Optum

Optum Behavioral Health Providers

Refresher

Fall 2022

Welcome to Optum – refresher training

1. Introduction to Optum / RI Health Plan Partners
2. Provider Express
3. Benefits and Authorization
4. Employee Assistance Program (EAP)
5. Virtual Visit
6. Network Responsibilities
7. Claims / Billing
8. Clinical / Program Network Integrity
9. Contacting Optum

Introduction to Optum / Rhode Island Health Plan Partners

Who is Optum?

Optum is a leading health services organization dedicated to making the system work better for everyone

Our core values:

Integrity | Compassion | Relationships | Innovation | Performance

Optum

Rhode Island Health Plan Partners

UnitedHealthcare®

Helping people live healthier lives

Health care coverage and benefits:

- Employer & Individual
- Medicare & Retirement
- Community & State
- Military and Veterans
- Global

Neighborhood Health Plan OF RHODE ISLAND™

Founded with the support of Rhode Island's Community Health Centers and began serving members in 1994

More than 200,000 members (one in five Rhode Islanders)

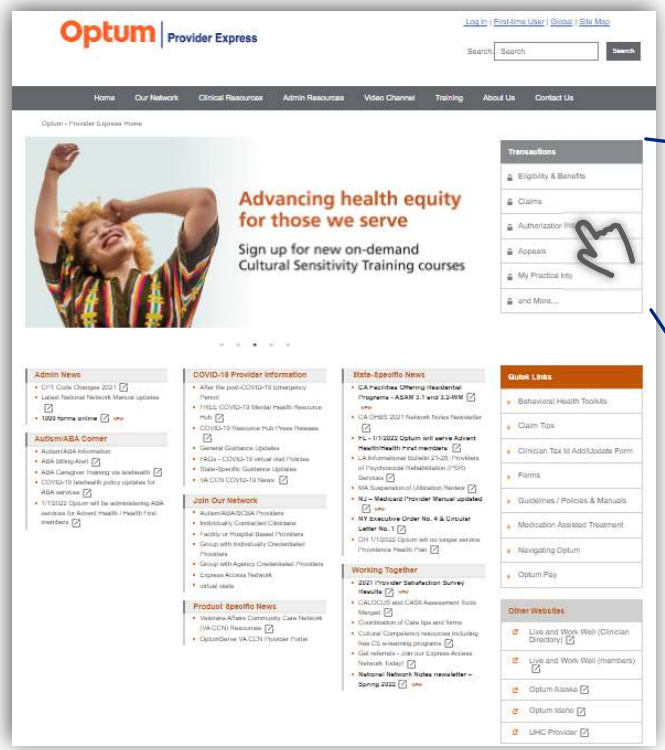
First community health center based health plan in the country to be rated "Excellent" by the National Committee for Quality Assurance for 18 consecutive years

- Medicaid
- Commercial/Exchange
- Medicare-Medicaid Plan (MMP)

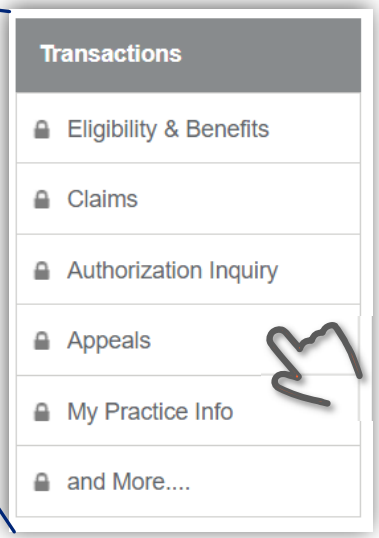
Provider Express

Benefits of using *Provider Express* regularly

Provider Express, providerexpress.com offers many tools that make working with Optum quick and easy. Available 24/7, Provider Express helps reduce paper and telephone transactions.



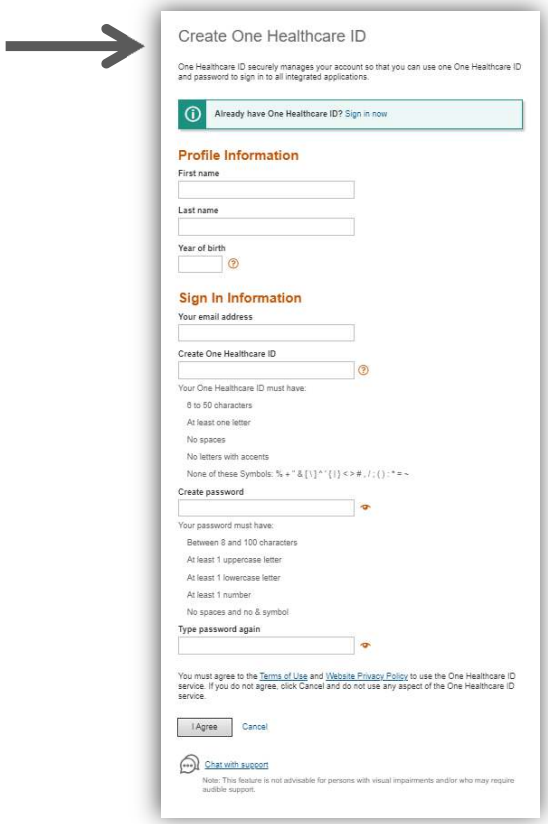
Use secure Transactions for many provider transactions:

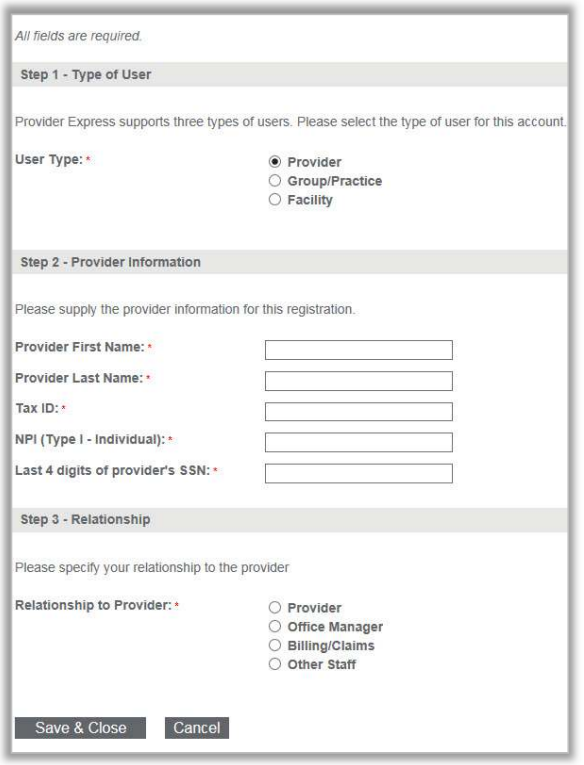


Logging into *Provider Express* for the first time

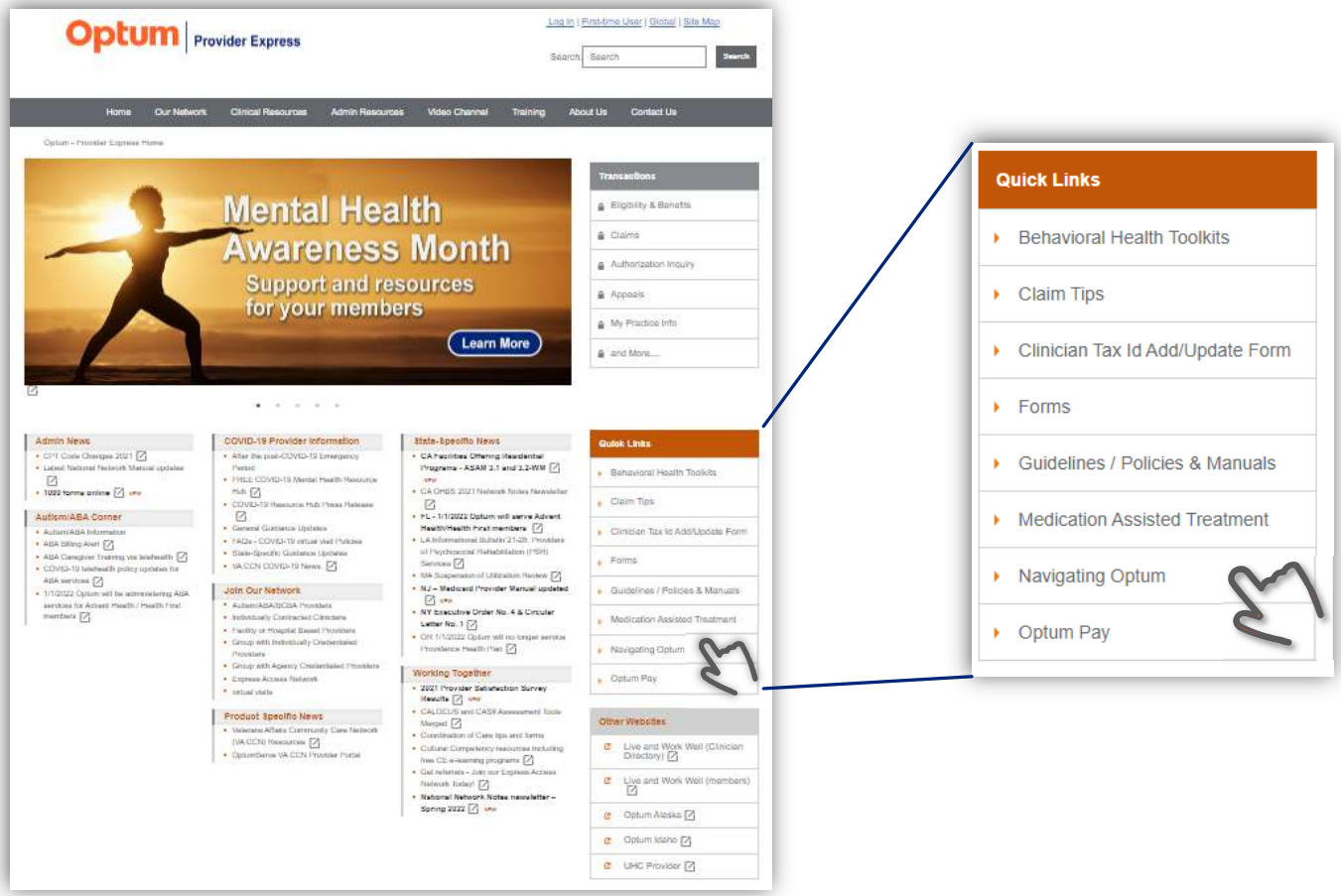
- Users logging in for the first time are required to create a One Healthcare ID, creating a unique password for secure log in

- Users then complete the *Provider Express* registration page. Click the *"Save & Close"* button to process the registration request

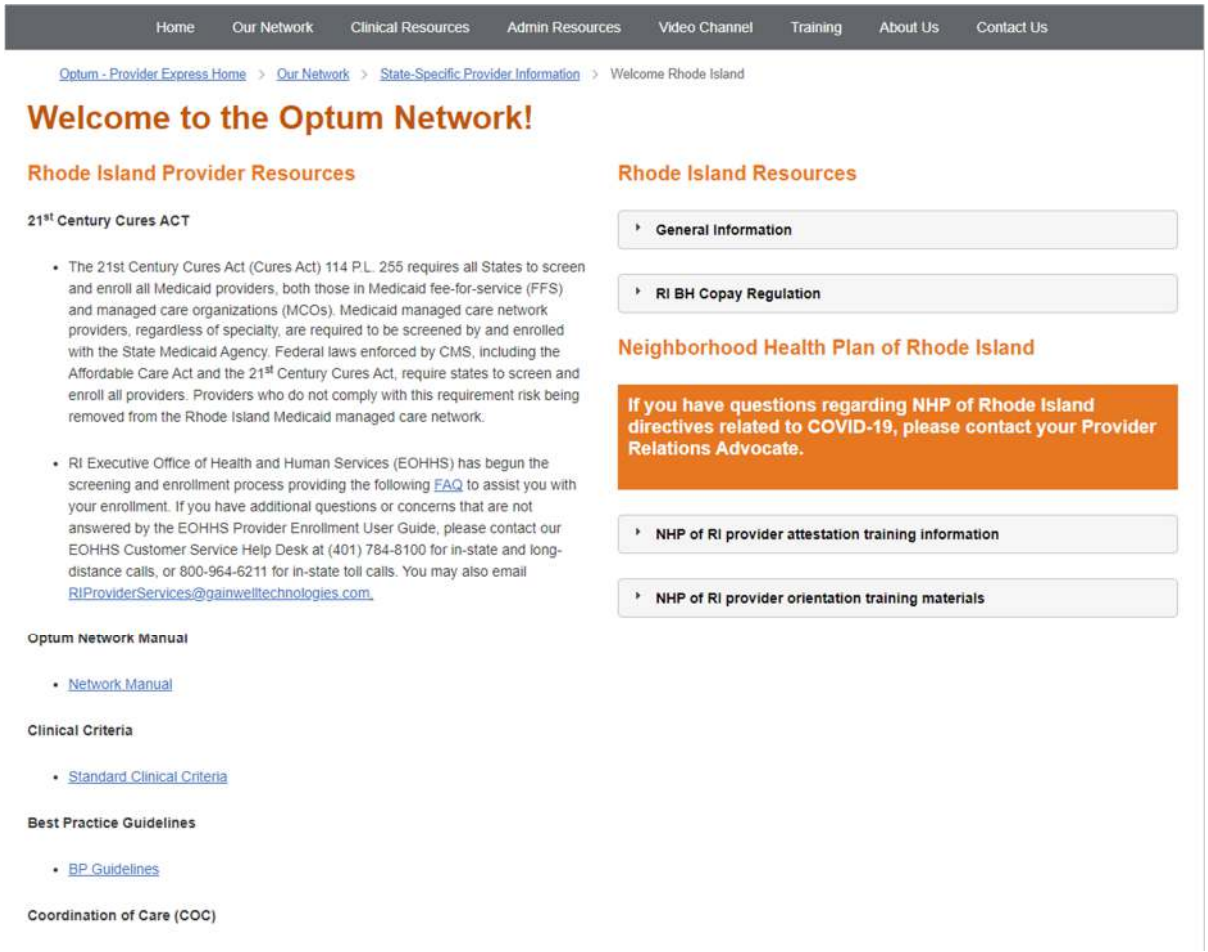




Great online resource for new network providers



RI specific Provider Express page



Home | Our Network | Clinical Resources | Admin Resources | Video Channel | Training | About Us | Contact Us

Optum - Provider Express Home > Our Network > State-Specific Provider Information > Welcome Rhode Island

Welcome to the Optum Network!

Rhode Island Provider Resources

21st Century Cures ACT

- The 21st Century Cures Act (Cures Act) 114 P.L. 255 requires all States to screen and enroll all Medicaid providers, both those in Medicaid fee-for-service (FFS) and managed care organizations (MCOs). Medicaid managed care network providers, regardless of specialty, are required to be screened by and enrolled with the State Medicaid Agency. Federal laws enforced by CMS, including the Affordable Care Act and the 21st Century Cures Act, require states to screen and enroll all providers. Providers who do not comply with this requirement risk being removed from the Rhode Island Medicaid managed care network.
- RI Executive Office of Health and Human Services (EOHHS) has begun the screening and enrollment process providing the following FAQ to assist you with your enrollment. If you have additional questions or concerns that are not answered by the EOHHS Provider Enrollment User Guide, please contact our EOHHS Customer Service Help Desk at (401) 784-8100 for in-state and long-distance calls, or 800-964-6211 for in-state toll calls. You may also email RIProviderServices@gainwelltechnologies.com.

Optum Network Manual

- Network Manual

Clinical Criteria

- Standard Clinical Criteria

Best Practice Guidelines

- BP Guidelines

Coordination of Care (COC)

Rhode Island Resources

- General Information
- RI BH Copay Regulation

Neighborhood Health Plan of Rhode Island

If you have questions regarding NHP of Rhode Island directives related to COVID-19, please contact your Provider Relations Advocate.

- NHP of RI provider attestation training information
- NHP of RI provider orientation training materials

Video resource page for providers on Provider Express

SELECT VIDEO CHANNEL FROM MAIN NAVIGATION BAR

VERTICALLY SCROLLING MENU OF NEWEST VIDEOS

SLIDING MENU OF THE MOST WATCHED VIDEOS

DOZENS OF SUBJECTS COVERED IN BRIEF, STEP-BY-STEP FASHION

Benefits and Authorizations

Understanding covered benefits

Optum uses Clinical Criteria based on sound clinical evidence to make coverage determinations, including externally adopted clinical criteria such as American Society of Addiction Medicine (ASAM) Criteria to inform discussions about evidence-based practices and discharge planning. In using its Clinical Criteria, Optum takes individual circumstances and the local delivery system into account when determining coverage of behavioral health services.

Optum Members have a variety of benefits available to them

Check a Member's benefits and eligibility on *Provider Express* through secure Transactions or call the number on the back of the members ID card

***Always check benefits before providing services to a member served by Optum**

Important authorization information

Routine outpatient services do **not** require prior authorization. The following frequently-used procedure codes are considered routine services:

90791	90832	90834	90846	90847
90849	90853	99241	99242	99243

Non-routine services **do** require an authorization:

Use providerexpress.com to request authorization for the following:

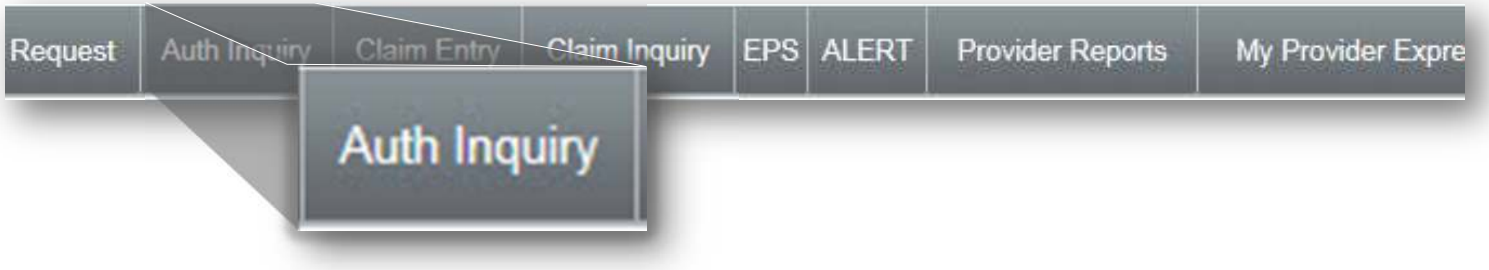
- Psychological Testing
- Transcranial Magnetic Stimulation (TMS)
- Applied Behavior Analysis

Login to Provider Express: Auth Request >> click appropriate link
Or without logging in: Clinical Resources >> Forms >> Clinical Forms

Please call the number on the back of the Member's ID card to authorize all other non-routine services

Optum

Check authorization status online



Once you have obtained authorization for clinical services, you have the capability in the secure Transactions on *Provider Express* to:

- Look up authorizations, even if the authorization was not generated through *Provider Express*
- View authorization details

Member experience - referrals

- Members can self-refer using liveandworkwell.com or by calling our intake department.
- Referrals are based on the details of your provider profile such as language, specialties, populations treated, gender, etc.
- If you are not able to accept a referral either because you are unavailable or feel that the referral is inappropriate, please direct the member back to their member portal, our intake department or refer the member to a peer that you feel would be more appropriate that is contracted with Optum.

Member experience - returning calls and voicemail

There are additional things you can do to improve the member experience and potentially decrease the volume of inappropriate calls that you receive while increasing the number of appropriate referrals that come your way:

- Review your member-facing provider profile on **Live and Work Well.**
- Keep your practice hours, specialties and current availability updated through **Provider Express**.
- List your email or website on your provider profile to offer an additional option for members to contact you.

Ensure your voicemail has helpful information such as:

- Hours of operation/ Current availability
- Expected callback timeframe is within required 24 hours
- E-mail, text messaging number or website (if preferred)
- Asking members to clearly and slowly state their name and phone number twice
- After hours emergency protocols

Coordination of care – it's important

- Affords the best quality of care and outcomes for your patients
- Enhances your practice through networking
- Accomplishes an expected standard of practice

To learn more, download our Coordination of Care flyer

To download a helpful Coordination of Care checklist, click here

Please be sure have the member sign a release of information form. You may use your own form or click here to access the Optum Confidential Exchange of Information form.

Cultural competency

At Optum we believe it is critical for providers to understand Cultural Competency in order to ensure your members get culturally sensitive and appropriate care. Therefore, we are pleased to highlight some information and key resources to help you on your journey, including free continuing education e-learning programs available through the Office of Minority Health, U.S. Department of Health & Human Services.

Cultural competency may be viewed in terms of a continuous progression of growth, development and change. It is important both for individuals and organizations to continuously and intentionally work to develop and strengthen competencies in order to provide effective services to diverse populations. The continuum ranges from potentially damaging and uninformed practices to constructive and professionally recognized practices that facilitate culturally relevant service delivery.

Cultural Competency and Linguistics Training

Cultural Sensitivity Trainings

Employee Assistance Program (EAP)

EAP authorizations, billing and claims

Authorizations are required for EAP services and may be initiated by either the member or the contracted provider prior to the first appointment. To request authorization, call the behavioral health number on the back of the member's insurance card. EAP authorization letters are sent directly to the member via e-mail or USPS. Inquire with the member about the EAP authorization code number, effective dates and expiration dates, and whether any of the authorized visits have already been used.

The easiest way to bill for EAP services is to submit claims on providerexpress.com. Providers may need a subscriber ID for Optum EAP members. If the member also has Optum for behavioral health coverage, their subscriber ID is often the same for EAP. If the member does not have Optum behavioral health coverage, providers may call into Optum EAP 24/7 to confirm the subscriber ID.

All EAP Claims must include an HJ modifier following the CPT code to be processed and paid correctly. When billing on providerexpress.com, providers will be prompted to select BH or EAP. When selecting EAP, the HJ modifier will automatically populate. If the services are provided virtually the GT modifier must also be included on the claim.

Updating EAP status

Update your EAP status online on Provider Express

- **Individual Providers** can update their EAP status by logging in to providerexpress.com and clicking Edit under General Information from their *Practice Information* page.

- **Group Practices** can update their EAP status by logging in to providerexpress.com and clicking Edit under General Information from their *Practice Profile* page.

- **Providers Credentialed under a Group** can update their EAP status by logging in to providerexpress.com and clicking Edit under General Information from their *Edit Clinician* page.

Optum Employee Assistance Program (EAP) (providerexpress.com)

Virtual Visits

Telehealth (virtual visits)

- Same member benefit as in-person visits
- Same member cost share
- Same provider reimbursement
- EAP, Commercial, Medicare and Medicaid
- Add place of service
- RI specific billing guidance is available on Provider Express

The virtual visits technology platform is available for use with no licensing cost or monthly fee for our network providers and Optum members. Providers must have submitted a signed attestation on Provider Express. If you are looking for a convenient, cost-effective telemental health solution, then we encourage you to register to use this platform. However other HIPAA compliant platforms may be used upon approval.

Prescribers and Non-Prescribers may now complete an attestation in the My Practice Info virtual visits tab in the secure transactions area of Provider Express.

Click here for a quick walk-through of the Auto Attestation Process

Network

Staying current with "*My Practice Info*"

Having the most up-to-date information at Optum ensures that referrals can find you and that you get reimbursed promptly and accurately.

- Change, add or modify your address and other demographic information
- Indicate your availability to accept new patients into your practice
- Let us know if you are going to be away for an extended period of time

Provider responsibilities

- Render services to Members in a non-discriminatory manner:
  - Maintain availability for a routine level of need for services
  - Offer routine non-urgent appointments within 10 days of the request for services
  - Provide after-hours coverage
  - Support Members in ways that are culturally and linguistically appropriate
- Determine if Members have benefits through other insurance coverage
- Advocate for Members as needed
- Provider to update information directly on providerexpress.com within ten (10) calendar days whenever you make changes to your office location, billing address, phone number, Tax ID number, entity name, or active status (e.g., close your business or retire); this includes roster management

Recredentialing

- Recredentialing is completed every 36 months (3 years):
  - Timeline is established by NCQA
- Under the Consolidated Appropriations Act (CAA), Providers are required to attest to their data every 90 days
- Several months prior to the recredentialing date, a recredentialing packet will be sent to the primary address on file for the provider
- Completion of the entire recredentialing packet is required for the recredentialing process to be completed
- Site audits will be completed for organizational providers as indicated by Optum policy
- Failure to complete the recredentialing paperwork or participate in the recredentialing site audit (when applicable) will impact the provider's status in the network

Supervisory protocol addendum

The Supervisory Protocol addendum allows for non-credentialed clinicians to render services while under the supervision of an independently licensed clinician:

- Clinicians rendering psychotherapy services must have a minimum of a master's degree
- All services that are rendered must be within the scope of the clinician's training
- Supervision must:
  - Occur regularly on a one-to-one basis
  - Be documented

Member rights and responsibilities

- Member Rights and Responsibilities can be found in the National Network Manual (Page 89-90). These rights and responsibilities are in keeping with industry standards.
- Optum requests that you display the Rights and Responsibilities in your waiting room or have some other means of documenting that these standards have been communicated to the members served by Optum.
- You may request a paper copy by contacting Provider Relations at 1-877-614-0484.

Attestation for Integrity

Neighborhood Health Plan OF RHODE ISLAND

MEDICAID MEMBERS ▾ COMMERCIAL MEMBERS ▾

Provider Training

Neighborhood Health Plan of Rhode Island network providers are required to complete an annual training. The provider training offers an overview of Neighborhood, including its plans, policies and procedures for providers. In addition, the training includes specific education for providers who serve INTEGRITY members, on topics including, but not limited to the following:

- Member Enrollment and Eligibility
- Covered Services, Benefit and Services (including carved-out), policies and procedures
- Provider Rights and Responsibilities pertaining to:
  - Complaints, Grievances, and Appeals procedures and timelines
  - ADA compliance, accessibility and accommodations
  - Cultural competency

An authorized representative from each provider organization must complete the training and attest to having done so (below). The authorized representative also attests that he/she will educate his/her employees using Neighborhood's training.

For your viewing and sharing convenience, the training is available below in both PowerPoint and pdf. Both versions include hyperlinks to external webpage content, but please note that PowerPoint needs to be in "presentation" mode for the links to be active.

- Click here to view the training curriculum (PowerPoint)
- Click here to view the training curriculum (Adobe pdf)

If you have questions about the training, please email providertraining@nhpri.org.

Express Access

Express Access Network is a network of Optum-credentialed providers who have agreed to offer Optum members, on all lines of business including EAP, a **routine** appointment within 5 business days of a member's request.

Click here to enroll

Claims / Billing

Claim submission options

Claim Entry through providerexpress.com

- Secure HIPAA-compliant transaction streamlines the claim submission process
- Submitting claims closely mirrors the process of manually completing a Form 1500
- Allows claims to be paid quickly and accurately

You must have a registered user ID and password to gain access to the online claim submission function. To obtain a user ID, call toll-free **1-866-842-3278**

Electronic Data Interchange (EDI)

- Secure, efficient, and cost-effective
- You may use any clearinghouse vendor to submit claims
- Payer ID for submitting claims to Optum is **87726**
- Additional information regarding EDI is available on providerexpress.com >> Admin Resources >> Claim Tips >> EDI/Electronic Claims

Tips for timely and accurate payment

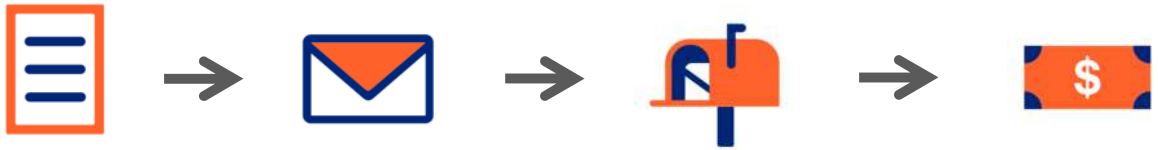
Filing electronically can help prevent these common errors:

Missing or incomplete information	Member demographic info has errors	Unclear or illegible information
Provider Express "Claim Entry" prevents the submission of claim if required fields are blank *Examples*: NPI number, DSM-5 derived diagnosis code	Member information is auto-populated when you use *"Claim Entry"* on *Provider Express* *Examples:* Name, DOB, ID number	The Claim Entry form on *Provider Express* ensures legibility *Examples*: Provider or Member information illegible, diagnosis code unclear

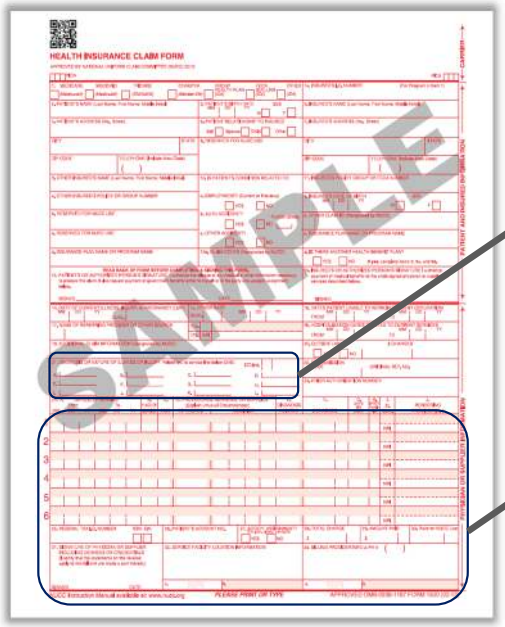
Filing paper claims

If you are unable to file electronically, follow these tips to ensure smooth processing of your paper claim:

- Use an original 02/12 1500 Claim Form (no photocopies)
- Type information to ensure legibility
- Use a DSM-5 derived ICD-10 code for primary diagnosis (Hint: the DSM-5 includes ICD codes along with the DSM diagnostic info)
- Complete all required fields (including ICD indicator and NPI number)

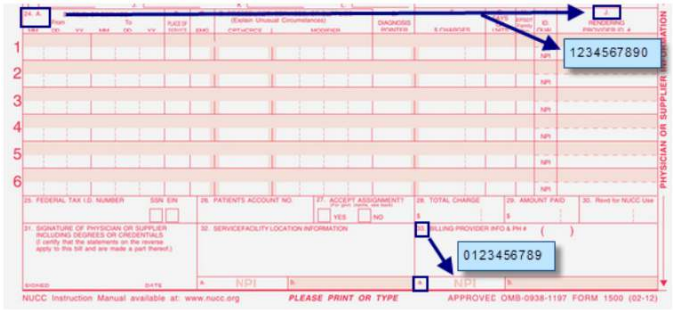


1500 claim form - formerly called CMS-1500 or HCFA



Include the ICD indicator:
0 for ICD-10

There are two distinct fields for placement of an NPI number



Link to National Uniform Claim Committee (NUCC) 1500 Claim Form Reference Instruction Manual

Timely filing of claims

Providers contracted with Optum are required to submit claims for services rendered to Optum Members within 90 days of the date of service.

- Corrected claims:
  - Commercial and Medicare can be submitted up to180 days from the denial EOB
  - Medicaid can be submitted up to 365 days from the denial EOB

As stated in the Optum Rhode Islands Network Manual:

- In accordance with the state contract and to clarify expectations, all requests for corrected claims payment must be received within 365 days from date of service to be considered for payment of services rendered for members of a State Program. As a reminder, the original claim submission must meet timely filing requirements of 90 days from date of service.

Taxonomy

https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/ourNetworkMain/welcomeNtwk/RI/BH3111_NPI.TaxReqrmntCHART.pdf

Optum

PROVIDERALERT

Reminder of TAXONOMY AND NPI Billing Information

Dear Provider:

This notification is being sent to you as a reminder of NPI and Taxonomy requirements on claim submissions. Optum, in compliance with CMS, requires specific fields to include a providers NPI number and Taxonomy code.

It is important to know that as of 12/15/2020, claims billed without this requirement will be rejected.

- This alert does not change how you currently bill except that for each instance where an NPI is entered on the claim form its corresponding Taxonomy must also be entered
- This requirement applies to all RI lines of business managed by Optum
- The Taxonomy number entered in each field must match with the NPI being used. To validate correct taxonomy match please utilize https://npiregistry.cms.hhs.gov/
- Using National Uniform Claim Committee CMS-1500 Claim (nucc.org) for reference
  - PO Box cannot be entered on paper claim forms
  - ZZ prefix is required in box 33 b with the taxonomy number only when billing a paper 1500 form
- There is a maximum 12 month window from date of service for consideration of corrected claims submission riManualAddendum (providerexpress.com)
  - Providers must work rejection reports timely. Rejected claims will need to be corrected, and the corrected claim must be resubmitted to Optum.
  - Claims denied for NPI/Taxonomy through the provider remittance advice must be corrected and resubmitted.
- All other Practice Management System Protocols will remain in force

Providers using Provider Express, after logging into your account, NPI and taxonomy information will auto-populate once you choose the rendering clinician.

For electronic (EDI) and paper submissions, please refer your EDI vendor to data chart on the next page. This information can also be found on Provider Express.

- **Path**: Provider Express → Our Network → State Specific → RI → General Information → NPI Taxonomy requirements on claims submissions information
- **Link to document**: https://www.providerexpress.com/content/dam/ope-provexpr/us/pdfs/ourNetworkMain/welcomeNtwk/RI/BH3111_NPI.TaxReqrmntCHART.pdf

Reference Grid:

		USE IF PROVIDER IS SUBMITTING CLAIM ON PAPER FORM				USE IF PROVIDER IS SUBMITTING CLAIM VIA PROVIDER EXPRESS	USE IF PROVIDER SUBMITTING CLAIM VIA EDI		REJECTION CODE AND DESCRIPTION	
	DATA	Facility Field Description	UB04 (Facility) INSTITUTIONAL	Professional Field description	CMS 1500 PROFESSIONAL	PROVIDER EXPRESS	EDI LOOP INSTITUTIONAL	EDI LOOP PROFESSIONAL	REJECTION CODE	REJECTION DESCRIPTION
1	NPI	NPI	FL56	Billing provider info	33a	Billing entity exists as it populates from provider record. No edit required.	2010AA NM109	2010AA NM109	PI	A3:562 Billing Entity's National Provider Identifier (NPI) Note: This code requires use of an Entity Code.
2	NPI	n/a	n/a	Rendering Provider info (bottom)	24J	Rendering entity exists as it populates from provider record. No edit required.	2310D NM109	2310B NM109	PI	A3:562 Entity's National Provider Identifier (NPI) Note: This code requires use of an Entity Code.
3	NPI	Facility Attending information	FL76	n/a	n/a	n/a	2310A NM109	n/a	PI	A3:562 Entity's National Provider Identifier (NPI) Note: This code requires use of an Entity Code.
4	Taxonomy	Facility other provider ID	FL57 (15 AN characters)	Billing provider info	33b	Populates from Provider record. Field can be edited and provider needs to confirm it is populated and is correct for TIN and NPI (group taxonomy)	2000A PRV03	2000A PRV03	TX	A6:145 PR Entity's specialty/taxonomy code. Usage: This code requires use of an Entity Code.
5	Taxonomy	n/a	n/a	Rendering Provider info (top)	24J	Rendering information populates from Provider record. Field can be edited and provider needs to confirm it is populated and is correct for TIN and NPI	n/a	2310B PRV03	TX	A6:145 PR Entity's specialty/taxonomy code. Usage: This code requires use of an Entity Code.
6	Taxonomy	Facility Attending information	FL 76 (0B, or 1G or G2 for taxonomy?)	n/a	n/a	n/a	2310A PRV03	n/a	TX	A6:145 PR Entity's specialty/taxonomy code. Usage: This code requires use of an Entity Code.
7	PO Box	Facility provider name and address. Cannot use PO Box on paper submission	FL1	Billing provider info	33	Billing provider exists as it populates from provider record. Only an issue if a PO Box is in Facets. Update billing address if it is a PO Box.	2010AA N301	2010AA N301	MB	A7:21 Missing or Invalid Information

Medicaid claim submission for HBTS/PASS/Respite, IHH/ACT and OTP Health Homes

The following services must be billed referencing the **group/agency name** and the **organization NPI #** and **Taxonomy** # in order to ensure proper processing. Please work directly with your **EDI clearinghouse** to ensure they are aware of the distinction between the billing of these services and the remaining codes contained within your fee schedule.

Code	Service Description
H0001	Alcohol and / or drug assessment
H0005	SA Group Counseling by Clinician
H0014	SA Ambulatory Detox Per diem
H0020	Methadone Treatment Program
H0032	MH Service Plan Development by Non-Physician
H0036	Community Psychiatric Services per 15 minute EOS Level
H0036 HN	Integrated Dual Diagnosis Treatment (15 minutes - max 4 units)
H0037	Integrated Health Home Services for Adults
H0038	MH Self Help Peer Svc Per 15 min
H0038 HQ	MH Self Help Peer Group Svc Per 15 min
H0040	Assertive Community Treatment
H0046	Mental Health Services, Not Otherwise Specified (60 Min)
H0046 HO	HBTS- Clinical Supervision – Master's level
H0046 HP	HBTS - Clinical Supervision – Doctoral Level Clinician
H0047	OTP Health Homes
H2011 U1	Crisis Intervention (15 minutes - max 4 units)
H2012	Behavioral Health Day Treatment, per Hour - Child/Adolescent
H2014 HO	Skills Training and Development (15 Min) Master Level Clinician
H2014 HP	Skills Training and Development (15 Min) Doctoral Clinician
H2016	PASS - Service Plan Implementation/Day

Code	Service Description
H2017	Psychiatric Rehabilitation (15 minutes)
H2019	Therapeutic Behavioral Services (15 Min)
H2021	In-Home Intervention/Community-Based Wrap Around Services
H2023	Supported Employment
H2024	Intensive Psychiatric Support Services
H2031	Mental Health Clubhouse services, per diem
T1005	Respite (Under age 21)
T1005 UN	Respite (Under age 21)
T1005 UP	Respite (Under age 21)
T1016	Case Management (15 Min)
T1016 U1	Case Management, each 15 minutes formerly known as Service Plan Implementation - Direction Coordination
T1019	PASS - Direct Services, Personal Care Services
T1019 TF	PASS - Direct Services, Personal Care Services
T1019 TG	PASS - Direct Services, Personal Care Services
T1023 U1	PASS - Assessment and Service Plan Development
T1024	HBTS - Home Based – Treatment Support/specialized treatment
T1027	PASS - Clinical Consultation
T2024	Respite (Under age 21) Service assessment

Example of date span billing for Health Home-IHH services billed on a Form 1500

Line 2 – Encounter Code Associated with Line 1
24A – single date
24D – billing code
24F – 0.00 (not a billable code)
24G - # of units

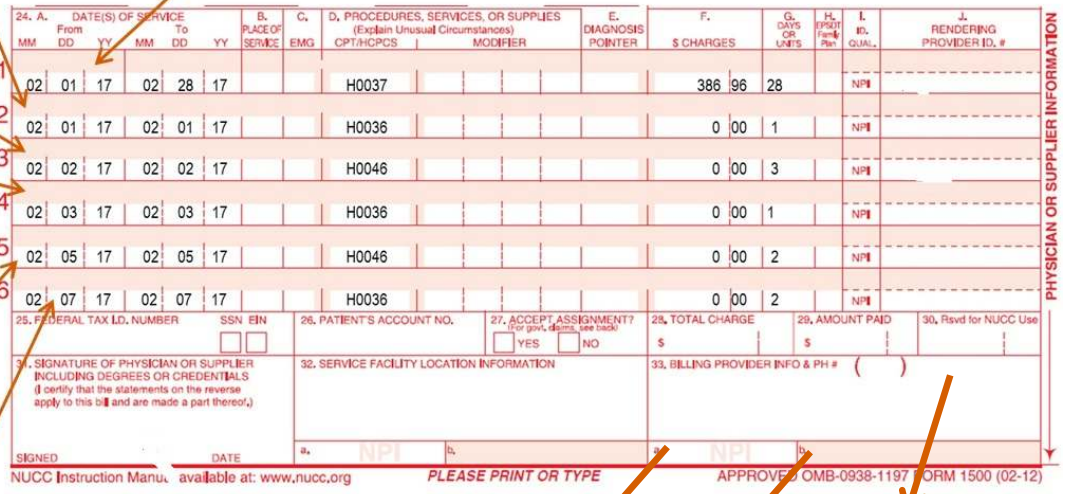
Line 1 - IHH Date Span
24A - date span
24D – billing code
24F – total charges (daily rate x # of units)
24G - # of units

Line 3 – Encounter Code Associated with Line 1
24A – single date
24D – billing code
24F – 0.00 (not a billable code)
24G - # of units

Line 4 – Encounter Code Associated with Line 1
24A – single date
24D – billing code
24F – 0.00 (not a billable code)
24G - # of units

Line 5 – Encounter Code Associated with Line 1
24A – single date
24D – billing code
24F – 0.00 (not a billable code)
24G - # of units

Line 6 – Encounter Code Associated with Line 1
24A – single date
24D – billing code
24F – 0.00 (not a billable code)
24G - # of units



	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02	01	17	02	28	17			H0037			386 96	28		NPI	
2	02	01	17	02	01	17			H0036			0 00	1		NPI	
3	02	02	17	02	02	17			H0046			0 00	3		NPI	
4	02	03	17	02	03	17			H0036			0 00	1		NPI	
5	02	05	17	02	05	17			H0046			0 00	2		NPI	
6	02	07	17	02	07	17			H0036			0 00	2		NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE $ | 29. AMOUNT PAID $ | 30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.

33. BILLING PROVIDER INFO & PH # ( ) a. NPI b.

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

Box 33a: Enter billing Group/Agency Organization NPI and Box 33b enter Taxonomy

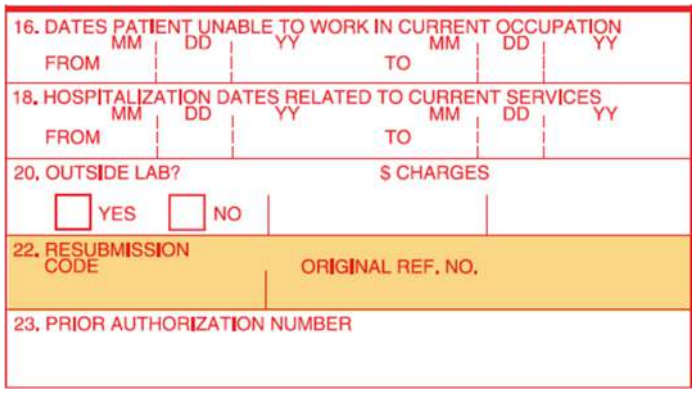
Box 33: Enter Group/Agency Name and Billing Address

Corrected claim submission

Corrected claims are typically submitted when the original claim had an error in data supplied.

When submitting a corrected claim, enter “7” to indicate “Replacement of prior claim”

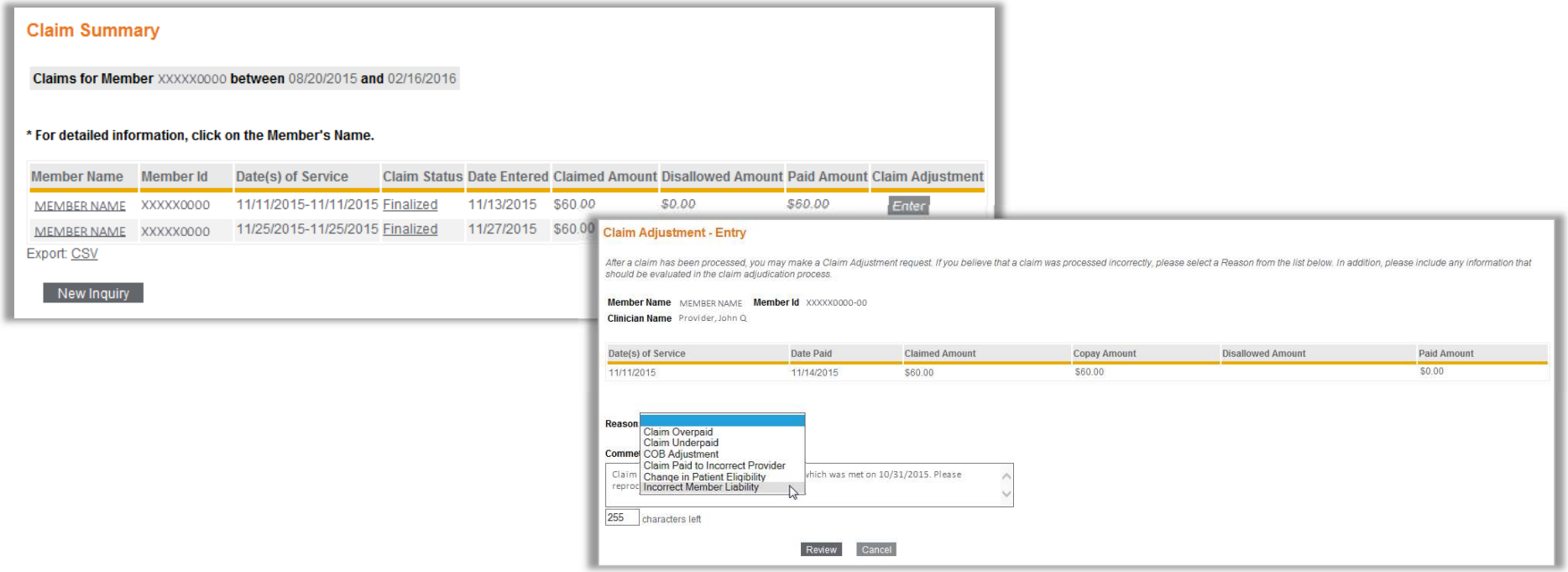
Paper Form 1500
Enter “7” in Field 22 (highlighted)



Electronic/EDI Transaction
Enter “7” in Box 12A

Quickly verify claim status or make adjustments

Check the status of your claim on *Provider Express* where you can also submit Claim Adjustment Requests online.



Claims payment timelines

UHC: EFT funding is 2x per week (Tuesday and Saturday)

Paper checks are cut on a daily basis (Tuesday through Saturday)

NHP: The Optum system runs claim payment cycles Tuesdays through Saturdays. The payment schedule makes direct deposit payments Mondays, Tuesday, Wednesdays, Thursdays, and Fridays.

The payment will settle to provider bank account two (2) days after the claim has been released for payment processing, excluding holidays.

Revised schedule will be effective from 02/16/2022

Clinical / Program and Network Integrity

Utilization management statement

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

- Externally adopted Level of Care Guidelines
- Optum Psychological and Neuropsychological Testing Guidelines
- Behavioral Health Clinical Policies
- American Society of Addiction Medicine (ASAM) Criteria

Level of Care Guidelines can be found at providerexpress.com

Behavioral and medical integration

Our Goal: Increase medical and behavioral health care integration

- 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

Our Goal: Increase 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, including high-risk, high-service utilizers with complex needs

Documentation standards

- Information regarding **documentation standards** for behavioral health providers can be located in 3 places:
  - Optum National Network Manual (located on providerexpress.com): from the home page, choose Clinical Resources > Guidelines/Policies & Manuals > National Network Manual
  - Rhode Island Provider Manual (located on providerexpress.com): from the home page choose Clinical Resources > Guidelines/Policies & Manuals > Manuals > State-Specific Manuals and Addendums
  - Audit tools

Treatment record – content standards

A few key documentation points:

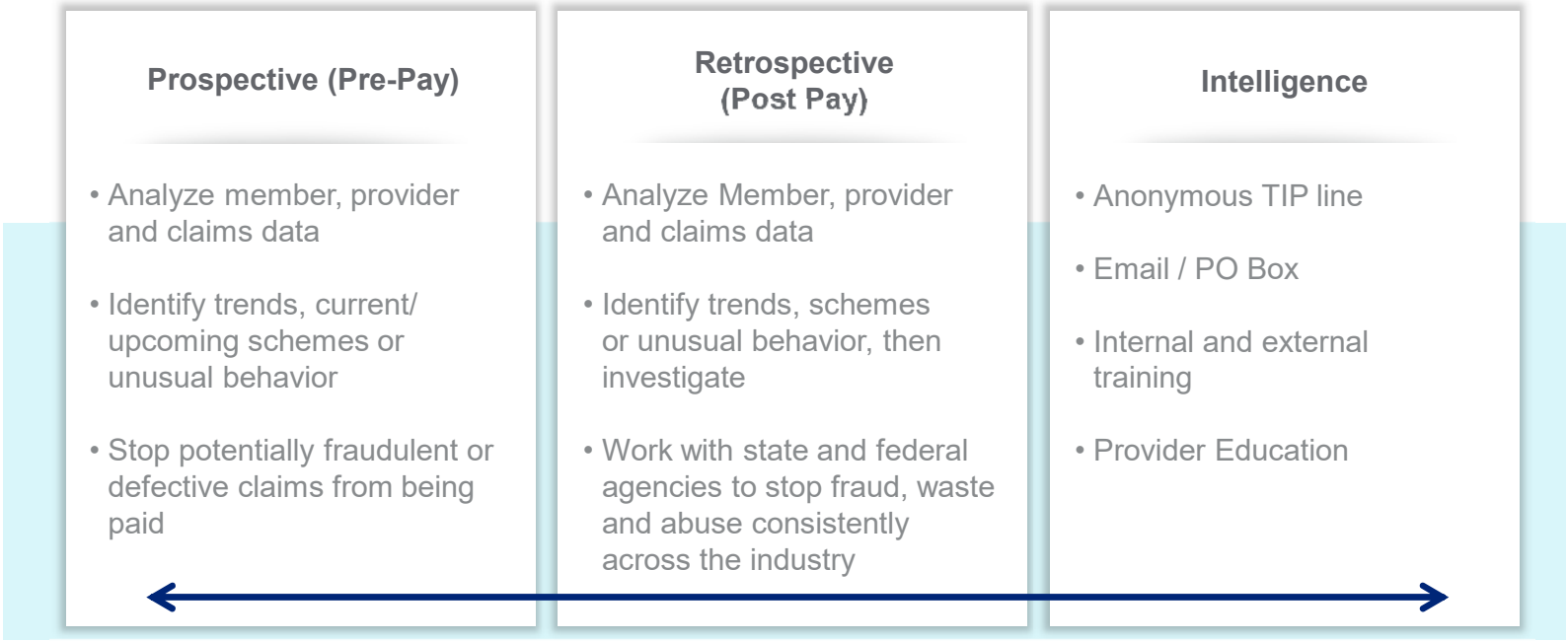
- When billing services for more than one family member, separate treatment records must be maintained
- Record the start and stop time or total time in session
- Optum requires that all non-electronic treatment records are written legibly in blue or black ink
- A more detailed list of treatment documentation requirements and content standards are available in the Network Manual National Network Manual - Effective September 26, 2022 (providerexpress.com)

Optum

Optum Program & Network Integrity (PNI) department

- A dedicated group responsible for working with providers to prevent, detect, investigate and ultimately resolve potential issues of fraud, waste, abuse and error (FWAE)
- Skilled and trained investigators, clinicians, data analysts and medical coding personnel

The department consists of three main investigative pathways:



Optum

What PNI (FWAE) looks for…

Inconsistent coding patterns within a group practice	Coding at high levels for Evaluation and Management (E&M) Services	Services not rendered due to no records submitted, incorrect name of Member, incorrect date of service or illegible records	Unbundling of procedures and services	Diagnosis concerns -- does diagnosis make sense to documentation studied?
Inadequate documentation -- missing pages, no Member name on every page submitted, dates of service are missing or appear altered	Misrepresentation of rendering provider -- different provider then billing provider	Misrepresentation of non-covered services as covered	Double billing	Improper use of modifiers

(Medical Record Auditor, AMA 3rd Edition, 2011)

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 arose 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

Provider quality audits

Provider audits are completed for a variety of reasons:

- At the time of Credentialing and Recredentialing for organizational providers without a national accreditation (for example, The Joint Commission or CARF)
- Quality of Care (QOC) and Sentinel Event investigations
- Investigation of Member complaints regarding the physical environment of an office or agency

Provider quality audits, (continued)

Elements reviewed during audits:

- Physical environment
- Policies and procedures
- Member treatment records
- Personnel files

Scoring of audits:

- 85% and higher is passing
- Scores between 80 – 84% require a Corrective Action Plan (CAP)
- Scores below 79% require a CAP and re-audit

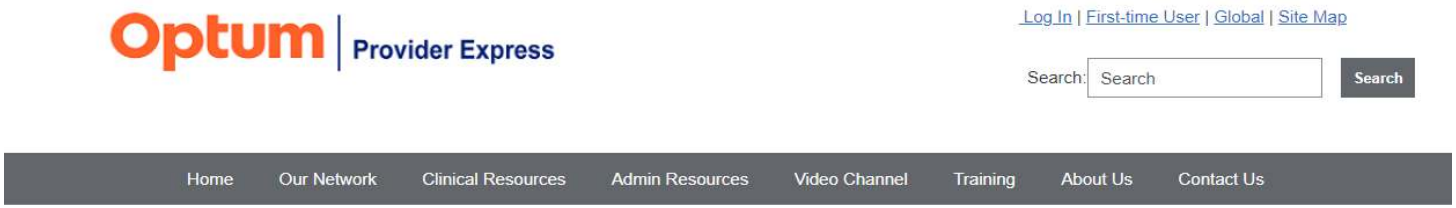
Provider quality audits, (continued)

Feedback to providers:

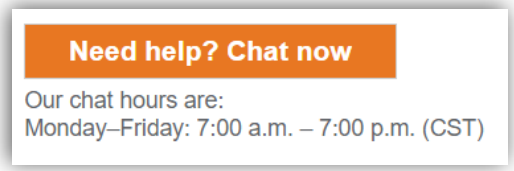
- Feedback is provided verbally at the conclusion of the audit
- A written feedback letter is mailed within 30 days for routine audits; for Quality-of-Care audits, the feedback letter is mailed after the requesting committee reviews the audit results
- When a Corrective Action Plan is required, it must be submitted within 30 days of the request
- Re-audits are completed within 3-6 months of acceptance of the Corrective Action Plan

Contacting Optum

Best way to contact Optum



From the "*Contact Us*" page you can get help with claims, Network Management or website support



Live Chat is available for website technical support

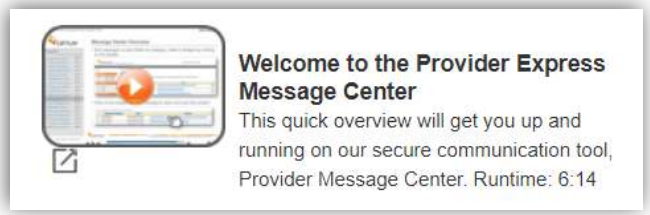
Check out our brief *Contact Us* video

Send secure communications on *"Message Center"*

- *"Message Center"* is an online tool that enables you and Optum staff to communicate with one another within a secure channel
- The *"Message Center"* is located within the secure Transactions area

Message Center Categories

- ❑ Authorizations/Notifications
- ❑ Credentialing status
- ❑ Previously submitted claims
- ❑ Member Eligibility and/or benefits
- ❑ Your contract
- ❑ Inquires for Network Management
- ❑ Previously submitted demographic changes/Tax ID number changes
- ❑ Use of the Provider Express Web portal



Check out our brief Message Center video

Your provider relations advocate is here to help

As a network Provider, your Provider Relations Advocate is your local guide to Navigating Optum.

Your Provider Relations Advocate can:

- Act as your Optum liaison
- Answer important questions
- Facilitate ongoing process improvement
- Keep you abreast of changes that impact your practice
- Provide useful tools and resources

Optum

Optum contacts

On-line message tool or the call center should always be your first point of contact. If further assistance is needed to address your concern, please contact your Provider Relations Advocate.

UHC:

Stacie Warner
Providence County
Provider Network Manager
Phone: 1-612-642-7670
Email: stacie.warner@optum.com

Christine Pellegrino-Celio
Kent, Bristol, Washington, Newport
Provider Network Manager
Phone: 1-401-732-7100
Email: Christine.Pellegrino-celio@optum.com

NHP:

Wendy Hamel Sherzer
Providence County
Provider Network Manager
Phone: 1-401-732-7120
Email: wendy.hamel.sherzer@optum.com

Aura Matos
Kent, Bristol, Washington, Newport
Provider Network Manager
Phone 1-401-248-2777
Email: aura_matos@optum.com

Thank You