# STAR Kids

UnitedHealthcare Community Plan

BH547_042016

# Our United Culture

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

**Integrity.** Honor commitments
Never compromise ethics

**Compassion.** Walk in the shoes of people we serve and those with whom we work

**Relationships.** Build trust through collaboration

**Innovation.** Invent the future, learn from the past

**Performance.** Demonstrate excellence in everything we do



Propriety and Confidential. Do not distribute.

# Introduction to Optum

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

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

UnitedHealthcare Community Plan is contracted with Optum to administer the behavioral health portion of the STAR Kids program in Texas to include mental health and substance use disorders.

**We are dedicated to helping make the health system better for everyone. For the individuals we serve, you play a critical role in our commitment to helping people live their lives to the fullest.**

Propriety and Confidential. Do not distribute.

# Behavioral Health Clinical Model

**Six key principles behind the Behavioral Health Clinical Model center on a change from traditional to integrated care**

1. Moving from a disease-centric model to a Member-Driven, Medical-Behavioral-Social Health Model by operating with a collaborative team approach to deliver care using a standardized protocol
2. Treating Members in a holistic manner by using a single Member driven treatment plan, including helping the Member access their natural community supports based on their strengths and preferences
3. Using of clinical systems and claims platforms that allow for a seamless coordination across inter-disciplinary care teams of the Member's needs
4. Focusing on multiple co-morbidities in patients with chronic clinical conditions to improve health outcomes and affordability
5. Screening and treatment of Mental Health and Substance Use Disorder diagnoses
6. Treating Members at the point of care where they are comfortable



Propriety and Confidential. Do not distribute.

# Behavioral and Medical Integration

**Our Goal:** Increase integration of medical and behavioral health care for all members.

- Providers are asked to refer members with known or suspected and untreated physical health problems or disorders to their Primary Care provider 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, this is especially true for high-risk, high-service utilizers and other members with complex needs.



OPTUM™

Propriety and Confidential. Do not distribute.

# Recovery and Resiliency

**Recovery**

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

**Resilience**

The ability to recover quickly from disruptive change, illness, or misfortune without being overwhelmed or acting in dysfunctional ways.



OPTUM™

Propriety and Confidential. Do not distribute.

# Recovery and Resiliency

**Guiding Principles of Recovery**

Recovery emerges from hope, is *person-driven* and occurs through *many pathways.*

Recovery is:

- Holistic
- *Supported by peers and allies*
- Supported through relationship and social networks
- Culturally-based and influenced
- Supported by addressing trauma
- Based on respect

Recovery involves *individual, family, and community strengths and responsibility.*



OPTUM™

Propriety and Confidential. Do not distribute.

# Role of the Recovery & Resiliency Team

- Our Recover & Resiliency Team (R& R) team consist of a manager and three Family/Youth Peer Support specialists.
- They have completed dynamic trainings, have life experience and years of experience working with high needs members and families.
- They work with individuals and families to develop wellness, whole-health and recovery action plans of care, including community/social connections.
- Family/Youth Peers empower members and families to make decisions in a person- centered model of care.
- Family/Youth Peers act as conduits to R & R services (peer support, development of a crisis/recovery plan, life planning activities, community connection, treatment options…) and to other services as appropriate (legal, shelter, basic needs, etc.).


Propriety and Confidential. Do not distribute.

# Overview of Texas STAR Kids

The Texas Health and Human Services Commission (HHSC) created the STAR Kids managed care program tailored to provide Medicaid benefits to children and young adults age 20 and younger with disabilities.

Included features are service coordination, a comprehensive needs assessment, and person-centered planning and service design.

Service Delivery Areas (SDA) are Jefferson Harris, Hidalgo, Central Medicaid Rural Service Area (MRSA), Northeast MRSA

This program will begin on November 1, 2016.

# Eligible Members

Medicaid populations who may participate in STAR Kids include children and young adults age 20 or younger at the time of enrollment and who receive:

- Supplemental Security Income (SSI) and SSI-related Medicaid
- SSI and Medicare
- Medically Dependent Children Program (MDCP) waiver services
- Intellectual and Developmental Disabilities (IDD) waiver services
- Youth Empowerment Services (YES) waiver services (will join at a later date)

STAR Kids who reside in a community-based intermediate care facility for individuals with intellectual disabilities (ICF-IID) or in a nursing facility (NF) will receive our care coordination to determine if they are able to live in the community with supports to meet their basic needs.

# Providers in our Behavioral Health Network

## Individual Practitioners

Licensed to practice independently, without supervision or oversight as determined by state law. Possession of an independent license from the Texas Department of Licensing and Regulation:

- MD, DO
- LP
- LPC, LMFT, LCSW
- APRN, NP, PA, RN, RNCNS
- BCBA certification

## Groups

Community Mental Health Centers, Federally Qualified Health Centers (CMHC/FQHC), Rural Health Centers and provider groups that employ licensed professional staff to render services under the agency. Services include mental health and/or substance use services

## Facilities

General Hospitals with mental health and/or substance use services. Free standing mental health centers and free standing substance abuse centers

- Acute Inpatient
- Residential
- Partial Hospitalization Programs
- Intensive Outpatient (IOP)

OPTUM™

Propriety and Confidential. Do not distribute.

# Covered Behavioral Services

- Inpatient mental health services, which may be a free-standing psychiatric hospital in lieu of an acute care inpatient hospital setting.
- Outpatient mental health services
- Evaluation and medication management services
- Substance use disorder treatment services, including outpatient services, such as:
  - Assessment
  - Detoxification services
- Counseling treatment
- Medication assisted therapy
- Residential services, which may be provided in a chemical dependency treatment facility in lieu of an acute care inpatient hospital setting, including
  - Detoxification services
  - Substance use disorder treatment (including room and board)
- Psycho-social rehabilitation services
- Mental health targeted case management
- Telehealth
- Peer Support Program



Propriety and Confidential. Do not distribute.

# Member Verification

Always verify member eligibility, benefits and health plan designation.

Online at: unitedhealthcareonline.com > Link > Eligibility & Benefits

Phone: 8**77-855-3405**

All relevant contact information will be on the back of the card for both medical and behavioral customer service.

SAMPLE MEMBER CARD

Please note this image is for illustrative purposes only.

# Utilization Management Statement

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

- Level-of-care Guidelines
- Psychological and Neuropsychological Testing Guidelines
- Coverage Determination Guidelines
- Texas Department of Insurance Alcohol and Drug Level of Care Guidelines
- Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG)

**Optum does not reward Medical Directors or licensed clinical staff for issuing denials of coverage or service**



OPTUM™

Propriety and Confidential. Do not distribute.

# Authorization Process

Standard/Routine Outpatient services do not require authorizations from any participating network provider. This includes code 90837 (Psychotherapy, 60 minutes with patient and/or family member).

Services requiring authorization:

- Psychological testing
- ECT
- Intensive Outpatient Treatment
- Partial Hospitalization Program
- Residential
- Inpatient
- TCM/PRS

Details are available at providerexpress.com. See Alert Program, then "Eligibility and Certification". (Wellness Assessments are not required for this population.)

Request an authorization by calling: **877-855-3405**

# Information Necessary for Authorization Request

**Necessary information includes:**

- Member First and Last Name
- Member ID number as listed on Texas STAR Kids ID card
- Date of Birth
- Date of Service
- Description of Services
- Number of Units
- Date Range Proposed for Service Delivery
- Supporting Clinical Information
- Name of Provider
  - Contact Name
  - Contact Phone Number
  - Provider Texas Medicaid Enrollment ID

# Targeted Case Management (TCM) and Psycho-Social Rehabilitation (PSR) Services

**Provider Requirements:**

- Training and certification to administer the Child and Adolescent Needs and Strengths (CANS) assessment tool for members between the ages of 0-18 years of age and the Adult Needs and Strength Assessment (ANSA) for members ages 19 and 20.

- Use the Department of State Health Services (DSHS) Resiliency and Recovery Utilization Management Guidelines (RRUMG) and the Adult Needs and Strengths Assessment (ANSA) or the Child and Adolescent Needs and Strengths (CANS) tools for assessing a Member's needs for services.

- Must have the full array of services available


Propriety and Confidential. Do not distribute.

# Authorization Process TCM/PSR

- Providers must submit the HHSC developed "Mental Health Targeted Case Management and Mental Health Rehabilitative Services Request Form" (SRF) for request for TCM/PSR services.

- The form can be found on the HHSC website under the Uniformed Manage Care Manual link located in Chapter 15 "Utilization Management". The form is Chapter 15.2. https://www.hhsc.state.tx.us/medicaid/managed-care/umcm/

- Providers may fax the form to **1-877-450-6011**



Propriety and Confidential. Do not distribute.

# Psycho-Social Rehabilitation(PSR) Services

The following PSR Services may be provided to individuals with an Serious and Persistent Mental Illness or a Serious Emotional Disorder as defined in the DSM-V and who require rehabilitative services as determined by either the ANSA or the CANS:

- Medication Training and Support
- Crisis Intervention
- Skills Training and Development
- Psychosocial Rehabilitative Services

The above-listed services, as well as any limitations to these services, are described in the Behavioral Health, Rehabilitation, and Case Management Services Handbook.

Rehabilitative Services must be billed using appropriate procedure codes and modifiers as listed in the TMPPM with the following exception: Criminal Justice Agency funded procedure codes with modifier HZ are not a covered service of UnitedHealthcare Community Plan.



Propriety and Confidential. Do not distribute.

# Discharge Planning

Effective discharge planning addresses how a Member's needs will be met during transition from one level of care to another or to a different treating clinician.

Optum Care Advocates begin this planning with the onset of care and it is documented and reviewed over the course of care.

The planning includes, the Member, Member Representative, the Clinician at the next level of care, and/or relevant community resources.

It involves assessment of the Member's needs including current functioning, resources, and barriers to treatment access or engagement in treatment.

Discharge instructions are specific, clearly documented and provided to the Member prior to discharge. When being discharged from an acute inpatient level of care, a patient's follow-up appointment will be scheduled prior to discharge to occur within seven (7) days of the date of discharge.

***Members have the right to decline permission to release information to other treating professionals, but should be informed about the potential risks and benefits of this decision and how it affects coordination of care.***

# Americans With Disabilities Act (ADA)

You are obligated to adhere to the ADA standards, governing the ready access and usability of facilities by individuals with disabilities; and are expected to provide reasonable accommodations to those with hearing, vision, cognitive, and psychiatric disabilities. This commitment includes:

- Waiting room and exam room furniture that accommodate members, including those with physical and non-physical disabilities
- Accessibility along public transportation routes and/or adequate parking
- Clear signage and directions(e.g., color and symbol signage) throughout facilities.
- For information about ADA regulations, please visit www.ADA.gov or call the toll-free ADA Information Line at **800-514-0301** (Voice) or **800-514-0383** (TTY).

# Cultural Competency

Every one deserves to be treated with respect for their cultural identity. Cultural Competency Training is based on National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS).

For more information, including national standards and training, we encourage you to visit thinkculturalhealth.hhsc.gov.

Culture refers to integrated patterns of human behavior within various racial, ethnic, religious or social groups, including:

- Language
- Thoughts
- Communications
- Actions
- Customs
- Beliefs
- Values
- Institutions

Competence implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities

# Importance and Value of Cultural Competency

- A growing diversity impacts the field of behavioral health by increasing the need for services that are tailored to specific cultures
- Given the diverse ethnic population in the United States we must ensure that we provide culturally appropriate services
- We need to address how services are delivered and ensure that people are comfortable approaching us and using our services
- We must be able to address the stigma many individuals perceive towards mental illness and to encourage open discussion about mental health or substance abuse
- It is important to emphasize the culturally appropriate aspects of our programs and services that enable the clients or consumers to become self-sufficient and to embrace life completely

# Protected Health Information

**What is Protected Health Information (PHI)?**

- HIPAA Privacy Rule defines PHI as individually identifiable health information about the past, present, or future physical or mental health or condition (including the provision of his/her health care, insurance, payment status, etc.) of an individual that is held or transmitted by a covered entity or its business associate, in any form.
- PHI is information that is recorded electronically, on paper, or transmitted orally about an individual.
- PHI must be protected from unauthorized use or disclosure by the Covered Entity and its Business Associates under HIPAA regulations.

For additional guidance on PHI, please see the Privacy Rule at:
http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html

# Treatment Record Documentation

Elements that should be present in your treatment record documentation are:

- Member name or identification number on each page of the record
- Member address; employer or school; home and work telephone numbers, including emergency contacts; marital or legal status; appropriate consent forms; and guardianship information
- Date of service, start/stop time of service, CPT code billed, notation of session attendees, the responsible clinician's name, professional degree, license, and relevant identification number
- Medication allergies, adverse reactions and relevant medical conditions; if the Member has no known allergies, history of adverse reactions or relevant medical conditions
- Medication tracking that provides a thorough picture of all medications taken by the patient from the onset of care through discharge

OPTUM™

Propriety and Confidential. Do not distribute.

# Treatment Record Documentation (continued)

- Presenting problems, the results of mental status exam's, relevant psychological and social conditions affecting the Member's medical and psychiatric status, and the source of such information
- Assessment and reassessment of special status situations, when present, including but not limited to imminent risk of harm, suicidal or homicidal ideation, self-injurious behaviors, or elopement potential. It is also important to document the absence of such conditions
- History: Medical and Psychiatric (previous treatment, clinician or facility identification, therapeutic interventions and responses, sources of clinical data, and relevant family information)
  - Tobacco, alcohol and drug use (illicit, prescribed or over-the-counter) should be included past and present for Members 12 years and older
  - Developmental (prenatal, perinatal through present age) for school-aged Members
- DSM Diagnosis (presenting problem(s), safety assessment, mental status examination, and other assessment data)

OPTUM™

Propriety and Confidential. Do not distribute.

# Treatment Record Documentation (continued)

- Discharge Plan (beginning at the initiation of treatment and changing as appropriate)
- Coordination of care (with PCP and other providers)
- Billing records should reflect the Member who was treated and the modality of care

All non-electronic treatment records should be written legibly in **BLUE** or **BLACK** ink, unless the medical record is electronic.

**Visit www.providerexpress.com for a complete description of expected Treatment Record Documentation**

OPTUM™

# Clinician Responsibilities

**Verify** Member's Medicaid eligibility and UnitedHealthcare eligibility prior to performing services

**Refer to in-network** providers

**Adhere to the Optum's**

- **authorization** policies
- appointment and **accessibility standards**
- **medical record keeping** and chart review standards

**Provide** appropriate health **education and instructions**

**Provide services** consistent with professional and ethical standards as set forth by national certification and state licensing boards, and applicable law and/or regulation regardless of a Member's Benefit Plan or terms of coverage

**Provide services** that are accessible, family-centered, sensitive to cultural differences, comprehensive, coordinated, and compassionate. To ensure that all members receive the right services at the right time for their individual health care needs in a non discriminatory manner

**Conduct** appropriate evaluations and psychometric testing for member who may need access to IDD services and supports and HCBS Waiver services.

**Determine** if Members have medical benefits through other insurance coverage

**Advocate** for members as needed



Propriety and Confidential. Do not distribute.

# Access to Care – Standards

| | |
|---|---|
| **Routine Outpatient** | **Members shall be seen by an appropriate provider within 14 days of the request for an appointment** |
| **Urgent**<br>If not addressed in a timely way could escalate to an emergency situation | **Shall be seen within 24 hours of telephone contact** |
| **Life threatening emergencies**<br>Imminent risk of harm or death to self or others due to a medical or psychiatric condition | **Referral is Immediate** |
| **Post Inpatient Discharge**<br>If you are unable to see the member during this time – refer to another in-network provider to satisfy this deadline | **All members must be seen within 7 days post discharge** |
| **Missed an Appointment**<br>The Care Advocate for behavioral services will contact members who have missed a post-discharge appointment to reschedule that appointment | **Within 24 hours** |



Propriety and Confidential. Do not distribute.

# Complaints

Send written complaint to:

United Behavioral Health
ATTN: Complaints
4212 San Felipe
PMB 448
Houston, TX 77027-2902

The complaint will be fully investigated and resolved within **30 calendar days.**

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

A written *Acknowledgement Letter* is sent to members submitting complaints related to Quality of Care (QOC) complaints.

- Since information related to the investigation and resolution of QOC concerns cannot be released to the complainant, the *Acknowledgement Letter* also serves as the member's *Resolution Letter* for QOC complaints.

OPTUM™

# Complaint  Investigation and Resolution

- You are required to cooperate with Optum in the complaint investigation and resolution process.

- If Optum requests written records for the purpose of investigating a Member complaint, you must submit these to Optum **within the requested timeframe.**

- Complaints filed by Members should not interfere with the professional relationship between you and the Member.

- Optum requires the development and implementation of appropriate Corrective Action Plans (CAP) for legitimate problems discovered in the course of investigating complaints.

# Sentinel Events

A *potential sentinel event* is defined as a serious, unexpected occurrence involving a member in any of the following ways:

- A completed suicide by a member who, at the time of his/her death, was engaged in treatment at any level of care or was engaged in treatment within the previous 60 calendar days;
- A serious suicide attempt by a member, requiring an overnight admission to a hospital medical unit, that occurred *while* the member was receiving facility based treatment (i.e., behavioral health inpatient, residential, partial hospital, intensive outpatient) OR within 30 days of discharge from facility based treatment;
- An unexpected death of a member that occurred while the member was receiving facility based treatment;
- A serious injury of a member, requiring an overnight admission to a hospital medical unit, that occurred on facility premises while the member was receiving facility based treatment;
- A report of a serious physical assault **of** a member, requiring medical intervention, that occurred on facility premises while the member was receiving facility based treatment;
- A report of a serious physical assault **by** a member, requiring medical intervention, that occurred while the member was receiving facility based treatment

# Sentinel Events Continued

- A report of a sexual assault of a member that occurred on facility premises while the member was receiving facility based treatment;
- A report of sexual assault by a member that occurred while the member was receiving facility based treatment;
- A homicide that is attributed to a member who, at the time of the homicide, was engaged in treatment at any level of care or was engaged in treatment within the previous 60 calendar days;
- A report of an abduction of a member that occurred on facility premises while the member was receiving facility based treatment; or
- An instance of care (at any level) ordered or provided to a member by someone impersonating a physician, nurse or other health care professional.

A sentinel event includes one of the above events **AND** 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 occurred during the course of a member receiving behavioral health treatment.

- **If you are aware of a sentinel event involving a Member, you must notify Optum Care Advocacy within *one business day* of the occurrence.**
- **You are required to cooperate with sentinel event investigations.**

OPTUM™

# Appeals

## Non Urgent (Standard)

- Must be requested within **30 days** from receipt of the notice of the Notice of Action decision

When an Appeal is requested, Optum will make an Appeal determination and notify the provider, facility, Member or authorized Member representative in writing within **30 calendar days** of the request.

## Urgent (Expedited)

- Must be requested within **30 days** of the mailing of Notice of Action decision notice or the intended effective date of the complaint decision, which ever is later.

**In Writing**

**Unless the Appeal is urgent (expedited), an Appeal request must be in writing by the Member or Member Representative**

OPTUM™

# Texas Fair Hearing Process

**90 Day Deadline**

A provider may be a representative for a Member. A fair hearing must be requested within 90 days of the date on the health plan's letter that tells of the decision you are challenging. If you do not ask for the fair hearing within 90 days, you may lose your right to a fair hearing.

**10 Day Deadline for Service Continuation**

If you ask for a fair hearing within 10 days from the time you get the hearing notice from the health plan, you have the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If you do not request a fair hearing within 10 days from the time you get the hearing notice, the service the health plan denied will be stopped.

**800- 288-2160**

UnitedHealthcare Community Plan
14141 Southwest Freeway, Suite 800
Sugar Land, TX  77478

OPTUM™

# Important Reminders

- Verify benefits prior to rendering any services and receive authorization as appropriate
- Members may not be balanced billed
- No co-pay, no out of pocket maximum, no deductible
- Notify Optum within 10 calendar days whenever you make changes to your office location, billing address, phone number, Tax ID number, your entity name, close your business or retire. This can be done on providerexpress.com or by calling 877-614-0484.

*Copy and paste this text box to enter notations/source information. 7pt type. Aligned to bottom. No need to move or resize this box.

Propriety and Confidential. Do not distribute.

# Claims

Required claim forms are CMS-1500 or UB-04 (hospitals)

**Online Claims:**

Submit and check on the status of electronic claims online at Link through unitedhealthcareonline.com > unitedheatlhareonline app > Claims & Payments > Claims Submissions.

**Paper Claims:**

Submit claims by paper, by mailing to the following address:

Optum
P.O. Box 30760
Salt Lake City, UT 84130-0760

- Customer Service is available for paper claim questions 80**0-496-5841**

# Claims Submission Option 1 – Online

## Entry through Link at unitedhealthcareonline.com

- Secure HIPAA-compliant transaction features a streamlined claim submission process
- Performs well on all connection speeds
- Allows claims to be paid sooner that paper claims

You must be an Optum network clinician or group practice and have a registered user ID and password to gain access to the online claim submission function.

# Claims Submission Option 2 – EDI/ Electronically

Electronic Data Interchange (EDI) is an exchange of information.

Performing claim submission electronically offers distinct benefits:

- **It's fast** - eliminates mail and paper processing delays
- **It's convenient** - easy set-up and intuitive process, even for those new to computers
- **It's secure** - data security is higher than with paper-based claims
- **It's efficient** - electronic processing helps catch and reduce pre-submission errors, so more claims auto-adjudicate
- **It's complete**- you get feedback that your claim was received by the payer
- **It's cost-efficient** - you eliminate mailing costs, the solutions are free or low-cost

- 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 www.unitedhealthcareonline.com > Tools and Resources > EDI Education for Electronic Transactions

OPTUM™

# Claims Submission

Providers must submit claims using the current CMS-1500 or UB-04 with appropriate coding including, but not limited to, ICD-10, CPT, and HCPCS coding.

Optum requires that you initially submit your claim within your contracted deadline. Please consult your Optum contract to determine your initial filing requirement. The timely filing limit is contained within your provider agreement.

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


Propriety and Confidential. Do not distribute.

# Electronic Payment & Statements (EPS)

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

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

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

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

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

*For more information, please call **(866) 842-3278**, option 5, or go to* UnitedHealthcareOnline.com > Help > Electronic Solutions > Electronic Payments & Statements.

Propriety and Confidential. Do not distribute.

# Telemental Health Billing

- Please contact your network manager to update your agreement before billing UnitedHealthcare Community Plan for telemental health services.
- Providers at the *originating site* (where the member is physically located when receiving treatment) must use the GT modifier.
  - Some providers may have previously billed originating site services using the T2016 code.
- The *distant site* provider (who is providing the therapy) should use the Q3014 code.
- UnitedHealthcare Community Plan requires the use of the Q3014 with the GT modifier as this is the industry standard for billing these services.



Propriety and Confidential. Do not distribute.

# Claim Tips

**Always file clean claims**

- Ensure complete diagnosis is listed
- Code to the highest specificity

**Claims filing deadline**

- 95 days from date of service

**Clean Claims**

- Paid within 30 days of receipt

# Link

Link is the new gateway to UnitedHealthcare' s online tools.

Use Link applications to help simplify daily administrative tasks:

- Check member eligibility and benefits
- Submit and manage claims
- Review coordination of benefits information
- Use the integrated applications to complete multiple transactions
- View care opportunity information for UnitedHealthcare Medicare Solutions members

To register for Link, sign in to **www.unitedhealthcareonline.com** using your Optum ID or click "New User" if you do not have an Optum ID. If you have questions, please call the Optum Support Center at 855-819-5909.

# UnitedHealthcare Provider Website

For important UnitedHealthcare Community Plan-specific information visit UHCCommunityPLan.com > For Health Care Professionals > Texas to see:

- Provider Manuals
- Forms
- Provider Reference Guides
- Reimbursement Policies
- Provider News, Alerts and Trainings
- Pharmacy and Drug information

# CommunityCare

CommunityCare is the online care coordination tool that allows the entire care team to enter and obtain current information, including:

- Care plans
- Prior authorizations
- Test and screening results

Send messages to a service coordinator (any change in member condition).

Care coordination between team members (behavioral health and other specialists to/from PCP).

Access CommunityCare through Link at unitedhealthcareonline.com.

# Other Online Tools

**Link at unitedheatlhcareonline.com**

- Provider portal with interactive activities such as verification of member benefits and eligibility, prior authorization requests, claims submissions and management.

**UHCCommunityPlan.com**

- This site should be used to access the Provider Directory.
- Customer Service Center phone number: 855-802-7095

**Liveandworkwell.com**

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

**providerexpress.com**

- National Optum Provider Manual
- Level of Care, Best Practice, and Coverage Determination Guidelines
- Provider demographic changes / Roster management
- Provider education materials (e.g., webinars, FAQ's)

# Joining Our Network

Clinicians can access the Network Participation Request Form (NPRF) on our website: **providerexpress.com**

- In the right side column click on "Join Our Network"
- Follow the prompts and answer all questions to reach the "Join our Clinician Network – Texas" page
- Click on the NPRF link, answer the five required fields, and then complete the electronic application form
- Attach all required documents as prompted by the system
- Be sure to click "Submit" when the application is complete

- Providers must have an active **Texas Provider ID number and/or Medicare Number and NPI number.** (If you haven't already, be sure to re-enroll.)
  - **Licensed Clinicians must have an active professional license**

- For practices that do not meet malpractice limits, submit the application and exceptions may be considered

OPTUM™

# Contact Information

| | |
|---|---|
| **Prior Authorization** | UnitedHealthcare Community Plan at 877-855-3405 |
| **Claims Paper Submission** | Mail paper claims to:<br>Optum<br>P.O. Box 30760<br>Salt Lake City, UT 84130-0760 |
| **Electronic Claim Submission** | Through unitedhealthcareonline.com or via EDI clearing house<br>Payor ID 87726 |
| **Claims Status** | Customer Service Center at 888-650-3462<br>Web portal at unitedhealthcareonline.com |
| **Claims Appeals<br>Eligibility Verification<br>Customer Service** | Optum<br>Attn. Appeals Department<br>PO Box 30512<br>Salt Lake City, UT 84130<br>Phone: 866-556-8166 Fax: 855-312-1470<br>View eligibility thru Link at unitedhealthcareonline.com |
| **Provider Assistance** | Phone: 877-614-0484 Fax: 866-388-1710<br>Email: **ohbs.centralregion@optum.com**<br>Provider Service Line at 877-855-3405 |
| **Update Practice Information** | providerexpress.com or via 1-877-614-0484<br>Also update your demographic information at TMHC |



OPTUM™

Propriety and Confidential. Do not distribute.

Thank you