OPTUM®

FAQs for Neighborhood Health Plan of Rhode Island (NHP)

Q1: How will providers be reimbursed for services rendered to Neighborhood Health Plan members?

A1: Providers currently contracted with Optum will be reimbursed for services rendered to NHP members as outlined in their existing contract with Optum.

Q2: What is the timely filing limit with Optum?

A2. Providers contracted with Optum are required to submit claims for services rendered to Optum members within 90 days of the date of service.

Q3. Where do providers find the Electronic Data Interchange (EDI) companion guides for the submission of electronic claims?

A3. Links to the EDI claim companion guides can be found on UHCprovider.com/EDI. From the UHCprovider.com home page > Resource Library > Electronic Data Interchange > EDI Companion Guides..

Q4: What payer ID number do I use when submitting claims for NHP members after January 1, 2019?

A4. Providers should use payer ID# 87726

Q5. How should providers bill for services for NHP members?

A5. Providers should bill services rendered to NHP members after January 1, 2019 as outlined by their contract with Optum.

Q6. How are providers added to existing Optum contracts?

A6. Providers can request to add clinicians to their existing contract by the following links:

For individual clinicians: Go to Provider Express home page > Our Network. Under "Join Our Network" select "Individually-Contracted Clinicians" and respond to prompts.

For Rostered Groups: Log into your account. From the Provider Express home page and click on "Log In" in the upper right corner. Enter your Optum ID information and respond to prompts.

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Q7. Will Optum have a supervisory protocol in place for those clinicians that are not independently licensed?

A7. Any agency that uses non-independently licensed providers to render care to NHP members must have a supervisory protocol in place that outlines how the non-independently licensed providers are supervised and how their services are submitted to Optum for payment.

Q8: How does Optum define procedure codes, number of units allowed and time duration per code?

A8: Contracted services, units of measurement and definition of time are outlined on the provider's fee schedule and according to CMS guidelines.

Q9. Does Optum require providers to submit Taxonomy numbers on claims?

A9. Optum requires providers to submit services with the appropriate NPI numbers on claims.

Q10: Which services require authorizations?

A10: Optum does not require authorization on the majority of outpatient services. Higher levels of care will be authorized in the same manner as currently in place.

Q11: How does Optum define the time/unit increment for 90791 and 90792?

A11: Optum allows one (1) unit per day.

Q12: Does Optum require authorization for code 90837?

A12: Yes, Optum requires authorization for 90837.

Q13. What procedure code do providers use when billing for crisis services and how many times can it be billed in a day?

A13: Providers are responsible for determining appropriate codes based on services rendered. Optum includes CPT codes 90839 and 90840 on fee schedules to support billing of these services.

Outpatient psychotherapy sessions lasting 60 minutes or longer are proven and medically necessary in the following non-routine circumstances:

- The member is experiencing an acute crisis, is not at imminent risk of harm to self or others, and psychotherapy for crisis is appropriate for providing rapid and time-limited assessment and stabilization. Prior authorization is not required when there is an acute crisis:
  - CPT 90839: Psychotherapy for crisis; first 60 minutes
  - CPT 90840: Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)

Table: OP Psychotherapy Sessions Lasting Longer than 60 Minutes policy

NOTE: For Medicaid members procedure code S9485 should be used when indicated.

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Q 14: How do providers bill for Enhanced Outpatient Services (EOS)?

A14: These services are billed with HCPCS code H0036.

Q15: How will Optum process claims for the INTEGRITY product (Medicare/Medicaid)?

A15: Providers will be required to submit claims to Optum for processing. Optum will process these services as primary under the member's Medicare benefit, and then will process any applicable balances under the member's Medicaid benefit.

Q16: How do providers confirm member eligibility?

A16: Providers may access member eligibility information by logging into Provider Express to access the Eligibility & Benefits secure transaction feature.

Q17: What number do providers call if they have questions regarding claim status?

A17: Providers can call the following numbers:

Product	NHP of RI
INTEGRITY	1-401-443-5995
Medicaid	1-401-443-5997
Commercial	1-833-470-0578

Q18: Will NHP members be receiving new member identification id numbers?

A18: NHP members will not be receiving new members identification numbers. During the month of December NHP will issue new identification cards to their membership as telephone numbers and pharmacy vendor have changed.

Q19. How will Home-Based Therapeutic Services (HBTS) claims for NHP members be processed?

A19: All HBTS services rendered to NHP members with medical and behavioral health diagnosis will be adjudicated by Optum.

Q20: Who can I contact at Optum if I have questions regarding the NHP transition from Beacon to Optum?

A20: Please reach out to Wendy Hamel-Sherzer at (401) 732-7120 or via email at wendy.hamel.sherzer@optum.com.

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