UnitedHealthcare Community Plan

Louisiana Medicaid

Behavioral Health Provider Manual

for 2022

(updated December 2022)

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Introduction

Welcome

We are pleased to have you working with us to serve the individuals covered under Louisiana Medicaid. We are focused on creating and maintaining a structure that helps people live their lives to the fullest. At a time of great need and change within the health care system, we are energized and prepared to meet and exceed the expectations of consumers, customers, and partners like you.

Our relationship with you is foundational to the recovery and well-being of the individuals and families we serve. We are driven by a compassion that we know you share. As we work together, you will find that we seek and pursue opportunities to collaborate with you to set the standard for industry innovation and performance.

We encourage you to make use of Provider Express, our industry-leading website, providerexpress.com and UHCprovider.com where you can get news, access resources and, in a secure environment, make demographic changes at the time and pace you most prefer. We continuously expand our online functionality to better support your day-to-day operations. Visit us often.

Important Notice

Optum provides this manual as a focused resource for clinicians serving the Louisiana Medicaid membership. This manual does not replace the primary National Network Manual. Rather, this Louisiana Medicaid manual supplements the primary National Network Manual by focusing on the core service array, roles and responsibilities, as well as processes and procedures specific to the State of Louisiana Medicaid programs. In addition, some sections of the primary National Network Manual are repeated for convenience.

The National Network Manual can be directly accessed here or by going to providerexpress.com (Provider Express > Quick Links > Guidelines/Policies & Manuals > Network Manual > National Network Manual).

Governing Law

This manual shall be governed by, and construed in accordance with, applicable federal, state and local laws. To the extent that the provisions of this manual conflict with the terms and conditions outlined in your Agreement, the subject matter shall first be read together to the extent possible; otherwise, and to the extent permitted by, in accordance with, and subject to applicable law, statutes or regulations, the Agreement shall govern.

Clinical Overview

UnitedHealthcare Community Plan (The Plan) manages the mental health and substance use disorder services to help adults and children enrolled in Louisiana Medicaid access the most effective treatment for their needs.

Optum and UnitedHealthcare are working closely with the state of Louisiana, consumers, family members, providers, and community stakeholders to develop, implement, and maintain a utilization management program for Louisiana Medicaid to monitor the appropriate utilization of covered services and to:

- Simplify the administrative processes for providers, enabling them to devote more staff time to treating Members
- Encourage Members to access services at the time they first recognize symptoms in themselves or in a family member
- Ensure that all services provided are medically necessary, are focused on measurable outcomes, and are supporting the Member's recovery and/or the family's resiliency

Our focus is on improving access to treatment, expanding the array of covered services, and improving the quality of care and treatment outcomes. Our goal is to enhance the statewide behavioral health system and make it easier for people to access care. In addition to adding more behavioral health care providers and programs, Optum aims to ensure that Members are able to get the care they need in their community.

Optum is committed to recovery, resiliency, and person-centered care. This includes assisting and supporting people in learning to manage their behavioral health and wellness challenges. Our practices are anchored in the belief that people with mental illness are able to live, work, and participate productively in their communities despite their behavioral health challenges, and are resilient and able to rebound from trauma, stigma, and other stresses.

We look forward to an active partnership as we all work together to improve the lives of Members in Louisiana.

Louisiana Medicaid Benefits

UnitedHealthcare Community Plan of Louisiana administers behavioral health managed care benefits for Louisiana Medicaid Members. All Medicaid Members shall be provided care in the same manner, on the same basis, and in accordance with the same standards offered to all other Members in their provider's care.

The following covered services are available and accessible to all Medicaid Members:

Service	Authorization Requirement
Inpatient Hospitalization	By Phone
Psychiatric Residential Treatment Facility (PRTF) (ages under 21)	By Phone
Residential Substance Use Services in Accordance with the American Society of Addiction Medicine (ASAM) Levels of Care	By Phone
Crisis Stabilization	By Phone
23-Hour Observation	By Phone
Assertive Community Treatment (ACT) (ages 18+)	Online Portal
Crisis Intervention Follow Up	Online Portal
Outpatient Electroconvulsive Therapy (ECT)	Email or Fax
Substance Abuse Intensive Outpatient Program (SA IOP)	By Phone
Therapeutic Group Home (ages under 21)	Email or Fax
Community Psychiatric Support and Treatment (CPST)	Online Portal
Psychosocial Rehabilitation (PSR)	Online Portal
Multi-Systemic Therapy (MST) (ages under 21)	Online Portal
Functional Family Therapy (FFT) (ages under 21)	Online Portal
Homebuilders (ages under 21)	Online Portal
Crisis Intervention (initial visit per diem)	*Not Required*
Outpatient Psychotherapy (individual, group, and family)	*Not Required*
Neuropsychological Testing	*Not Required*
Pharmacologic Management	*Not Required*
Evaluation and Assessment	*Not Required*
Outpatient Substance Abuse Services	*Not Required*
Peer Support Services	Online Portal
Psychological Testing	Online form can be found here: Optum Psych Testing Request Form (Provider Express > Quick Links > Forms > Optum Forms – Authorization > Louisiana)
Behavioral Health Personal Care Services (PCS)	Online Portal
Individual Placement Support (IPS)	Online Portal
Smart Technology Authorization Request (STAR)	Online Portal or By Phone

Table: Covered Services

- For services requiring authorization request to be made by phone: **1-866-675-1607**
- For services requiring authorization request to be made via online portal or by email/fax: visit Provider Express Louisiana page (Home > Our Network > State Specific Provider Information > Louisiana>Authorization Templates> Healthy Louisiana Mental Health Rehabilitation and Evidence Based Practices Request Form (online)

Adult Crisis Response Services

It is Louisiana Department of Health's goal to develop a statewide model for crisis response that maintains regional and geographic relevance and builds upon the unique and varied strengths, resources, and needs of Louisiana's individual communities.

The vision is that the system:

- Values and incorporates "lived experience" in designing a crisis system and crisis service delivery and is built on principles of recovery and resiliency using person-centered processes.
- Encompasses a continuum of services that includes crisis prevention, acute intervention and post-crisis recovery services and supports.
- Provides interventions to divert individuals from institutional levels of care including inpatient placements, emergency departments utilization, nursing facilities and other out of home settings; and
- Provides timely access to a range of acute crisis responses, including locally available home and community-based services and mobile crisis response.
- Results in a crisis continuum that includes and respects a bed-based crisis service but does not rely on that level of service as the foundation of the crisis continuum.

This will be achieved by implementing the following services:

- **Mobile Crisis Response (MCR)** is an initial community-based, mobile crisis response intended to provide relief, resolution, and intervention to individuals where they are located through crisis supports and services during the first phase of a crisis in the community.

- **Behavioral Health Crisis Centers (BHCC)** are facility-based services that operates twenty-four (24) hours a day, seven (7) days a week, as a walk-in center providing short-term behavioral health crisis intervention.

- **Community Brief Crisis Support (CBCS)** is an ongoing crisis intervention response rendered for up to fifteen (15) days and designed to provide relief, resolution and intervention through maintaining the member at home / in the community, de-escalating behavioral health needs, referring for treatment needs, and coordinating with local providers.

- **Crisis Stabilization (CS)** are short-term bed-based crisis treatment and support services for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization.

24-hour Behavioral Health Crisis Line for **UnitedHealthcare: 1-866-232-1626**

Licensed Mental Health Professionals (LMHPs) include:

- Advanced Practice Registered Nurses (APRNs must be nurse practitioner specialists in adult psychiatric and mental health, and family psychiatric and mental health, or certified nurse specialists in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health and child-adolescent mental health and may

practice to the extent that services are within the APRN's scope of practice.)

- Licensed Addiction Counselors (LAC)
- Licensed Clinical Social Workers (LCSW)
- Licensed Marriage and Family therapists (LMFT)
- Licensed Professional Counselors (LPC)
- Licensed Psychologists
- Medical Psychologists
- Psychiatrists
- Physician Assistants working under the protocol of a participating Psychiatrist

Note: Physician Addictionologists must be certified by the American Society of Addictions Medicine (ASAM) or the American Board of Addiction Medicine (ABAM) or have added qualifications in Addiction Psychiatry through the American Board of Psychiatry and Neurology (ABPN).

All providers including individual clinicians, groups/agencies, and facilities must have valid, active state licenses to perform the levels of care under their Medicaid contract, per the LDH Behavioral Health Provider Services Manual, as applicable.

For the services that can be rendered by non-independently licensed providers (e.g., CPST, PSR, etc.), all individuals must meet education, training, and all other requirements set forth in the LDH Behavioral Health Provider Manual. It is the agency's responsibility to ensure all non-independently licensed providers meet these criteria before they are submitted to Optum when adding, changing, or removing providers from the agency roster.

Emergency services may be rendered without the requirement of prior authorization. Payment cannot be denied for treatment of what constitutes an emergency behavioral health condition on the basis of a behavioral health diagnosis or symptoms.

Description of Behavioral Health Services

The complete Louisiana Behavioral Health Services Provider Manual maintained by the Louisiana Department of Health (LDH) is accessible online. The summary below serves as a quick reference guide only and does not replace nor supersede the requirements in the LDH Manual. All providers need to be familiar with this manual and must adhere to all requirements within. The current version of the manual is located here:

lamedicaid.com/provweb1/providermanuals/BHS_Main.htm

Service	Service Description
Addiction Services	Includes an array of individual-centered outpatient, intensive outpatient and residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance use symptoms and behaviors.
Assertive Community Treatment (ACT)	Interventions that address the functional problems of individuals who have the most complex and/or pervasive conditions associated with a serious mental illness or co-occurring addictions disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the individual's ability to cope and relate to others and enhancing the highest level of functioning in the community.
Community Psychiatric Support and Treatment (CPST)	CMS-Approved Medicaid Mental Health Rehabilitation Services designed to reduce disability from mental illness, restore functional skills of daily living, build natural supports, and achieve identified person-centered goals or objectives through counseling, clinical psycho-education, and ongoing monitoring needs as set forth in an individualized treatment plan.
Crisis Intervention (CI)	Crisis intervention (CI) services are provided to an individual who is experiencing a psychiatric crisis and are designed to interrupt and/or ameliorate a crisis experience; via a preliminary assessment, immediate crisis resolution & de-escalation, and referral & linkage to appropriate community services to avoid more restrictive levels of treatment.
Electroconvulsive Therapy (ECT)	Electroconvulsive Therapy (ECT) is a standard psychiatric treatment in which seizures are electrically induced to provide relief from psychiatric illnesses.
Family Psychotherapy	Family members can talk with a behavioral health care professional about emotional problems they may be having and learn coping skills the family can use to manage them.
Functional Family Therapy (FFT)	FFT is an evidence-based program (EBP) targeted for youth between ages 10 and 18, primarily demonstrating externalizing behaviors or at risk for developing more severe behaviors, which affect family functioning.
Group Psychotherapy	A group of people with similar emotional issues meet with a behavioral health care professional; the group members share experiences and practice coping skills in order to learn how to manage issues as independently as possible.

Service	Service Description
Homebuilders®	Homebuilders is an intensive, in-home evidence- based program (EBP) utilizing research-based strategies (e.g., Motivational Interviewing, Cognitive and Behavioral Interventions, Relapse Prevention, Skills Training), for families with children (≤ age 17) at imminent risk of out of home placement (requires a person with placement authority to state that the child is at risk for out of home placement without Homebuilders) or being reunified from placement. Homebuilders is provided through the Institute for Family Development (IFD).
Individual Psychotherapy	Individuals can talk with a behavioral health care professional about emotional issues they may be having and learn coping skills to manage them.
Inpatient/Hospital-based Care	The need for one or more nights in a hospital for emergency treatment which cannot otherwise be treated in the community by a provider.
Multi-systemic Therapy® (MST)	Multi-systemic therapy (MST) is an evidence-based program (EBP) that provides an intensive home/family and community-based treatment for youth who are at risk of out-of-home placement or who are returning from out-of-home placement.
Outpatient Therapy	Individual, family, group psychotherapy and mental health assessment, evaluation and testing.
Peer Support	Provided by a Peer Support Specialist (who received behavioral health services themselves) to help individuals learn to manage difficulties in their lives. As of 03/01/21, Peer Support Services are a covered benefit when performed by Local Governing Entities (LGEs).
Pharmacologic Management	Individuals meet with a doctor or other prescriber to discuss medications.
Psychological/Neuropsychological Testing	Individuals complete written, visual or verbal tests that are administered by a psychologist measuring thinking and emotional abilities.
Psychosocial Rehabilitation (PSR)	CMS-Approved Medicaid Mental Health Rehabilitation Services designed to assist the individual with compensating for or eliminating functional deficits and interpersonal or environmental barriers associated with mental illness through skill building and supportive interventions to restore and rehabilitate social and interpersonal skills and daily living skills.
Therapeutic Group Home (TGH)	Therapeutic Group Homes (TGHs) provide a community-based residential service in a home-like setting of no greater than eight beds, under the supervision and program oversight of a psychiatrist or psychologist.

Service	Service Description
Crisis Response Service for Adults	Crisis Stabilization (CS) are short-term bed-based crisis treatment and support services for members who have received a lower level of crisis services and are at risk of hospitalization or institutionalization. Mobile Crisis Response (MCR) is an initial community-based, mobile crisis response intended to provide relief, resolution, and intervention to individuals where they are located through crisis supports and services during the first phase of a crisis in the community. Behavioral Health Crisis Centers (BHCC) are facility-based services that operates twenty-four (24) hours a day, seven (7) days a week, as a walk-in center providing short-term behavioral health crisis intervention. Community Brief Crisis Support (CBCS) is an ongoing crisis intervention response rendered for up to fifteen (15) days and designed to provide relief, resolution and intervention through maintaining the member at home / in the community, de-escalating behavioral health needs, referring for treatment needs, and coordinating with local providers.

Eligibility Requirements for Evidence–Based Practices

The Louisiana Department of Health (LDH) requires UnitedHealthcare Community Plan, to identify providers who offer specific Evidenced-Based Practices (EBPs). UnitedHealthcare Community Plan will validate that the provider is eligible (based on the criteria listed below) to offer the EBP at the time of credentialing and through routine roster updates the provider completes. **For each EBP, the provider must submit all required documentation in order to be identified in provider systems, including the directory, as eligible to offer the EBP service. If the requirements are not met then claims will deny.**

The eligibility requirements are as follows:

1.1. Functional Family Therapy

1.1.1. The agency must have an FFT license from FFT, LLC.

1.2. Functional Family Therapy-Child Welfare (FFT-CW) (EB01)

1.2.1. The agency must have an FFT license with FFT-CW specialty from FFT, LLC.

1.3. Child-Parent Psychotherapy (CPP) (EB02)

1.3.1. The clinician must have a certificate stating that he/she has fulfilled the requirements of an implementation level course in Child-Parent

Psychotherapy from a trainer endorsed by the University of California, San Francisco.

1.4. Parent-Child Interaction Therapy (PCIT) (EB03)

1.4.1. The clinician must have a certification from PCIT, International

1.5. Youth PTSD Treatment (YPT) (EB04)

1.5.1. The clinician must have an Advanced Certificate from Tulane Psychiatry in Youth PTSD Treatment.

1.6. Preschool PTSD Treatment (PPT) (EB05)

1.6.1. The clinician must have an Advanced Certificate from Tulane Psychiatry in Preschool PTSD Treatment.

1.7. Homebuilders®

1.7.1. The agency must be certified by the Institute for Family Development (IFD).

1.7.2. The agency must contract with the IFD for training, supervision and monitoring of services.

1.8. Multi-Systemic Family Therapy (MST)

1.8.1. The agency must be licensed to provide MST services by MST Services, Inc. or any of its approved subsidiaries.

1.8.2. The agency must contract with MST Services for training, supervision and monitoring of services.

1.9. Assertive Community Treatment (ACT)

1.9.1. Agencies offering ACT services must meet national fidelity standards as evidenced by the Substance Abuse and Mental Health Service Administration (SAMHSA) Assertive Community Treatment (ACT) Evidence-Based Practice Toolkit.

1.9.1.1. The provider must complete the SAMHSA "Evaluating Your Program: Assertive Community Treatment" assessment tool and submit the cover sheet and score sheets as part of their application.

1.10. Triple P (Positive Parenting Program® System) – Standard Level 4

1.10.1. The clinician must have an Accreditation Certification in Triple P – Standards Level 4, issues by Triple P America.

1.11. Trauma Focused – Cognitive Behavioral Therapy (TF – CBT)

1.11.1. The clinician must have a certification from the Trauma Focused Cognitive Behavioral Therapy National Therapist Certification Program

1.12. Eye Movement Desensitization and Reprocessing Therapy (EMDR)

1.12.1. The clinician must have a certification from EMDRIA (EMDR International Association)

Evidence-Based Practice	EBP Tracking Code	Valid CPT/HCPCS Codes	EBP Credentialing documentation to be submitted to Optum/UHC
Functional Family Therapy-Child Welfare (FFT-CW)	EB01	H0036 with modifier HE	Agency FFT License with FFT-CW specialty from FFT, LLC
Child-Parent Psychotherapy (CPP)	EB02	90837, 90834, 90832, 90847, 90846	Certificate stating that the clinician has fulfilled the requirements of an implementation level course in Child-Parent Psychotherapy, from a trainer endorsed by the University of California, San Francisco
Parent-Child Interaction Therapy (PCIT)	EB03	90837, 90834, 90832, 90847, 90846	Certification from PCIT, International pcit.org/united-states.html
Youth PTSD Treatment (YPT)	EB04	90837, 90834, 90832, 90847, 90846	Advanced Certificate from Tulane Psychiatry in Youth PTSD Treatment
Preschool PTSD Treatment (PPT)	EB05	90837, 90834, 90832, 90847, 90846	Advanced Certificate from Tulane Psychiatry in Preschool PTSD Treatment
Positive Parenting Program® System (Triple P)	EB06	90837, 90834, 90832, 90847, 90846	The clinician must have an Accreditation Certification in Triple P – Standards Level 4, issues by Triple P America
Trauma Focused – Cognitive Behavioral Therapy (TF – CBT)	EB07	90837, 90834, 90832, 90847, 90846	The clinician must have a certification from the Trauma Focused Cognitive Behavioral Therapy National Therapist Certification Program
Eye Movement Desensitization and Reprocessing Therapy (EMDR)	EB08	90837, 90834, 90832, 90847,90846	The clinician must have a certification from EMDRIA (EMDR International Association)

Table: EBP Billing and Reference Guide

For services requiring an authorization, if we deem the service medically necessary, the service authorization will begin on the date of the request for the service.

Pharmacologic/Medication Management Services

Psychiatrists, prescribing APRNs, and Medical Psychologists are not required to obtain prior authorization for the initial consultation, routine medication management sessions and other routine outpatient services, such as: 90791, 90792, 90833, 90834 and evaluation & management (E&M) codes as applicable.

Inpatient Services

Emergency services may be rendered without the requirement of prior authorization.

Payment cannot be denied for treatment of what constitutes an emergency behavioral health condition on the basis of a behavioral health diagnosis or symptoms.

We require notification of inpatient emergency admissions within 24 hours of admission. We reserve the right to deny a claim for payment based solely on lack of notification.

We are staffed with independently licensed staff 24 hours a day/7 days per week (including weekends and holidays) to respond to authorization requests.

Residential Services

Authorization for both Substance Abuse Residential Treatment and Psychiatric Residential Treatment Facilities need to be requested prior to the Member's admission to those levels of care when possible. If prior notification cannot occur, notification of admission is required within one (1) business day (Monday – Friday) of admission.

Psychological Testing

Psychological testing must be pre-authorized. Psychological testing is considered after a standard evaluation (CPT code 90791 or 90792 including clinical interview, direct observation and collateral input, as indicated) has been completed and one of the following circumstances exists:

- There are significant diagnostic questions remaining that can only be clarified through testing
- There are questions about the appropriate treatment course for a patient, or a patient has not responded to standard treatment with no clear explanation, and testing would have a timely effect on the treatment plan
- There is reason to suspect, based on the initial assessment, the presence of cognitive, intellectual and/or neurological deficits or impairments that may affect functioning or interfere with the patient's ability to participate in or benefit from treatment, and testing will verify the presence or absence of such deficits or dysfunction

Generally, psychological testing solely for purposes of education or school evaluations, learning disorders, legal and/or administrative requirements is not covered. Also not covered are tests performed routinely as part of an assessment. We recommend that you contact the Louisiana Provider Services Line at **1-866-675-1607** to determine authorization requirements and procedures.

For information regarding test administration by a psychometrist, psychometrician or psychologist-extender, please refer to the Psychological/Neuropsychological Testing Guidelines located on Provider Express (Home > Clinical Resources > Guideline/Policies & Manuals > Psychological/Neuropsychological Testing Guidelines). This guide also addresses other procedures related to testing and report writing.
You can also contact the Louisiana Provider Services Line at **1-866-675-1607** for assistance with any questions.

Home and Community Based Services

This is a home or community-based program available to adults, adolescents and children who are recovering from a Severe and Persistent Mental Illness that promotes recovery, assists the Member to integrate with their community, and provides services aimed at helping the Member improve their quality of life.

This service uses network providers to help Members develop skills needed to increase their capacity to thrive in their home, employment, school or social environments. These services target skills that may have been lost due to the Member's behavioral health condition. The services vary in intensity, frequency, and duration in order to support Members in managing functional difficulties, or to otherwise realize recovery goals.

Personal Care Services (PCS)

Personal care services (PCS) include assistance and/or supervision necessary for members with mental illness to enable them to accomplish routine tasks and live independently in their own homes.

Provider Qualifications for PCS

For PCS service components and provider qualifications, please refer to the LDH Behavioral Health Services Provider Manual.

You may also email questions to networkse@optum.com.

Authorizations for PCS

Authorization Requests for Personal Care Services are made through the "Healthy Louisiana Mental Health Rehabilitation and Evidence Based Practices Request Form".

This request form is located on the Louisiana Resource Page. Go to: providerexpress.com > Our Network > State-Specific Provider Information > Louisiana > Authorization Templates

Individual Placement and Support (IPS)

Individual Placement and Support (IPS) refers to the evidence-based practice of supported employment for members with mental illness. IPS helps members living with mental health conditions work at regular jobs of their choosing that exist in the open labor market and pay the same as others in a similar position, including part-time and full-time jobs. IPS helps people explore the world of work at a pace that is right for the member. Based on member's interests, IPS builds relationships with employers to learn about the employers' needs in order to identify qualified job candidates.

Provider Qualifications for IPS

IPS must be provided only under the administrative oversight of licensed and accredited local governing entities (LGEs). Providers must meet state and federal requirements for providing IPS. For more information regarding IPS service components and provider

qualifications, please refer to the LDH Behavioral Health Services Provider Manual.

You may also email questions to networkse@optum.com.

Authorizations for IPS

Authorization Requests for Individual Placement and Support are made through the "Healthy Louisiana Mental Health Rehabilitation and Evidence Based Practices Request Form".

This request form is located on the Louisiana Resource Page. Go to: providerexpress.com > Our Network > State-Specific Provider Information > Louisiana > Authorization Templates

Peer Services and Supports

This is a form of community support service in which a Certified Peer Specialist utilizes their training, lived experience, and experiential knowledge to assist the Member/Member's parent or legal guardian with achieving the recovery and resiliency goals. Assistance can take a variety of forms such as by providing information about services or self-care, supporting the development of skills, and facilitating access to services and resources.

These services may be delivered while the Member is receiving behavioral health treatment, in advance of the start of behavioral health treatment in order to facilitate engagement in care, or as part of the Member's transition from other services. As of 03/01/21, Peer Support Services are a covered benefit when performed by Local Governing Entities (LGEs).

The services help the Member/Member's parent or legal guardian become more socially connected and increase engagement in treatment and empowerment.

Care Advocacy

The Behavioral Health Care Advocacy Center (CAC) focuses on activities that impact Medicaid Members' stabilization and recovery and promote active participation in their care. This approach consists of targeted interventions intended to facilitate Member services, identify Members who may be at risk, and to assist you in the coordination and delivery of care to Members. This approach supports a collaborative relationship between you and the Care Advocate. Care Advocacy activity may include:

- Emphasizing the integration of medical and behavioral care by promoting communication among all treating providers involved in Members' care.
- Ensuring that Members being discharged from facility-based care have appropriate discharge plans, that they understand them and that they are able to access and afford the recommended services.
- Proactively reaching out to providers to discuss Members' care when an individual has been identified as being at-risk.
- Offering clinical consultations with medical staff.

- Reaching out to Members in some circumstances to educate, evaluate risk, and offer assistance.
- Supporting Members to actively participate in treatment and follow-up care.
- Referencing web-based and written information regarding behavioral health conditions for Members and treating providers designed to support informed decision making.

Care Advocate Availability

The Optum Care Advocacy Center in Baton Rouge is open for standard business operations Monday through Friday from 8 a.m. to 5 p.m. Central Time and can be accessed by calling **1-866-675-1607**. In addition, we are staffed 24 hours a day/7 days per week (including weekends and holidays) to discuss urgent and emergent situations (such as potential inpatient admissions), to handle Members in crisis, or any other questions about the care advocacy process.

Affirmative Incentive Statement

Coverage determinations are based only on the appropriateness of care as defined by applicable Clinical Criteria, The Plan and applicable state and federal laws.

You will find information about the Clinical Criteria and Clinical Practice Guidelines, on providerexpress.com. Louisiana Medicaid Supplemental Clinical Criteria can be found on the Louisiana State page on Provider Express. You can receive a paper copy of Optum documents from Provider Relations.

Optum expects all treatment provided to Optum Members be outcomes-driven, clinically necessary, evidence-based, and provided in the least restrictive environment possible. Optum does not reward its staff, practitioners, or other individuals for issuing denials of coverage or service care. Utilization management decision makers do not receive financial or other incentives that encourage decisions that result in underutilization of services.

Eligibility Inquiry

The services a Member receives are subject to the terms and conditions of The Plan. It is important that you inquire about what services are covered and the Member's enrollment status before providing services.

Utilization Management Begins at Intake

Optum believes that a "no wrong door" approach is the best way to ensure that Members or their families can access services at the time they first recognize symptoms. Therefore, we have intake policies that facilitate immediate access to treatment:

- A Member can contact a network provider's office and request an appointment
- A family member can contact a network provider's office and request an appointment for a Member

The Member Service Line, **1-866-675-1607**, is available 24 hours a day, 365 days a year, and provides a Member or family member with immediate contact with someone who can help identify a network provider most appropriate to the Member's needs and preferences. If requested, we will contact the provider, on the Member's behalf, and finalize arrangements to help the Member get to the provider's office or access emergency/crisis services.

Assisting with Recovery

We encourage you to assist Members with their recovery by providing information about their condition, its treatment, and self-care resources. Members have the right to information that will support decision-making, promote participation in treatment, enhance self-management, and support broader recovery goals.

We encourage you to discuss all treatment options and the associated risks and benefits and solicit Members' input about their treatment preferences. Nothing in this manual is intended to interfere with your relationship with Members.

Assessment

Thorough clinical assessments are required and should be included in the clinical record. The initial diagnostic assessment includes a biopsychosocial history that provides information on previous medical and behavioral health conditions, interventions, outcomes, and lists current and previous medical and behavioral health providers. The mental status exam includes an evaluation of suicidal or homicidal risk. A substance use screening should occur for Members over the age of 12 years, noting any substances abused and treatment interventions.

Other areas to be covered in the assessment are developmental history, education, legal issues, and social support. Cultural and spiritual considerations should be covered. A note should also be made of any community resources accessed by the Member. A culmination of these assessment aspects, including negative findings, will yield a DSM-5 diagnosis (ICD-10 is used for billing purposes). The assessment must be completed with the frequency as indicated by LDH in the Behavioral Health Provider Services Manual, in addition to any other LDH requirements (e.g., LOCUS/CALOCUS).

Treatment, Recovery & Resiliency, and Discharge Planning

The treatment plan stems from the Member's condition and is used to document realistic and measurable treatment goals as well as the evidence-based treatments that will be used to achieve the goals of treatment. Effective treatment planning should take into account significant variables such as age, level of development, and the history of treatment. Other variables to consider are whether the proposed services are covered in The Plan and are available in the community.

Finally, you should also consider whether community resources such as support groups, consumer-run services, and preventive health programs can augment treatment.

The provider should also take into account the Member's expressed or documented preferences in a psychiatric advance directive or crisis plan. For some Members, treatment is part of a broader recovery & resiliency effort, so the recovery & resiliency goals documented in a recovery plan should also be considered.

A change in the Member's condition should prompt a reassessment of the treatment plan and selection of level of care. When the condition has improved, the reassessment determines whether a less restrictive level of care may be adequate to treat the condition, or whether the Member no longer requires treatment. When a Member's condition has not improved or has worsened, the reassessment determines whether the diagnosis is accurate, the treatment plan requires modification, or a change in the level of care is needed.

Effective discharge planning enables the Member's safe and timely transition from one level of care to another and documents the services they will receive post-discharge. Discharge planning begins at the onset of treatment when the provider anticipates the discharge date and forms an initial impression of the Member's post-discharge needs. The initial discharge plan may evolve in response to changes in the Member's condition and preferences.

The final discharge plan documents the:

- Anticipated discharge date
- Proposed post-discharge services
- Plan to coordinate discharge with the provider at the next level of care (when indicated)
- Plan to reduce the risk of relapse
- Agreement by the Member with discharge plan

As the Member transitions from one level of care to another, we expect that the first appointment at the next level of care will be scheduled according to the Member's needs. The first post- discharge appointment following inpatient care should occur no later than seven (7) days from the date of discharge. This timeframe is in accordance with the Health Effectiveness Data and Information Set (HEDIS®) standard for follow-up treatment after discharge from inpatient care.

Optum Behavioral Health Care Advocates and Community Care Workers monitor discharge planning and are available to assist with identifying and facilitating access to treatment services and community resources. Optum expects that the provider will collaborate with the Member during treatment, recovery, and discharge planning whenever possible.

Follow-Up After Hospitalization for Mental Illness (FUH)

Description:

- Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses, and who

had a follow-up visit with a mental health practitioner within 7 days after discharge

Key Aspects of the Measure:

- What types of appointments qualify as a post-discharge appointment?

Qualifies	Does Not Qualify
Outpatient appointment for mental health services with a mental health provider	Appointment with a primary care physician
Partial hospitalization for mental health treatment	Appointment primarily for substance use treatment
Intensive outpatient for mental health treatment	Pastoral counseling
Group/family mental health treatment with a mental health provider	Care coordination/Health Home activities
Outpatient ECT	School counseling

*Appointments by virtual visit (telemental health) qualify for FUH

What type of practitioners can provide a qualified post-discharge appointment?

- A HEDIS® qualified appointment is an outpatient appointment with a licensed mental health practitioner. The chart below shows which license types do and do not qualify under the HEDIS® FUH measure:

License Types	
Qualifies	**Does Not Qualify**
Psychiatrists	Primary care physicians
Psychologists	Drug and alcohol counselors
Licensed Clinical Social Workers	Non-licensed clinicians
Licensed Professional Counselors	
Licensed marriage and Family Therapists	
Psychiatric Nurses (RN or APRN with psychiatric specialty)	
Physician Assistants with a psychiatric specialty	
Behavioral Health Facilities	
Qualifies	
Community Mental Health Centers Certified Community Behavioral Health Clinics Partial Hospitalization Programs Intensive Outpatient Programs Electroconvulsive Therapy	

7 Day Calendar Example:

- The day of discharge is Day Zero
- To count towards the FUH measure, the aftercare follow-up visit must occur any time between Days 1 and 7

Sun	Mon	Tue	Wed	Thu	Fri	Sat
13	14	15 Discharged	16 Day 1	17 Day 2	18 Day 3	19 Day 4
20 Day 5	21 Day 6	22 Day 7	23 Day 8	24 Day 9	25 Day 10	26 Day 11

Coordination of Care

Communication with Primary Physicians and Other Health Care Professionals

To coordinate and manage care between behavioral health and medical professionals, we require that you seek to obtain the Member's consent to exchange appropriate treatment information with medical care professionals (e.g., primary physicians, medical specialists) and/or other behavioral health providers (e.g., psychiatrists, therapists). We require that coordination and communication take place at: the time of intake, during treatment, the time of discharge or termination of care, between levels of care, and at any other point in treatment that may be appropriate. Coordination of services improves the quality of care to Members in several ways:

- It allows behavioral health and medical providers to create a comprehensive care plan
- It allows a primary care physician to know that his or her patient followed through on a behavioral health referral
- It minimizes potential adverse medication interactions for Members who are being treated with psychotropic and non-psychotropic medication
- It allows for better management of treatment and follow-up for Members with coexisting behavioral and medical disorders
- It promotes a safe and effective transition from one level of care to another
- It can reduce the risk of relapse

To facilitate effective communication between professionals involved in a Member's care, Optum requires network providers to coordinate services with the Member's primary care physician (PCP) at a minimum, by applying the following standards for care coordination:

- During the diagnostic assessment session, request the Member's written consent to exchange information with all appropriate treatment professionals
- After the initial assessment, provide other treating professionals with the following information within two weeks:
  - Summary of Member's evaluation
  - Diagnosis
  - Treatment plan summary (including any medications prescribed)
  - Primary clinician treating the Member

Attempt to obtain all relevant clinical information that other treating providers may have, pertaining to the Member's mental health or substance use problems:

- Update other behavioral health and/or medical clinicians when there is a change in the Member's condition or medication(s):
  - When serious medical conditions warrant closer coordination

- At the completion of treatment, send a copy of the discharge summary to the other treating professionals

Some Members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum, as well as accrediting organizations, expects you to make a “good faith” effort at communicating with other behavioral health providers and any medical care providers who are treating the Member as part of an overall approach to coordinating care.

Management of Outpatient Services

Outpatient Management

The goal of our outpatient management program is to reduce administrative burden through the use of Practice Management and the Algorithms for Effective Reporting and Treatment (ALERT) Program. For services that are in-scope, the precertification requirements have been removed. The in-scope Services include:

- Individual/Group/Family Therapy
- Outpatient Addiction Services (ASAM Level 1)

The ALERT Program uses claims data and service combinations to identify Members who have a frequency or duration that is higher than expected. When this occurs, a licensed Care Advocate will contact the provider telephonically to:

- Review eligibility for the service(s)
- Review the treatment plan/plan of care
- Review the case against applicable medical necessity guidelines

There are three potential outcomes of this review:

- Close case (Member is eligible, treatment plan/plan of care is appropriate, care is medically necessary)
- Recommendations to Treatment Plan based on best practices. (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/intensity of care does not appear to be medically necessary)

Potential Outcomes of Peer Review

- Approval
- Partial Adverse Benefit Determination
- Full Adverse Benefit Determination

Quality Improvement

We are committed to the highest quality of care provided in a manner consistent with the dignity and rights of Members and to meeting or exceeding customer expectations. Our Quality Improvement (QI) Program is outlined in the UnitedHealthcare Community Plan of Louisiana Care Provider Manual, which can be found at UHCprovider.com > Administrative Guides > Community Plan Care Provider Manuals > Louisiana. In addition to the activities previously outlined, the QI Program monitors: accessibility, quality of care, appropriateness, effectiveness and timeliness of treatment and Member satisfaction. The QI Program is comprehensive and incorporates the review and evaluation of all aspects of behavioral health care. If you have any feedback regarding QI projects and processes, please contact Network Management.

Compliance with the QI Program is required in accordance with your Agreement, including cooperation with Optum and customers in our efforts to adhere to all applicable laws, regulations and accreditation standards.

The key components of the QI Program required of you as a participating provider include, but are not limited to:

- Ensuring that care is appropriately coordinated and managed between you and the Member's primary care physician (PCP) and other treating clinicians and/or facilities
- Cooperation with on-site audits and requests for treatment records
- Cooperation with the Member complaint process (e.g., supplying information necessary to assess and respond to a complaint)
- Responding to inquiries by our Quality staff
- Participation in Quality initiatives related to enhancing clinical care or service for Members
- Assisting us in maintaining various accreditations as appropriate and as requested
- Submission of information related to our review of potential quality of care concerns
- Helping to ensure Members receive rapid follow-up upon discharge from an inpatient level of care

Adverse Incidents

An adverse incident is an unexpected incident that occurs during the course of a patient receiving inpatient or outpatient behavioral health treatment, or that otherwise occurs while under the care of a behavioral health provider. Adverse incidents include, but are not limited to, concurrent urgent quality of care issues that can reasonably be expected to cause harm or affect patient safety.

The State of Louisiana provides examples of adverse incidents which include, but are not limited to:

- Abuse or neglect including the endangerment, exploitation, or coercion of a child or adult
- Seclusion/restraint while in care, including both chemical and physical restraints, as well as protective holds
- Death, including all deaths regardless of location

Adverse incidents must be reported by providers as soon as possible, but no later than one business day. The following steps outline the reporting process:

1. Collect all pertinent information about the event
2. Complete the **Louisiana Department of Health Adverse Incident Reporting Form** and **fax it** to our secure fax number at **1-888-554-3362** (form can be found on the Provider Express Louisiana page (Home > Our Network > State-Specific Provider Information > Louisiana)
3. Have information readily available to assist in the investigation, if warranted

Sentinel Events

Sentinel events are defined as a serious, unexpected occurrence involving a Member that is believed to represent a possible quality of care issue on the part of the practitioner/facility providing services, which has, or may have, deleterious effects on the Member, including death or serious disability, that occurs during the course of a Member receiving behavioral health treatment. If you are aware of a sentinel event involving a Member, you must notify us within one business day of the occurrence by calling the number on the back of the Member's ID card.

We have established processes and procedures to investigate and address sentinel events. This includes a Provider Advisory Committee, chaired by a medical director, and incorporates appropriate representation from the various behavioral health disciplines as needed. You are required to cooperate with sentinel event investigations.

Member Satisfaction Surveys

On at least an annual basis as required by contract, we conduct a behavioral health Member Satisfaction Survey of a representative sample of Members receiving behavioral health services within the network. The results of the survey are reviewed. Action plans are developed to address opportunities for improvement. Both the survey results and action plans are shared as necessary and appropriate.

Provider Satisfaction Surveys

We regularly conduct a satisfaction survey of a representative sample of clinicians delivering behavioral health services to Members. This survey obtains data on clinician satisfaction with our services including Care Advocacy, Network Services, and claims administration.

The results of the survey are compared to previous years for tracking and trending. Action plans are developed to address opportunities for improvement. Both the survey results and action plans are shared as necessary and appropriate.

Complaint Investigation

Providers may file a complaint by contacting the Provider Services Line at **1-866-675-1607**. The complaint or dispute will be documented and resolved; resolution will be communicated to the provider. Please refer to the UnitedHealthcare Community Plan of Louisiana Care Provider Manual, which can be found at UHCprovider.com > Administrative Guides > Community Plan Care Provider Manuals > Louisiana for additional information about the complaint process.

Treatment Record Documentation and Quality Audits

The Treatment Record Documentation and Quality Audits in support of Louisiana Medicaid are conducted utilizing the Behavioral Health Provider Quality Monitoring Tool Elements established by Louisiana Medicaid. The elements include documentation requirements related to:

- General Administrative Requirements
- A focus on ensuring that Member's Rights are respected and adhered to, in a culturally appropriate manner
- Completion of a thorough Initial biopsychosocial assessment completed at the outset of treatment and updated annually
- Treatment Planning is completed by appropriately licensed clinicians in collaboration with the member, and updated on a regular basis
- Progress Notes reflect the services rendered in relation to the treatment plan, and the member's response to treatment
- There is clear evidence of appropriate collaboration and coordination of care between treating professionals
- Appropriate Medication Management documentation as needed
- Safety elements are addressed as needed
- Appropriate discharge planning and linkage to next levels of care are clearly documented

Licensed Mental Health Professional (LMHP) Treatment Record Review Process

LMHPs treating 50 or more Members annually will participate in a treatment record review at least once every two years. The purpose of the review is to ensure that LMHPs provide high quality services that are documented to established standards. The documentation standards will be made available to all LMHPs on Provider Express Louisiana page.

Assertive Community Treatment (ACT) Fidelity Monitoring Process

Organizational Providers who provide ACT services will participate in regular Fidelity Monitoring, which will include periodic site visits, and ongoing monitoring. The purpose of the monitoring will to be to ensure that providers operate using evidence-based practices. Optum is contracted with Case Western Reserve University, in collaboration with the other Louisiana MCOs, to conduct the ACT Fidelity Monitoring.

Prescription Management Program (PMP), Required Documentation by Prescribers

All prescribers must use the Prescription Monitoring Program (PMP) to conduct Member-specific queries at the time when an initial prescription for a controlled substance is written. Queries must then be completed annually.

The prescriber shall print the PMP query and file it in the Member's treatment record. We will complete random chart reviews to verify compliance with this process. Prescribers may complete additional queries at their discretion.

The goal of the program is to improve the state's ability to identify and inhibit the diversion of controlled substances and drugs of concern in an efficient and cost-effective manner that shall not impede the appropriate utilization of these drugs for legitimate medical purposes.

Confidentiality

Providers must comply with all requirements related to protection of Personal Health information, including but not limited to requirements set forth in Chapter 42 of the Code of Federal Regulations (CFR) Section 431.306 (42 CFR §431.306) regarding Release of Information.

Network Requirements

Network providers are required to support Members in ways that are culturally and linguistically appropriate, and to advocate for the Member as needed.

Network providers are required to notify us on Provider Express under My Practice Info within **ten (10) calendar days** whenever you make changes to your practice including office location, weekend or evening availability, billing address, phone number, e-mail address, Tax ID number, entity name, or active status (e.g., close your business or retire); this includes roster management.

For agency practices, all Licensed Mental Health Professionals (LMHPs) must be maintained on your roster with unique NPI numbers and active licenses. For providers of MHR and EBP services, you must also include non-independently licensed providers with unique NPI numbers and submit the unlicensed provider roster and must electronically sign that you attest that each unlicensed provider has met all the requirements as put forth in the LDH Behavioral Health Provider Services Manual prior to rendering services to Members.

Providers are prohibited from balance billing any Member for any reason for covered services.

Optum requires that providers not employ or contract with any employee, subcontractor or agency that has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

Network Training Requirements

Providers are required to participate in a comprehensive provider training and support program to gain appropriate knowledge, skills, and expertise to comply with the requirements.

The annual training program will address the following areas:

- Orientation to Optum:
  - Credentialing and Re-credentialing
  - Provider Website Orientation
  - Member Eligibility Verification
  - Claims and Billing Guidelines
- Clinical Model:
  - Crisis Management
  - Treatment Planning
  - Use of Evidence-Based Practices
  - Care Coordination
- Cultural competency
- Documentation requirements
- Utilization requirements

Access to Care

On-Call and After-Hours Coverage

You must provide or arrange for the provision of assistance to Members in emergency situations 24 hours a day, seven days a week. You should inform Members about your hours of operation and how to reach you after-hours in case of an emergency. Each Member's treatment plan must also include a crisis plan that informs the Member what to do in the case of an emergency. In addition, any after-hours message or answering service must provide instructions to the Members regarding what to do in an emergency situation. When you are not available, coverage for emergencies should be arranged with another participating provider.

Access to Outpatient Mental Health and Substance Use Disorder Services

To ensure that all Members have access to appropriate treatment as needed, we develop, and maintain a provider network with adequate types and numbers of providers. We require that network providers adhere to specific access standards, which are outlined as follows:

Specialized Behavioral Health Providers	Appointment Availability Standard
Non-Urgent Routine	14 days
Urgent Non-emergency Care	48 hours
Psychiatric Inpatient Hospital (emergency involuntary)	4 hours
Psychiatric Inpatient Hospital (involuntary) 24 hours	24 hours
Psychiatric Inpatient Hospital (voluntary) 24 hours	24 hours
ASAM Level 3.3, 3.5 & 3.7 10 business days	10 business days
Withdrawal Management 24 hours when medically necessary	24 hours when medically necessary
Psychiatric Residential Treatment Facility (PRTF)	20 calendar days

- Emergent, crisis or emergency behavioral health services must be available at all times and an appointment shall be arranged within one (1) hour of the request
- An outpatient appointment for behavioral health or substance abuse must be offered within seven (7) days of an acute inpatient discharge

Optum expects that Members will generally have no more than a 45-minute wait time for their appointment in your office; this includes time spent in the waiting room and consultation room.

If the provider is delayed Members should be notified immediately. If the wait is anticipated to be longer than 90 minutes, Members should be offered a new appointment time. In addition, any rescheduling of an appointment must occur in a manner that is appropriate for the Member's health care needs and ensures continuity of care consistent with good professional practice.

Members who walk-in seeking an appointment and do not have an urgent need should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

Optum will monitor compliance with appointment access standards and the provision of after-hours coverage through monitoring of Member complaints and telephonic assessment of appointment availability.

If you are unable to take a referral, immediately direct the Member to contact us at **1-866-675-1607** so that they can obtain a new referral.

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Geographic Access Standards

Optum is expected to meet certain geographic access standards; these standards must be met for 90% of the membership we serve (Exception PRTF – 100%).

Type	Ratio (Provider: Member)	Rural Parishes (miles^2)	Urban Parishes (miles^2)
Behavioral Health			
Psychiatrists			
Psychiatrists		30	15
Behavioral Health Specialists (adult)			
Advanced Practice Registered Nurse (Behavioral Health Specialty; Nurse Practitioner or Clinical Nurse Specialist); or		30	15
Medical or Licensed Psychologist; or			
Licensed Clinical Social Worker			
Behavioral Health Specialists (pediatric)			
Advanced Practice Registered Nurse (Behavioral Health Specialty; Nurse		30	15
Practitioner or Clinical Nurse Specialist); or			
Medical or Licensed Psychologist; or			
Licensed Clinical Social Worker			
Psychiatric Residential Treatment Facilities (PRTFs) (pediatric)			
Psychiatric Residential Treatment Facility		200	
Psychiatric Residential Treatment Facility Addiction (ASAM Level 3.7)			
Psychiatric Residential Treatment Facility Other Specialization			
Substance Use Residential Treatment Facilities - Adult Population			
ASAM Levels 3.3/ 3.5		30	30
ASAM Level 3.7		60	60
ASAM Level 3.7-WM		60	60
Substance Use Residential Treatment Facilities - Adolescent Population			
ASAM Level 3.5		60	60
Psychiatric Inpatient Hospital Services			
Hospital, Free Standing Psychiatric Unit		90	90
Hospital, Distinct Part Psychiatric Unit			

Table: Geographic Access Standards

Credentialing

Optum will complete initial credentialing of a provider within 60 days of receipt of a completed credentialing application. A completed credentialing application includes all necessary documentation, attachments, and a signed Agreement.

New Enrollment Requirements for All UnitedHealthcare Community Plan Providers

All UnitedHealthcare Community Plan providers are now required to enroll as a Louisiana Medicaid provider using Medicaid's new Provider Enrollment Portal. Enrollment is necessary to comply with federal laws and continue to receive reimbursement for providing care to UnitedHealthcare Community Plan members. This is separate from the enrollment, screening, and credentialing processes you completed to join the UnitedHealthcare Community Plan provider network. Managed care providers must still be enrolled, credentialed, and contracted in keeping with UnitedHealthcare Community Plan requirements.

Please keep reading for guidance on how to comply with the new requirements. Additional information is also available at ldh.la.gov/medicaidproviderenrollment.

Billing and Claims

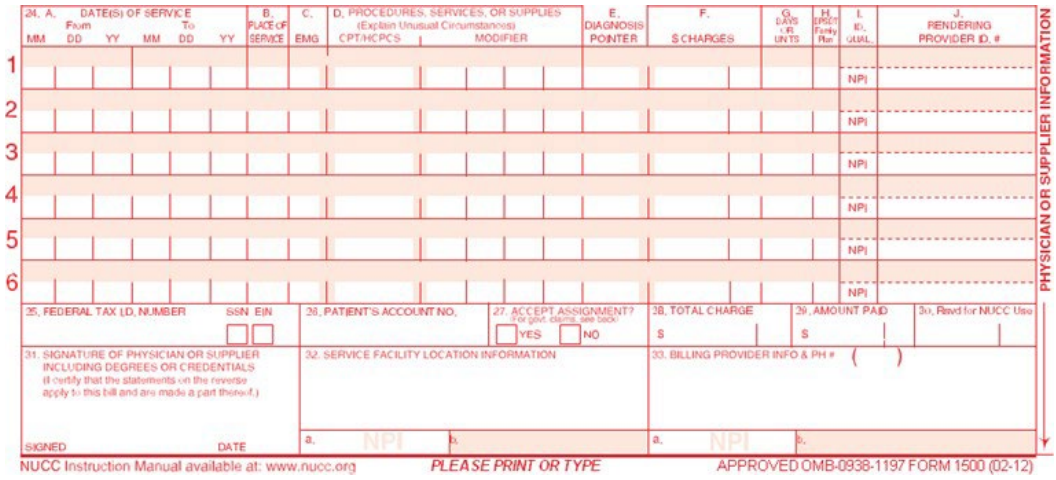
Billing Guidelines

- Keep your NPI handy:
  - You will need to bill your registered NPI on your claims
  - The NPI you need to bill is the servicing provider ID assigned to you, as an individual
  - For claims billed with HCPCS codes, the rendering provider's NPI is placed in box 24J of your Form 1500 (formerly called CMS-1500) claim form (some exceptions required; check *providerexpress.com* > Our Network > State-Specific Information > Louisiana page)
  - For claims billed with revenue codes, use the UB-04 form
- Billing Limitations (it is important that providers acquaint themselves with the current billing restrictions; always refer to the UnitedHealthcare Community Plan Reimbursement Policies (*uhcprovider.com* > Policies & Protocols > For Community Plan > Reimbursement Policies for Community Plan)
- Optum Reimbursement Policies (providerexpress.com > Clinical Resources > Guidelines/Policies/Manuals > Reimbursement Policies)
- Some of the services are not able to be billed on the same day as other covered services

- Most codes have a daily or annual limit to the amount of services that may be provided

- Report the provider doing the service, using that provider's registered NPI in the NPI field of box 24J of the Form 1500:
  - Include your Tax ID number in box 25, Service Location, box 32 (where service was rendered) and Billing Information, box 33

Example partial Form 1500 below:



- 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 NPIs for rostered clinicians)
  - Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at cms.gov

Claims Submission

Claims may be submitted in different ways:

- Online at *uhcprovider.com*
- Electronic Data Interchange (EDI) using any clearinghouse:
  - Payer ID is 87726
  - More information is available on UHCprovider.com
- U.S. Mail:

UnitedHealthcare Community Plan of Louisiana
P.O. Box 31341
Salt Lake City, UT 84131-0341

Claim Reconsiderations, Appeals and Grievances

Denial

Your claim may be denied for administrative or medical necessity reasons.

An Administrative Denial is when we didn't get notification before the service, or the notification came in too late.

Denial for medical necessity means the level of care billed wasn't approved as medically necessary.

If a claim is denied for these reasons, you may be able to request a claim reconsideration or file an appeal.

Other top reasons for denial include:

- **Duplicate claim** – This is one of the most common reasons for denial. It means resubmitting the same claim information. This can reset the clock on the time it takes to pay a claim.
- **Claim lacks information**. Basic information is missing, such as a person's date of birth; or information incorrect, such as spelling of a name. You can resubmit this type of claim with the correct information
- **Eligibility expired**. Most practices verify coverage beforehand to avoid issues, but sometimes that doesn't happen. One of the most common claim denials involving verification is when a patient's health insurance coverage has expired and the patient and practice were unaware.

  Also, in many cases, practices may check eligibility when an appointment is made, but between the appointment being made and the actual visit, coverage can be dropped. We recommend an eligibility check again once the patient has arrived.
- **Claim not covered by UnitedHealthcare Community Plan**. Another claim denial you can avoid is when procedures are not covered by us. You can easily avoid this problem by using real-time verification.
- **Time limit expired**. This is when you don't send the claim in time.

Claim Correction

What is it?

A corrected claim replaces a previously denied submitted claim due to an error. A denied claim has been through claim processing and determined it can't be paid.

When to use:

Submit a corrected claim to fix one that has already processed.

How to use:

Use the claims reconsideration application on Link. To access Link, sign in to UHCprovider.com using your One Healthcare ID. You may also submit the claim by mail with a claim reconsideration request form. Allow up to 30 days to receive payment for initial claims and a response.

Additional Information:

When correcting or submitting late charges on 837 institution claims, use bill type xx7: Replacement of Prior Claim. Do not submit corrected or additional information charges using bill type xx5: Late Charge Claim.

If UnitedHealthcare Community Plan, the LDH or its subcontractors discover an error when UnitedHealthcare Community Plan adjudicates a claim, we will reprocess the claim within 30 calendar days of discovery. If UnitedHealthcare Community Plan cannot meet this time frame, the LDH will approve a specified date. UnitedHealthcare Community Plan will automatically recycle all affected claims. We will not require you to resubmit those claims.

Resubmitting a Claim

What is it?

When you resubmit a claim, you create a new claim in place of a rejected one. A rejected claim has not been processed due to problems detected before processing.

When to use it:

Resubmit the claim if it was rejected. A rejected claim is one that has not been processed due to problems detected before claim processing. Since rejected claims have not been processed yet, there is no appeal — the claim needs to be corrected through resubmission.

Common Reasons for Rejected Claims:

Some of the common causes of claim rejections happen due to:

- Errors in member demographic data – name, age, date of birth, sex or address
- Errors in care provider data
- Wrong member insurance ID
- No referring care provider ID or NPI number

How to use:

To resubmit the claim, follow the same submission instructions as a new claim.

Warning: If your claim was denied and you resubmit it, you will receive a duplicate claim rejection. A denied claim has been through claim processing and we determined it cannot be paid.

You may appeal a denied claim by submitting the corrected claim information or appealing the decision. See Claim Correction and Reconsideration sections of this chapter for more information.

Level 1 Dispute — Claim Reconsideration

What is it?

Claim issues include overpayment, underpayment, denial, or an original or corrected claim determination you do not agree with. A claim reconsideration request is the quickest way to address your concern about whether the claim was paid correctly.

When to use:

Submit a claim reconsideration when you think a claim has not been properly processed. Request for claim reconsideration review must be received from the provider within 180 calendar days of the Remittance Advice paid date or original denial date. A determination will made within 30 days of receipt.

For administrative denials:

- In your reconsideration request, please ask for a medical necessity review and include all relevant medical records.
- For medical necessity denials:
  - In your request, please include any additional clinical information that may not have been reviewed with your original claim
  - Show how specific information in the medical record supports the medical necessity of the level of care performed – for example, inpatient instead of observation

How to use:

If you disagree with a claim determination, submit a claim reconsideration request electronically, or by phone:

- Electronically: Use the Claim Reconsideration application on Link. Include electronic attachments. You may also check your status using Link. You can also find it on UHCprovider.com.
- Phone: Call Provider Services at **1-866-675-1607** or use the number on the back of the member's ID card. The tracking number will begin with SF and be followed by 18 numbers.

Claims Dispute Timeframe:

The complaint resolution analyst acknowledges the provider complaint immediately either by phone or in writing, but no later than three business days from the time the complaint is received, regardless of the method the care provider used to communicate the complaint.

Allow up to 30 days for UnitedHealthcare Community Plan to process Claim Disputes.

Valid Proof of Timely Filing Documentation (Reconsideration)

What is it?

Proof of timely filing occurs when the member gives incorrect insurance information at the time of service. It includes:

- A denial or rejection letter from another insurance carrier
- Another insurance carrier's explanation of benefits
- Letter from another insurance carrier or employer group indicating:
  - Coverage termination prior to the date of service of the claim
  - No coverage for the member on the date of service of the claim

  A submission report is not proof of timely filing for electronic claims. It must be accompanied by an acceptance report. Timely filing denials are often upheld due to incomplete or wrong documentation submitted with a reconsideration request. You may also receive a timely filing denial when you do not submit a claim on time.

How to use:

Submit a reconsideration request electronically, phone, mail or fax with the following information:

- Electronic claims: Include the EDI acceptance report stating we received your claim
- Mail or fax reconsiderations: Submit a screen shot from your accounting software that shows the date you submitted the claim. The screen shot must show:
  - Correct member name
  - Correct date of service
  - Claim submission date

Additional Information:

Timely filing limits can vary based on state requirements and contracts. If you do not know your timely filing limit, refer to your Provider Agreement.

Level 2 Dispute — Appeals

What is it?

An appeal is a second review of a reconsideration claim.

When to use:

If you do not agree with the outcome of the claim reconsideration decision in step one, use

the claim appeal process. Send appeals 60 calendar days from the first-level reconsideration decision date or the PRA.

How to use:

Claim appeals must be submitted in writing. Submit related documents with your appeal. These may include a cover letter, medical records and additional information. Send your information electronically, by mail or fax. In your appeal, please include any supporting information not included with your reconsideration request.

- Electronic claims: Use the Claims Management or Claims Link application on Link. You may upload attachments.
- Mail: Send the appeal to:

Optum
Appeals and Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512

Appeals and Grievances

Call **1-866-675-1607** and a Provider Services representative will assist you with the Appeals and Grievances process. You may file an appeal with written consent from the member within 60 calendar days of the notice of action.

Contact Us

You can contact us at **1-866-675-1607** with questions about claims, benefits and eligibility, authorizations, credentialing, network services and other professional services.

Technical Support for Provider Express (providerexpress.com)

For questions about using this site, issues with requesting a user ID and password, or for technical issues, call the Provider Express Support Center at **1-866-209-9320** (toll-free) from 7 a.m. to 9 p.m. Central time.