, but if you have a complaint, please contact us:
  - Call 1-866-673-6315 extension 38806 and a Customer Service representative will assist with the complaint process
  - The complaint will be fully investigated and resolved within **30 calendar days**

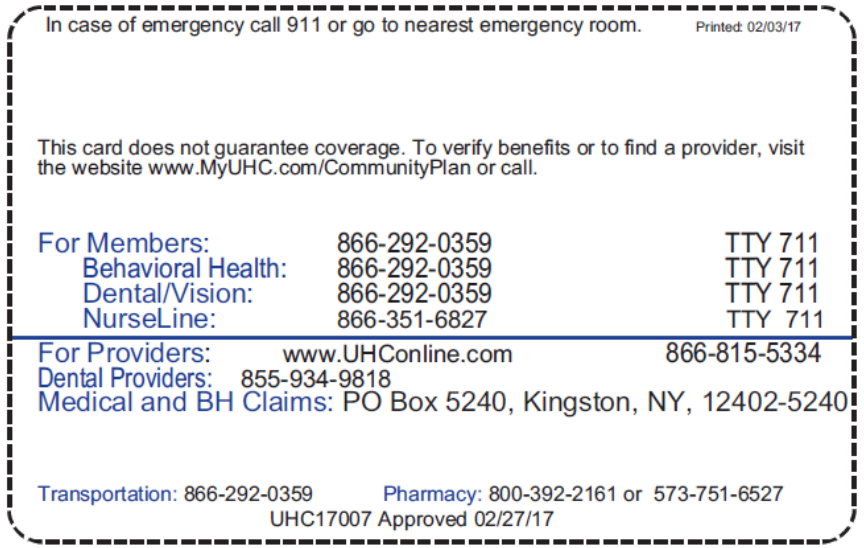
- A written *Resolution Letter* will then be sent upon completion of the investigation for Quality of Service (QOS) complaints

- A written *Acknowledgement Letter* is sent to Members submitting complaints related to Quality of Care (QOC) complaints
  - Since information related to the investigation and resolution of QOC concerns cannot be released to the complainant, the *Acknowledgement Letter* also serves as the Member's *Resolution Letter* for QOC complaints

Member Information

Member Information: Card Examples





Please note this image is for illustrative purposes only.

Network Participation

Providers in our Behavioral Health Network

Individual Practitioners	Groups/Agencies
The following license types will be individually credentialed to provide services for this Membership: • Advanced Practice Registered Nurse (APRN) • Clinical Nurse Specialist (CNS) • Doctor of Osteopathic Medicine (DO) • Licensed Clinical Social Worker (LCSW) • Licensed Psychologist (LP) • Licensed Professional Counselor (LPC) • Medical Doctor (LP) • Physician Assistant (PA) • Registered Nurse (RN) • *Provisionally licensed LCSW, LPC and psychologists, LMSW *medicaid only	• Community Mental Health Centers • Federally Qualified Health Centers (CMHC/FQHC) • Rural Health Centers • Provider groups that employ licensed professional staff to render services under the agency (Services include mental health and/or substance use services)

Joining Our Network

Clinicians:

- Complete the Network Participation Request Form (NPRF) online via **providerexpress.com**
- Also complete the CAQH universal application online at **www.caqh.org**
- Additional required application materials will be distributed once the NPRF has been received:
  - Signed Optum Provider Agreement
  - Applicable fee schedules
- For more information regarding the contracting process, visit **www.providerexpress.com** > Our Network

Joining Our Network

Facility Contracting:

- Facility level contracting applies to levels of care such as Acute Inpatient, Residential Services or Partial Hospitalization Programs
- Please contact Optum Provider Relations Advocate to discuss new facility contracting or to initiate updating your current facility contract
- Facility applications can be found via **providerexpress.com**. Click on “Join Our Network” on the main page, follow the prompts for the state of Missouri to be routed to the Facility Network Request Form.

This is the process for all lines of business

Provider Resources

Provider Resources

For important UnitedHealthcare Community Plan-specific information visit **UHCCommunityPlan.com** > For Health Care Professionals > Missouri to see:

- Provider Directory
- Claims and Member information
- Clinical Practice Guidelines
- Provider Forms
- Reimbursement Policies
- Provider News, Alerts and Trainings
- Pharmacy and Drug information

Provider Resources

Liveandworkwell.com

- Member and family education and support
- Also available in Spanish

providerexpress.com *Best Resource for BH providers

- Level of Care, Best Practice and Coverage Determination Guidelines
- Provider demographic changes / Roster management
- Claim submission/status/reconsideration requests

Q&A

Thank You!

Aline Hanrahan
Clinical Director
aline.hanrahan@optum.com

Dave Lauter
Provider Relations Director
david.lauter@optum.com

Justin Wilhite
Provider Relations Advocate
justin.wilhite@optum.com

Amy Young
Provider Relations Advocate
amy.young@optum.com