Frequently Asked Questions
AllWays Health Partners

Effective January 1, 2019, Optum began managing the Behavioral Health and Substance Use benefits for AllWays Health Partners, formerly known as Neighborhood Health Plan. This includes employees and dependents of Partners Health Systems.

Contracting

Q1. How do I know if I am currently contracted with Optum?

A1. Currently, contracted providers should have a copy of their agreement, regulatory addendums, and applicable fee schedules.

Q2. What if I can't find my contract?

A2. Providers can call Optum provider Service line at 1-877-614-0484 to validate their contracting status and request a copy of their agreement.

Q3. If I am currently contracted with Optum do I need to do anything to see AllWays Health Partners members?

A3. If you are currently contracted with Optum you do not need to take any further actions and can begin seeing members as soon as January 1, 2019.

Q4. I hear discussion of differing rates in the market. Can you explain what the differences are?

A4. Providers currently contracted with Optum have established rates of reimbursement documented via their contracts. These rates are typically established by line of business (Commercial, Medicaid, etc.) Optum has conducted a market analysis to determine the applicability of rate increases in Massachusetts. Providers eligible for rate changes were notified by January 1, 2019. Rate changes will be effective 3/1/19, which reflects our contractual obligation to supply providers with 60 days' notice.

Q5. I don't want to wait until March 2019 for the rate change. What can I do now?

A5. You can submit your request via email to provider.services@optum.com. Optum network managers will review the request and reach out to you within 15 business days.

Q6. Can you lay out the process of how and when these requests will be evaluated, what happens when/if they're approved, and when providers can expect to hear back about their request?

A6. Optum reviews a number of factors when determining the requests for rate changes that may include but are not limited to geography, areas of expertise, practice size, etc. When a rate negotiation is completed, the effective date is 90 days from execution of the updated provider addendum.

Q7. My peers are telling me that they are signing a Partners only contract. Can you supply some additional detail on what the difference is between my existing Optum contract and a Partners only contract?

A7. For providers that are currently contracted, they are contractually bound to see and treat all members that are covered by Optum. For non-contracted providers, AllWays Health Partners has agreed to offer a contract that limits the provider's panel to Partners' employees and/or their dependents. Providers may choose to treat those members under a Partners-Only agreement or can join the Optum network and treat all members covered by Optum.

Q8. What if I am out-of-network and do not want to join the Optum network, but want to continue to see an AllWays member after the Transition of Care (ToC) period?

A8. The Transition of Care period for Commercial and My Care Family (Medicaid/ACO) members has been extended to August 31, 2019 (1/1/19 through 8/31/19). For Partners ASO members (Partners' employees and their dependents), the ToC period is now available through September 30, 2019 (1/1/19 through 9/30/19).

For providers working with Commercial and/or Medicaid members after the ToC period, who choose to remain out-of-network: in some instances, an out-of-network provider may request a Single Case Agreement (SCA) to cover services for a member. Reimbursement would be dependent upon the member's benefit plan and medical necessity. A provider may request a SCA by contacting Optum at the numbers listed below in the ToC Section.

For providers seeing Partners employees or their dependents after September 30, who choose to remain out-of-network: in some instances, an out-of-network provider may request a Single Case Agreement (SCA) to cover services for a member. Reimbursement would be dependent upon the member's benefit plan and medical necessity. Contact Optum for more info by calling the number on the back of the member's ID card—note, the phone numbers are also provided below in the ToC Section.

Q9. If I am interested in joining the network or finding out more information about Optum where can I go?

A9. Provider Express – providerexpress.com is Optum industry-leading provider website which includes both public and secure pages for behavioral health providers. Public pages contain general updates and useful information, such as.

- Access forms library
- Review clinical guidelines
- Access *Network Notes*, the provider newsletter
- Level of Care Guidelines
- Training/Webinar offerings
- AllWays Health Partners webpage: from the Provider Express home page go to Our Network > State-specific information > Massachusetts

Q10. How long does Optum credentialing process take?

A10. Once Optum receives a complete application, the process can take up to 90 days, with physician contracting taking no more than 60 days.

Q11. How can I check the status of my credentialing application?

A11. Providers call Optum provider service line at 1-877-614-0484.

Q12. If I am in the process of credentialing can I see AllWays Health Partners members?

A12. Until you are credentialed you may continue to treat members with whom you have an established relationship. Once credentialing is complete, you may see new AllWays Health Partners' members.

For Partners ASO members (Partners employees and their dependents) – Continuity of Care must be initiated by the member/parent/guardian. A Continuity of Care form must be completed by the employee (on behalf of themselves or their dependent). This form can be found at allwaysmember.org and must be submitted to AllWays Health Partners' Customer Service team for approval. Please advise your patients to contact AllWays Customer service directly.

Q13. During the credentialing process how will my claims be reimbursed?

A13. If you are not contracted with Optum, your claims will be processed as an out-of-network provider until the credentialing process is complete during the ToC. After the ToC, claims will be processed as out-of-network and according to the member out-of-network benefit. Please note, for those providers that have submitted their contracting and credentialing documents, you will be paid in accordance with your negotiated rate for those Partners employees who have approved continuity of care on file.

Q14. There are some reports that the rates for providers seeing Partners' employees or dependents are supposed to match BCBS and other reports that it will be higher than the new Optum rates but not as high as BCBS. Can you please confirm?

A14. Optum has worked with AllWays Health Partners to determine the correct rates to be contracted with Partners' providers seeing Partners Health Plan employees and/or dependents. If you are not contracted with Optum, you need to outreach Optum Network Management at 877-614-0484 to begin the contracting/credentialing process so that you can continue to see Partners' employees and/or their dependents beyond 9/30/2019.

Q15. Why am I receiving multiple contracts?

A15. Optum is making every effort to streamline the number of contracts that providers are receiving. Due to variances in how Beacon and Optum contract, it is possible for a provider affiliated with a group to receive an individual contract. Please reach out to the network managers listed at the end of this FAQ for further guidance on next steps.

Q16. Do all clinicians need to be on the Optum roster if the provider bills as an agency? Is the answer the same for Commercial and Medicaid?

A16. Optum utilizes 2 differing contracting methodologies for groups and agencies. Depending on the contracting type, providers may or may not need to be rostered. Please reach out to your Provider Relations Manager listed at the end of this document to confirm your contracting methodology.

Q17. Do all clinicians need to be independently licensed? Is the answer the same for Commercial and Medicaid?

A17. Optum requires all providers to be independently licensed unless the agency or group has executed a supervisory protocol addendum.

Transition of Care and Clinical Services

Q1. If I am an out-of-network provider, can I continue to see my existing member in 2019?

A1. The Transition of Care (ToC) benefit, originally available for the first ninety days has been extended through August 31, 2019 for AllWays Health Partners' Commercial and My Care Family (Medicaid/ACO members) members. This allows an out-of-network provider to continue to treat a member until: the provider joins the network, member completes treatment within the ToC period because treatment is no longer medically necessary/indicated, or the member transitions to an in-network provider.

For Commercial members with OON benefits, they can continue to see the OON provider and use their OON benefits (with associated cost-sharing).

Providers **seeing Partners' employees and or dependents**: There is a Transition of Care (ToC) benefit available as well, which has now been extended through September 30, 2019 for Partners' employees and dependents **only**. This allows an out-of-network provider to continue to treat Partners' employees or dependents until: the provider joins the network, member completes treatment within the ToC period because treatment is no longer medically necessary/indicated, or the member transitions to an in-network provider. Partners' employees and or dependents with OON benefits may can continue to see an OON provider and use their OON benefits (with associated cost-sharing).

Q2. If I am a provider not in the Optum network and am using the ToC benefit for a member, do I need an authorization?

A2. During the approved transition of care period through August 31st, no authorization is required for standard outpatient services for providers seeing Commercial and My Care Family (Medicaid/ACO) members. After the transition period, authorizations are required.

Providers seeing Partners' employees and or dependents: During the approved transition of care period through September 30, no authorization is required, but the Partners' employee must complete a Continuity of Care form to request a continuation of standard outpatient services during the ToC period. The form can be found at allwaysmember.org.

Below are the numbers to call for authorization and/or questions:

AllWays Commercial	**844-451-3518**
AllWays MassHealth/ACO (aka My Care Family)	**844-451-3519**
Partners Health Plan	**844-451-3520**
Group Insurance Commission (GIC), City of Boston and Plumbers	**844-875-5722**

Q3. What services require authorization?

A3. Please see below table for ***Medicaid Members only***:

Q4. If I am an out-of-network provider and received authorization prior to 1/1/2019 for services (such as, but not limited to, IP/PHP/IOP/ Residential) during the ToC period, will my authorization continue to be effective?

A4. Yes, the authorization will be valid. If additional days are required after that initial authorization, they will be subject to standard utilization criteria and processes. Please contact our clinical staff by calling the Behavioral Health number on the back of the member's ID card or as referenced above.

Q5. Where do I locate Optum level of care guidelines?

A5. Level of care guidelines can be located on provider express or by the link below: providerexpress.com/content/ope-provexpr/us/en/clinical-resources.html

Q6. Do the following services fall under the outpatient benefit and not require authorizations? Self-Help/Peer Services, Crisis Intervention Service, Skills Training and Development, Therapeutic Behavioral Services, Family Training and Counseling for Child Development, Behavioral Health Outreach Service/Targeted Case Management

A6. The services above do not require prior authorization.

Q7. If no authorization is required for a service, is registration required? Is the answer the same for Commercial and Medicaid? If so, how does a provider do this?

A7. For services not requiring an authorization, registration is not required.

Q8. At what point does the licensed care advocate reach out to the provider to review eligibility for services, review treatment plan, review medical necessity, etc.

A8. For those service managed via the ALERT program, see response to question

Q9. Can you please explain how the ALERT system will be applied to CBHI services and the requirements for providers?

A9. The ALERT program uses claims analysis algorithms to identify cases that may benefit from further review by a licensed care advocate. If a case is selected, an ALERT care advocate will reach out to the provider to telephonically review the case to determine if treatment meets the guidelines. Treatment shaping may occur during this call to ensure care meets the intended outcomes of these services. A case may be referred to further review by a peer reviewer if medical necessity of the services is in question. Any adverse determination resulting from the peer review is subject to appeal.

Q10. How do providers track utilization of CBHI units/services – is it unlimited or do they just plug in the same thing for other clients (360 for 90 days) using the intake date?

A10. Providers can continue to utilize tracking of units according to their own internal process. The expectation is that members are receiving services according to their need and according to medical necessity and service criteria.

Q11. Will children/adolescents be assigned a member identification (ID) number, or should providers use their social security number? Currently just their social security number displays.

A11. Providers can utilize member name, DOB, and social security number to validate members. Due to a system configuration limitation (Optum system allows for a maximum of 9 characters/digits in the member ID number, while AllWays Health Partners' has 10, Optum system does not currently allow for searches by member ID number. Optum is aggressively working on a "fix" to this impediment, but we appreciate your patience in searching by member name, DOB, and social security number in the interim. We understand that this is not ideal and sometimes there is difficulty in locating a member – if you believe a member is eligible, but the Optum system is showing that the member is inactive / ineligible, please reach out to Optum Customer Service team. If the problem persists, please contact AllWays Health Partners' Customer Service team, and they will explore the issue further. Again, thank you for your patience and understanding as we work on enhancing Optum system.

Q12. Our understanding of the Commonwealth's standardized specifications is that a person entering Residential Rehabilitation Services (RRS) receives 90 days without authorization. As the individual is approaching day 90, plans and providers may then discuss authorizations for continuing care beyond day 90, consistent with the individual's recovery plan.

A12. This is correct. Please note, however, that RRS providers must call Optum within 7 calendar days of the member's admission to alert the Clinical team of the member's admission. Given that this is a benefit for My Care Family (Medicaid/ ACO) members only, the correct phone number to call is: 844-451-3519.

Q13. If I am in the credentialing process will the ToC period apply to the services I offer?

A13. See question/answer #1 under Transition of Care above. Please note, until a fully executed contract is in place, a Single Case Agreement is needed after the ToC ends.

Q14. Are there any guidelines that need to be followed for submitting CPT codes 90837 and 90838?

A14. Providers will need to follow the **Behavioral Clinical Policy: Extended Outpatient Psychotherapy Sessions**. This policy can be located on Provider Express > Clinical Resources > Guidelines/Policies & Manuals > Behavioral Clinical Policies > Extended Outpatient Psychotherapy.

Eligibility & Claims Processing

Q1. Will the member's identification number stay the same?

A1. Currently Optum's system is configured to accept a 9-digit member identification number; AllWays Health Partners' identification numbers are 10 digits. When searching member eligibility on Provider express, please utilize the member's name, DOB, and social security number. Optum is actively working to reconfigure their system and implement additional search criteria (including the AllWays Health Partners' member identification number). Thank you for your patience while Optum works to enhance their system.

Q2. What is the best method to use when looking up member eligibility on Provider Express?

A2. Providers can find this information using the Name and DOB, or the member's social security number. Optum is still working on verifying the member's eligibility using the member's ID card. However, there should be no limitations when processing claims.

Q3. What ID# should be used for billing/claim submission?

A3. For billing purposes, it is recommended that Providers use the established ID# on the members ID card.

Q4. If I am an out-of-network provider using the ToC benefit for a member. How do I submit a claim?

A4. You can file using EDI or paper claims.

EDI submissions:

- Submit batches of claims electronically, right out of your practice management software. The Optum Payer ID is 87726.
- To learn more about Electronic Data Interchange, visit Provider Express. From the Home Page, select Admin Resources > Claim Tips > EDI/Electronic Claims

Paper claims:

- 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)
- Institutional claims must be submitted using the UB-04 claim form
- Paper claims submitted via U.S. Postal Service should be mailed to:

Commercial	Medicaid
Optum P.O. Box 30757 Salt Lake City UT 84130-0760	Optum P.O. Box 30760 Salt Lake City UT 84130-0760

Q5. If I have additional questions regarding this transition who can I contact?

A5. Please reach out to one of Optum Provider Services Managers:

Cristina Almeida, Director of Provider Services
Phone: 877-614-0484
Email: cristina.almeida@optum.com

Gabriel Nathan, Senior Network Manager - Massachusetts
Phone: 877-614-0484
Email: gabriel.nathan@optum.com

Janet Choup, Network Manager - Massachusetts
Phone: 877-614-0484
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