Provider Orientation
AllWays Health Partners

Updated March 26, 2019

OPTUM®

Go Live Date: January 1, 2019

Thank you so much for joining today.

We will be getting started momentarily.

Agenda topics

- Introduction
- Covered members, eligibility and benefits
- Clinical overview
- Covered services and authorizations
- Residential Rehabilitation Services (RRS)
- Cultural Competency
- Clinical Audits
- Adverse Incident Reporting
- Claims
- Appeals
- Program and Network Integrity
- Websites
- Network Management

Introduction

Reminder

Effective January 1, 2019, Neighborhood Health Plan, Massachusetts became AllWays Health Partners

This presentation will use AllWays Health Partners rather than Neighborhood Health Plan

Medicaid: My Care Family℠

My Care Family is an Accountable Care Organization (ACO) Partnership Plan for MassHealth (Medicaid). The logo below is associated with My Care Family.

Who is Optum?

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

Our core values:

Integrity | Compassion | Relationships | Innovation | Performance

Optum

Making the health system work better for everyone

Information and technology-enabled health services:

- Technology solutions
- Pharmacy solutions
- Intelligence and decision support tools
- Health management and interventions
- Administrative and financial services

Optum philosophy of care

Our managed care plan:

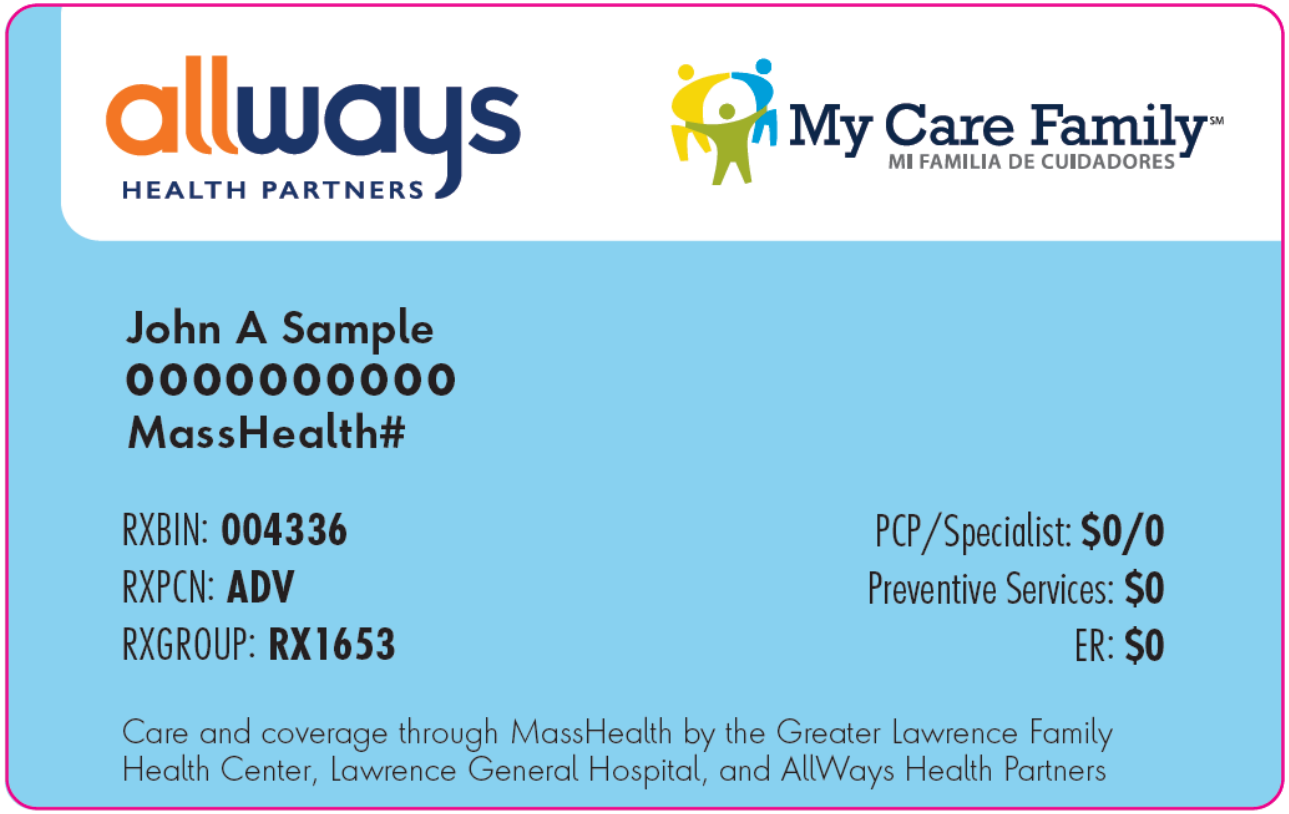
- Integrates medical and behavioral health delivery systems
- Focuses on member involvement in identifying needs
- Supports collaboration

Six key goals:

1. Improve screening and treatment of mental health and substance use disorder diagnoses
2. Treat individuals at the point of care where they are comfortable
3. Treat individuals in a holistic manner, using a single treatment plan, helping each individual access his/her natural community supports based on personal strengths and preferences
4. Improve communication and collaboration between behavioral health and medical clinicians
5. Operate with a collaborative team approach to deliver care using a standardized protocol
6. Establish the necessary permissions from the individual to coordinate care

Covered Members, Eligibility and Benefits

Member identification card, front, My Care Family (Medicaid)



Member identification card, front, My Care Family (Medicaid)

MEMBERS

Customer Service: **1-800-462-5449**
(TTY 711)

For behavioral health services (mental health or substance use) call Optum Behavioral Health Services: **1-844-451-3519** (TTY 711)

CVS Caremark Prescription Services: **1-866-546-0662**

Visit **mycarefamily.org**, a secure member portal for detailed plan and provider information

Call your treating provider within 48 hours of an emergency visit.

PROVIDERS

Claims Info and Provider Manual:
allwaysprovider.org

Provider Services: **1-855-444-4647**

Behavioral Health: **1-844-451-3519**

Pharmacy: **1-800-421-2342**

mycarefamily.org **This card does not guarantee coverage.** *ID-50 (08/18)*

Understanding covered benefits

Coverage Determination Guidelines standardize the interpretation and application of terms of the Member's Benefit Plan including terms of coverage, exclusions and limitations

Coverage Determination Guidelines can be found on *Provider Express*, our industry leading provider website

Optum Members have a variety of benefits available to them

Check a Member's benefits and eligibility on *Provider Express* through secure Transactions

Benefits will be different for commercial and My Care Family members; it is essential to verify benefits before rendering services.

Eligibility and benefits verification using Provider Express

Provider Express - providerexpress.com

Our industry-leading provider website

- Includes both public and secure pages for behavioral health providers

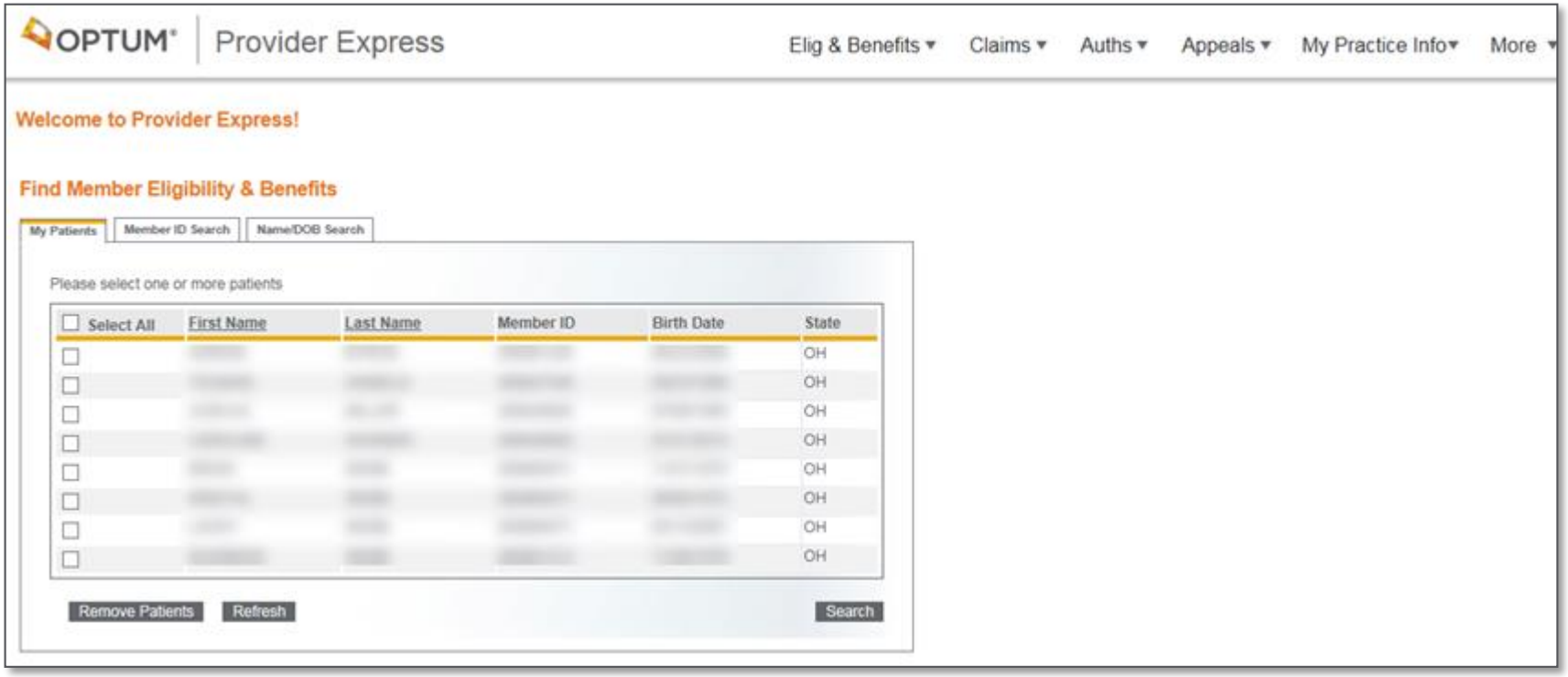
Eligibility & Benefits allow users to search for a member's eligibility by using My Patients list, Member ID Search or the Name/DOB Search.

The My Patients list is also built using this transaction.

Eligibility and benefits, member search

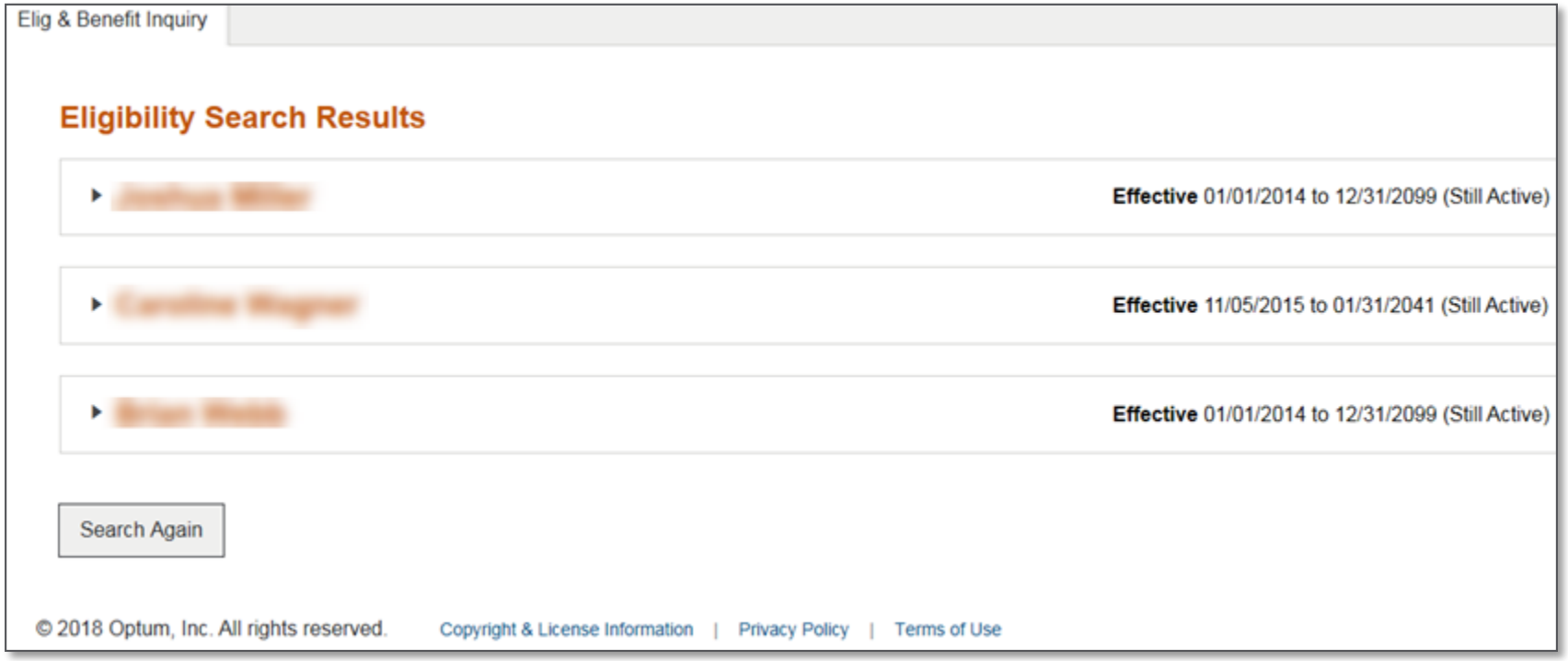
Provider Express offers three methods for searching eligibility:

- My Patients (a list you build yourself)
- Member ID
- Name/DOB



Eligibility and benefits, member search (continued)

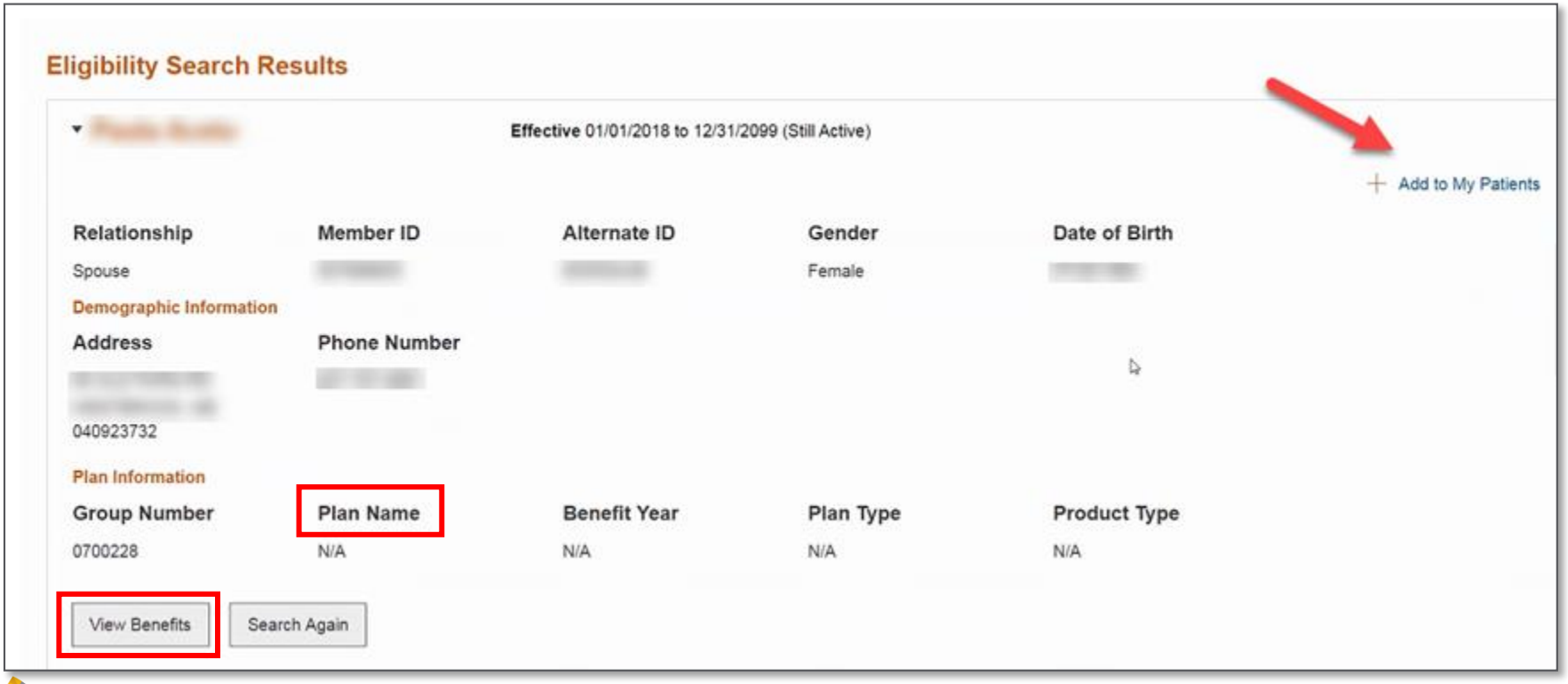
If multiple members are selected from the My Patients list, the results show in rows. The triangle to the left of the name expands/collapses the eligibility details.



Eligibility and benefits, eligibility information

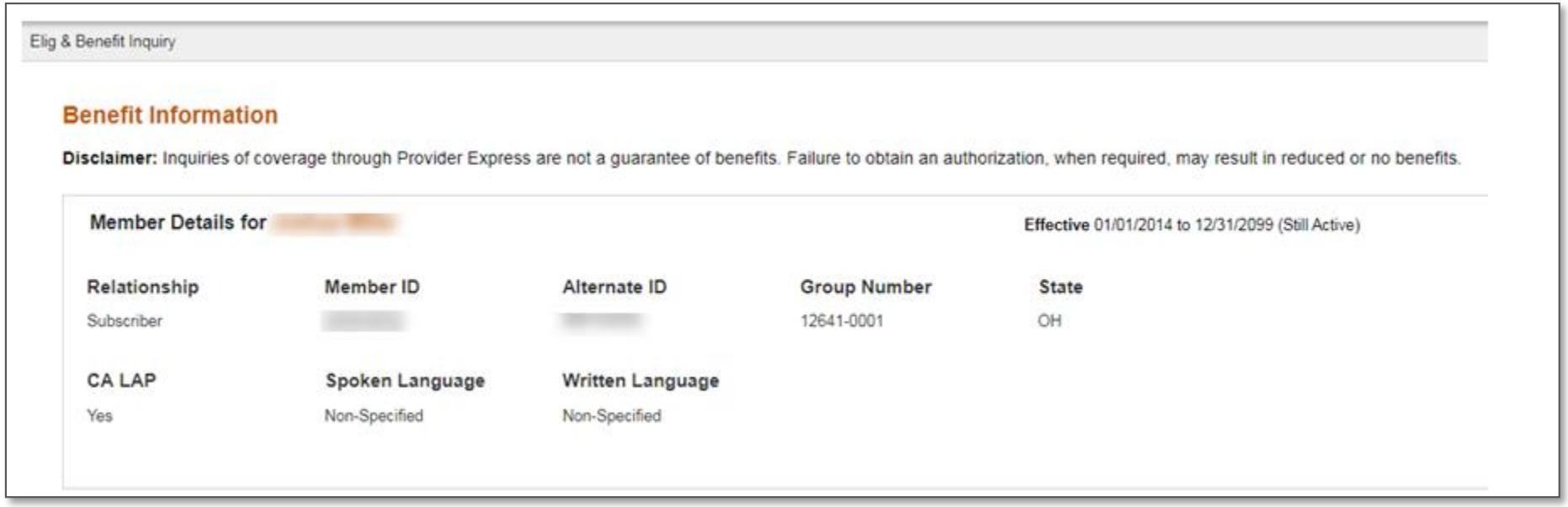
Regardless of the search method, if a matching member record is found, the eligibility information will display.

Here you will find the group number, plan name (when available), relationship, the most recent effective date of coverage, and the termination date (if applicable).



Eligibility and benefits, viewing benefits

The Member details section includes the Member ID, Alternate ID (if applicable), Group Number, State and if the California Language Assistance Program (CA LAP) is applicable, the Spoken Language and Written Language the member identified. For some members, a Plan ID will display.



Clinical Overview

Progressing members towards healthier

Optum Behavioral Health's clinical model helps members become healthier by approaching them holistically to improve behavioral and medical outcomes.

Utilization management care advocacy model

Ensure members receive evidenced-based treatment in the least restrictive setting

Stage all aspects of care to influence key players (facility, providers, family) and facilitate care plans

Align resources and meaningful interventions for high-risk members

Promote member self direction and engagement in care

Covered Services and Authorizations

Covered Services, Inpatient

Inpatient services: *24-hour services, delivered in a licensed hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both.*

- Inpatient Mental Health Services
- Inpatient Substance Use Disorder Services (Level 4)
- Observation/Holding Beds
- Administratively Necessary Day (AND) Services

Covered Services, Diversionary Services

Diversionary Services: *these services provide clinically appropriate alternatives to Behavioral Health Inpatient Services, or support returning to the community following a 24-hour acute placement; or provide intensive support to maintain functioning in the community*

24-hour diversionary services

•Community Crisis Stabilization (CCS)

•Community-Based Acute Treatment for Children and Adolescents (CBAT)

•Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)

•Clinical Support Services (CSS) for Substance Use Disorders (Level 3.5)

•Residential Rehab Services (RRS), High Intensity, Population Specific (Level 3.3), My Care Family (MassHealth) members only

•Residential Rehab Services (RRS), Low Intensity (Level 3.1), My Care Family (MassHealth) members only

•Transitional Care Unit (TCU) for DCF Youth, My Care Family (MassHealth) members only

NOTE: Providers should contact Optum at 844-451-3519 for Authorizations and Admissions Reporting for MassHealth members.

Covered Services, Diversionary Services

Non 24-hour diversionary services

- Community Support Program (CSP)
- Partial Hospitalization (PHP)
- Psychiatric Day
- Structured Outpatient Addiction Program (SOAP)
- Intensive Outpatient Program (IOP)
- Recovery Support Navigators, My Care Health (MassHealth) members only
- Recovery Coaches, My Care Health (MassHealth) members only

Covered Services, Standard Outpatient Services

- Family Consultation
- Case Consultation
- Diagnostic Evaluation
- Dialectical Behavioral Therapy (DBT)
- Psychiatric Consultation on an Inpatient Medical Unit
- Medication Management (office based)
- Medication Administration
- Couples/Family Treatment
- Group Treatment
- Individual Treatment
- Inpatient-Outpatient Bridge Visit
- Assessment for Safe and Appropriate Placement (ASAP) for DCF Youth
- Collateral Contact
- Opioid Treatment Services
- Ambulatory Detoxification (Level 2.WD)
- Psychological Testing
- Special Education Psychological Testing for My Care Family (MassHealth) members
- ECT at DMH Licensed Facilities

Authorization process for RRS

Substance Use Disorder (SUD) Residential Rehabilitation Services: Optum complies with all requirements outlined in Session Laws, Acts (2014), Chapter 258.

- SUD Residential Rehabilitation Services Level 3.1: no authorization is required for the first ninety (90) days
- SUD Residential Rehabilitation Services, all other Levels: no authorization is required for the first fourteen (14) days
- Providers are required to notify Optum within seven (7) days of an RRS admission by calling Optum at 844-451-3519

Authorizations can be requested in two ways:

- Contracted providers can request authorizations for most services via the online portal system on Provider Express (providerexpress.com). You will need to log-in to request authorizations. The previous slide includes information about which services can be requested online and which require a phone call.
- Calling Optum via the number on the member's card

ASAM Criteria will inform the concurrent review process

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

Discharge planning

- Effective discharge planning
  - Addresses how a Member's needs are met during a level of care transition or change to a different treating provider
  - Begins at the onset of care and should be documented and reviewed over the course of treatment
  - Focuses on achieving and maintaining a desirable level of functioning after the completion of the current episode of care
- Discharge instructions should be specific, clearly documented and provided to the member prior to discharge:
- Throughout the treatment and discharge planning process, it is essential that Members be educated regarding:
  - The importance of enlisting community support services
  - Communicating treatment recommendations to all treating professionals
  - Adhering to follow-up care

Medical necessity

Medically necessary services, as outlined in 130 CMR 450.204, are those services

- Which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity
- For which there is no other medical service or site of service, comparable in effect, available and suitable for the member requesting the service, that is more conservative or less costly

Medically necessary services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality.

Utilization management statement

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

- Optum Level of Care Guidelines
- Behavioral Health Clinical Policies
- American Society of Addiction Medicine (ASAM) Criteria

Level of Care Guidelines can be found at providerexpress.com

Path: Provider Express > Clinical Resources > Level of Care Guidelines

Residential Rehabilitation Services (RRS), for Medicaid Members

Residential Rehabilitation Services (RRS)

Optum will use ASAM criteria as the basis for determining medical necessity for RRS.

The 6 dimensions of ASAM include

Dimension 1: Acute Intoxication and Withdrawal Potential

Dimension 2: Biomedical Conditions and Complications

Dimension 3: Emotional, Behavioral, or Cognitive Conditions or Complications

Dimension 4: Readiness to Change

Dimension 5: Relapse, Continued Use, or Continued Problem Potential

Dimension 6: Recovery Environment

Billing and Coding for RRS

RRS will be billed as *professional* claims on the CMS 1500 claim form using the Claim Entry tool on Provider Express. On the claim form, facility information (not individual clinician information) should be entered.

The following codes and modifiers are to be used when billing for RRS:

Billing Code and Modifier	Services
H0019	Adult RRS
H0019 – HA	Youth RRS
H0019 – HF	TAYYA (Transition Age Youth and Young Adults) RRS
H0019 – HR	Family RRS
H0019 – TH	Pregnant RRS
H0019 – HH	Co-occurring Enhanced RRS

Support for claims questions

RRS providers will be able to talk directly with a customer service representative (CSR) live on the phone to address any claims questions or concerns.

- CSRs are available to review any claims questions
- CSRs are available to walk a provider through the claims filing process

Providers may contact a CSR by calling the phone number on the back of the member's insurance card.

Cultural Competency

Cultural competency

- As a health care provider, it is important for you to remember to be culturally sensitive to the diverse population you serve:
  - There are diverse cultural preferences that we ask providers to keep in mind when serving members
  - All services should be conducted in accordance with Title VI of the Civil Rights Act of 1964 and should be provided in a manner that respects the Member's cultural heritage and appropriately uses natural supports in the Member's community

Provider Express Resources:
Provider Express > Clinical Resources > Cultural Competency

Cultural competency, (continued)

- Providers are required to deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, and to provide for interpreters in accordance with 42 CFR §438.206

- All providers shall comply with any state or federal law which mandates that all persons, regardless of race, creed, color, religion, sex, age, income, sexual orientation, gender identity, national origin, political affiliation, or disability, shall have equal access to employment opportunities, and all other applicable federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI

Cultural competency, (continued)

- Providers shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, age, income, sexual orientation, gender identity, national origin, political affiliation, or disability. Some cultural preferences to remember include:
  - Ask what language the Member prefers to help eliminate communication barriers and, when necessary, use the interpretation services available to you
  - Understand the Member's religious beliefs
  - Understand the role of the Member's family in their decision-making process
- Providers should collect Member demographic data, including, but not limited to ethnicity, race, gender, sexual orientation, religion, and social class
  - Members must be given the opportunity to voluntarily provide this information, it cannot be required

Cultural competency, (continued)

Some additional resources for information on Cultural Competency:

- cms.hhs.gov/ocr – Office of Civil Rights
- LEP.gov – Limited English Proficiency (LEP): Site promotes importance of language access to federal programs and federally assisted programs
- diversityrx.org – Promotes language and cultural competency to improve the quality of health care for minorities
- ncihc.org – National Council on Interpreting in Health Care: Organization promotes culturally competent health care

Importance and value of cultural competence

- Given the diverse ethnic population in Massachusetts, providers must be prepared to provide culturally appropriate services
- Service settings and approaches should be culturally sensitive to engage individuals from diverse backgrounds to access services
- Promoting open discussions about mental health or substance use issues is an important step to reduce the stigma many individuals experience
- Emphasizing individualized goals and self-sufficiency encourages Members to live their lives to the fullest

Provider Clinical Audits

Provider audits

Organizational providers (including facility based services, partial hospital programs, intensive outpatient programs, residential programs and most agencies) that do not have a national accreditation (such as The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), etc.) will require on-site clinical audits at the time of credentialing and recredentialing.

Clinical audits may also be completed to investigate a quality of care (QOC) concern or a sentinel event.

- On-site audits are completed as part of the bi-annual network review; audit frequency may be higher than bi-annual when indicated by audit outcomes

Record review audits are completed of providers who render services to AllWays members of any age.

- A sample of providers are randomly selected for review on an annual basis

Documentation standards

Documentation requirements for AllWays Health Partners providers are described in the AllWays Health Partners Addendum to the Optum National Manual. From the home page, select Our Network > Welcome to the Network > Massachusetts > AllWays Health Partners > Provider Manual Addendum. This manual addendum will be posted prior to January 1, 2019.

Reminders: Release of Information (42 CFR §431.306)

- Providers must have criteria outlining the conditions for release of information about Members
- Providers must have a signed release of information to respond to an outside request for information
- All staff members within the provider agency/group are subject to the same confidentiality requirements
- A release of information should be obtained to allow communication and collaboration with other treating providers (including previous treating providers)

Adverse Incident Reporting

Behavioral health adverse incident reporting

Behavioral Health reportable adverse incidents include, but are not limited to, the following:

- Any death (include cause of death if known)
- Any absence without authorization (AWA)
- Any serious injury resulting in hospitalization
- Any sexual assault or alleged sexual assault
- Any sexual activity in a 24-hour level of care facility
- Any violation or alleged violation of the Department of Mental Health physical restraint and/or seclusion regulations
- Any physical assault or alleged physical assault on or by a covered individual or by staff
- Any contraband found prohibited by provider policy
- Any injury or illness requiring transportation to an acute care hospital for treatment while in a 24 hour program

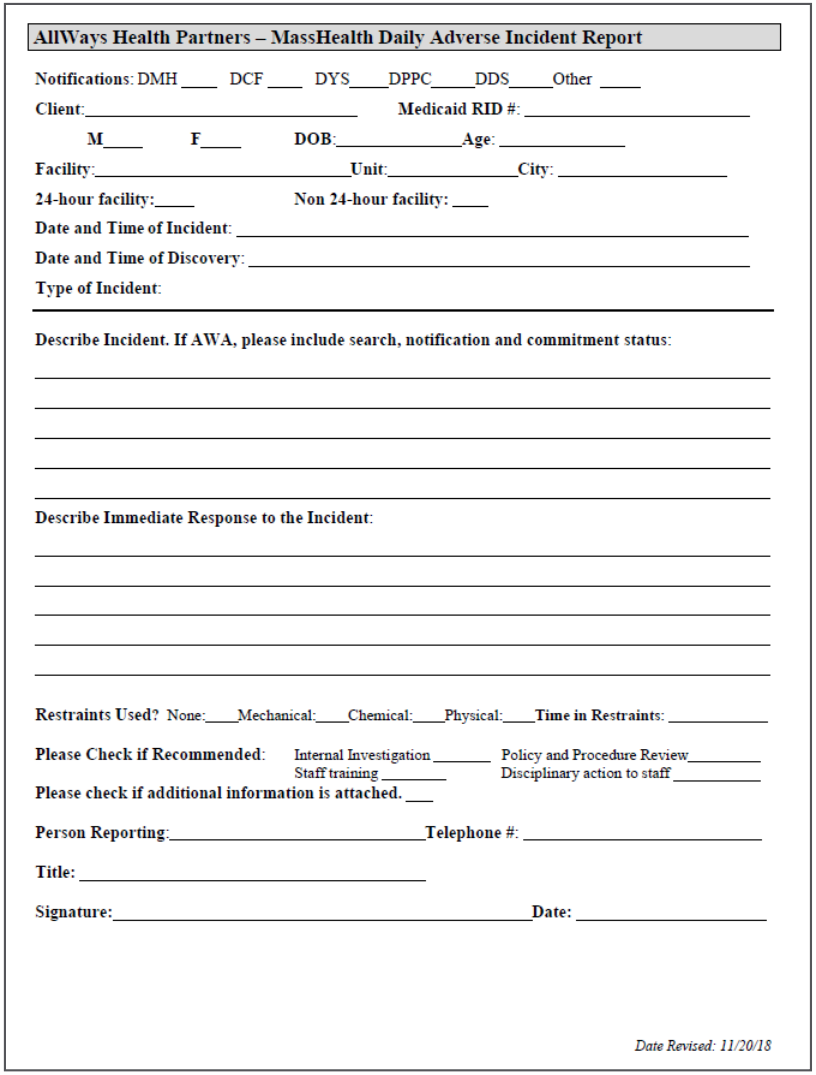
Behavioral health adverse incident reporting (continued)

- Accidental injuries
- Any unscheduled event that results in the evacuation of a program or facility
- Fall
- Fire setting
- Homicide
- Medication abuse or error
- Property damage
- Seizure
- Self injury
- Substance use
- Suicide attempt or gesture

Report submission instructions

- When an adverse incident occurs, the provider must complete the applicable Adverse Incident Report form and submit it to Optum within 24 hours of discovery of the incident; if the incident occurs on a holiday or weekend, the form must be submitted on the next business day
- All forms are faxed to Optum; we will provide a fax number with the form when we post it to Provider Express
- The form will be available on Provider Express approximately one week before 1/1/19; from the Home page, select Our Network > Welcome to the Network > Massachusetts > AllWays Health Partners > Adverse Incident Report Forms

Adverse Incident Report form, MassHealth



AllWays Health Partners – MassHealth Daily Adverse Incident Report

Notifications: DMH ____ DCF ____ DYS____DPPC_____DDS_____Other _____

Client:_____ **Medicaid RID #:** _____

M____ **F**____ **DOB:**_____**Age:** _____

Facility:_____**Unit:**_____**City:** _____

24-hour facility:____ **Non 24-hour facility:** ____

Date and Time of Incident: _____

Date and Time of Discovery: _____

Type of Incident:

Describe Incident. If AWA, please include search, notification and commitment status:

_____

_____

_____

_____

_____

Describe Immediate Response to the Incident:

_____

_____

_____

_____

_____

Restraints Used? None:____Mechanical:____Chemical:____Physical:____**Time in Restraints:** _____

Please Check if Recommended: Internal Investigation _____ Policy and Procedure Review_____
Staff training _____ Disciplinary action to staff _____

Please check if additional information is attached. ___

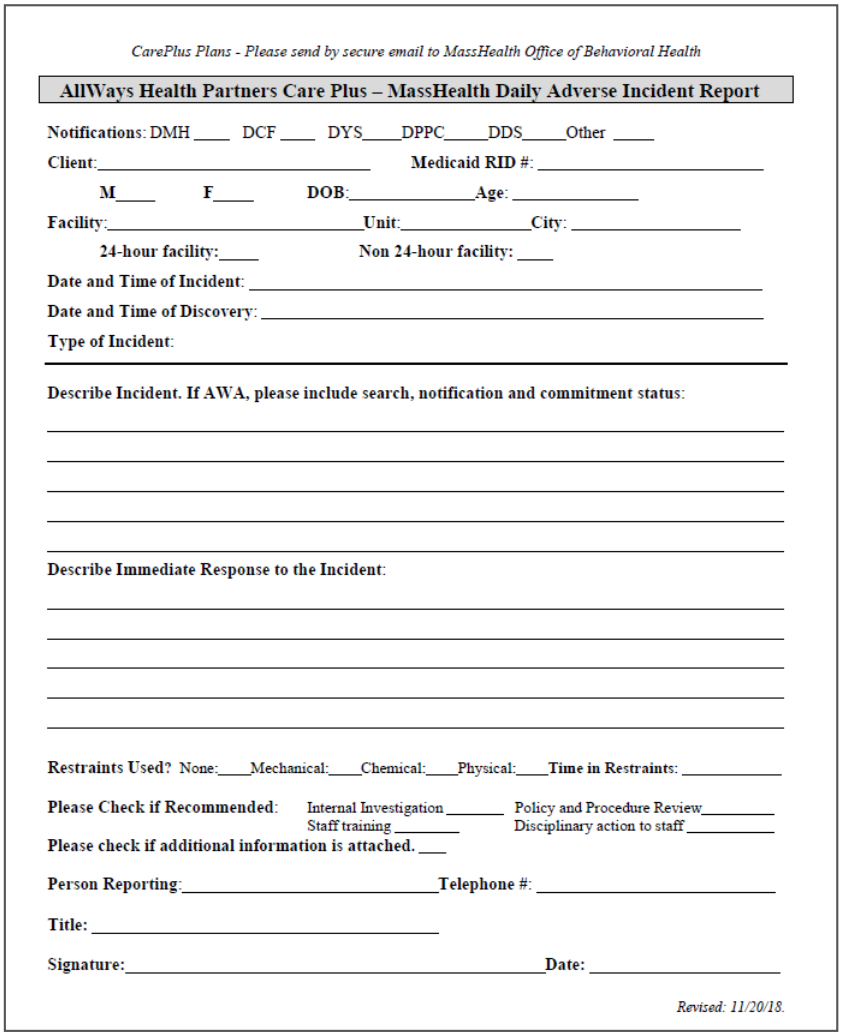
Person Reporting:_____**Telephone #:** _____

Title: _____

Signature:_____**Date:** _____

Date Revised: 11/20/18

Adverse Incident Report form, Care Plus MassHealth



CarePlus Plans - Please send by secure email to MassHealth Office of Behavioral Health

AllWays Health Partners Care Plus – MassHealth Daily Adverse Incident Report

Notifications: DMH ____ DCF ____ DYS____DPPC____DDS____Other ____

Client:_____ **Medicaid RID #:** _____

M____ **F**____ **DOB:**_____**Age:** _____

Facility:_____**Unit:**_____**City:** _____

24-hour facility:____ **Non 24-hour facility:** ____

Date and Time of Incident: _____

Date and Time of Discovery: _____

Type of Incident:

Describe Incident. If AWA, please include search, notification and commitment status:

_____

_____

_____

_____

_____

Describe Immediate Response to the Incident:

_____

_____

_____

_____

_____

Restraints Used? None:____Mechanical:____Chemical:____Physical:____**Time in Restraints:** _____

Please Check if Recommended: Internal Investigation _____ Policy and Procedure Review_____
Staff training _____ Disciplinary action to staff _____

Please check if additional information is attached. ___

Person Reporting:_____**Telephone #:** _____

Title: _____

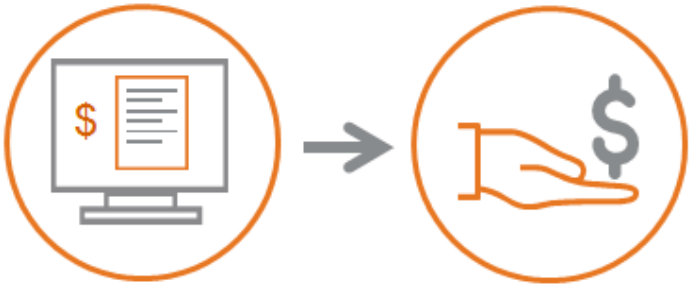
Signature:_____**Date:** _____

Revised: 11/20/18.

Claims

Claims filing made easy

File your claim electronically for a fast, secure and convenient claims experience



Benefits of Electronic Filing:

- **It's fast** - Eliminate mail and paper processing delays
- **It's convenient** - Easy set-up and intuitive process
- **It's secure** - Data security is higher than with paper-based claims
- **It's efficient** - Electronic processing helps prevent errors
- **It's cost-efficient** - you eliminate mailing costs and the solutions are free or low-cost

Claims submission option 1, Online: Provider Express

Our network clinicians report the highest level of satisfaction when they submit claims online through *Provider Express:*

- Free
- Available 24/7
- Intuitive and easy-to-use
- HIPAA Compliant
- Real-time, quick claims processing
- Available to clinicians and groups
- Outpatient behavioral and EAP claims

Get started today with your Optum ID:

- Register for an Optum ID today by clicking this First-time User link
- Need help registering for an Optum ID? Watch this quick video

Tips for timely and accurate payments, Provider Express

Filing claims electronically on Provider Express 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, ICD-10 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

Claims submission option 2: **EDI/ Electronically**

Submit batches of claims electronically, right out your practice management system software:

- Ideal for high volume Providers
- Can be configured for multiple payers
- Clearinghouse may charge small fee

To learn more about Electronic Data Interchange, visit Provider Express. From the Home Page, select Admin Resources > Claim Tips > EDI/Electronic Claims

Claims submission option 3: **Paper**

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)

Claims submission option 3: **Paper**

- 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

Receive payments faster

Benefits of Electronic Payments and Statements (EPS)

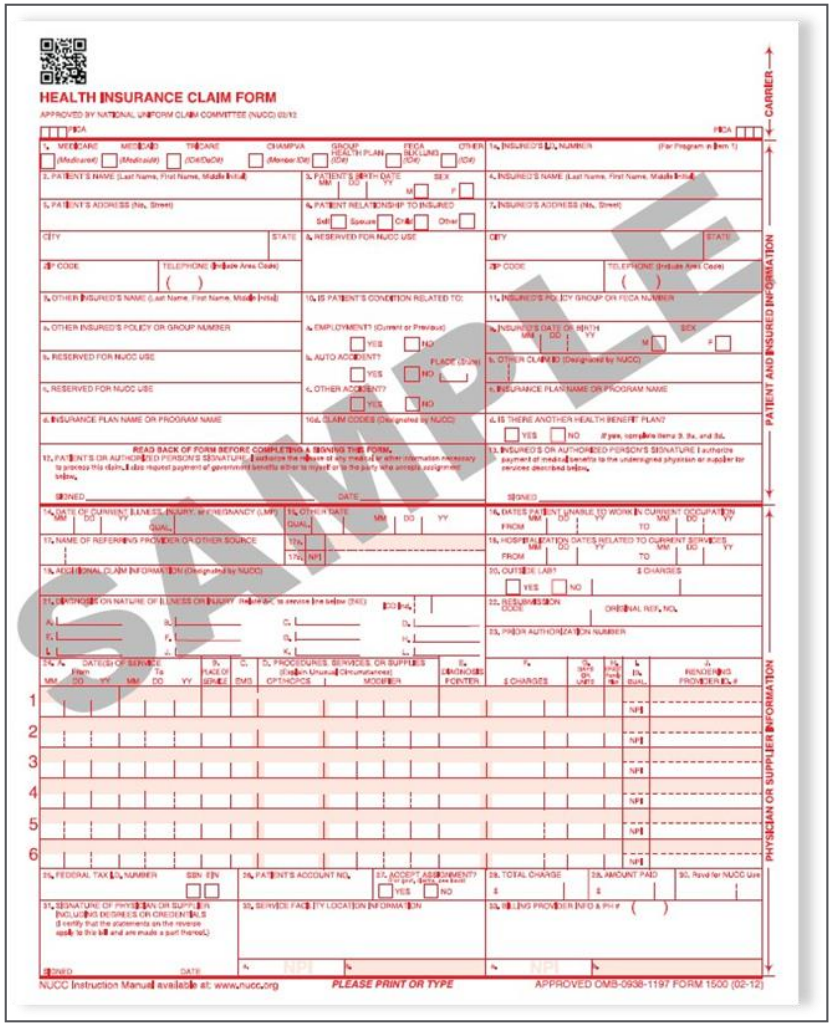
- Easy set-up, free to use
- Payments deposited into your bank
- Simplified claims reconciliation
- 24/7 access to your information
- Secure payment and remittance advice

Registering for EPS is easy!

- Login to *Provider Express* with your Optum ID
- Select “EPS” under the “More” heading and follow the prompts to enroll
- Contact Optum Financial Services for assistance: 1-877-620-6194

Claim form – CMS Form 1500 (v 02/12)

When completing this form for RRS, facility information (name, address, NPI, etc.) is used for all sections.



Claim tips

To support clean claim submissions remember:

- NPI numbers are always required on all claims
- A complete diagnosis is required on all claims
- The correct date of service corresponding to the date the service occurred must be listed on the claim form; do not list the claim submission date as the date of service

Claims filing deadline:

- AllWays Health Partners allows claim submissions up to ninety (90) days from the date of service

Claims Processing:

- Clean claims, including adjustments, will be adjudicated within forty-five (45) days of receipt of the claim

Balance Billing:

- The member cannot be balance billed for behavioral services covered under the contractual agreement

Claim tips, (continued)

Member Eligibility:

- Provider is responsible to verify member eligibility through providerexpress.com

Examples of coding Issues related to claim denials:

- Incomplete or missing diagnosis
- Invalid or missing HCPCS/CPT codes and modifiers
- Use of codes that are not covered services
- Required data elements missing, (e.g., number of units)
- Provider information is missing or incorrect
- Required authorization missing
- Units exceed authorization (e.g., 10 inpatient days were authorized, facility billed for 11 days)

Appeals

Appeals

Provider Disputes

Optum has a formal process for handling practitioner/facility disputes that is compliant with the standards and regulations set forth by National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) and state/federal regulations. These standards and regulations serve as guidelines to ensure that:

- Review turnaround time requirements are met;
- Appropriately qualified professionals are involved in the review of practitioner/facility disputes;
- Relevant clinical/administrative information is consistently gathered and reviewed as part of the investigation;
- Practitioners/facilities are informed of the rationale for disputes that are upheld, in whole or in part.

One (1) level of internal dispute review is available through Optum, unless required by state law or contractual requirement.

Appeals: standard and expedited

Non-Urgent (Standard)	Urgent (Expedited)
▪ Commercial: must be requested within 180 days from receipt of the notice of adverse determination. ▪ MassHealth (Medicaid): must be requested within 60 calendar days from receipt of the notice of adverse determination. ▪ Optum will make an appeal determination and notify the in writing within 30 calendar days of receipt of request.	▪ Practitioner/facilities can file an urgent appeal on behalf of a member ▪ Must be requested as soon as possible after the adverse determination ▪ Optum will make a reasonable effort to contact you prior to making a determination on the appeal. If Optum is unsuccessful in reaching you, an urgent appeal determination will be made based on the information available to Optum at that time ▪ Notification will occur as expeditiously as the member's health condition requires, not exceeding 72 hours of the receipt of the request.

Appeals: contact information

Optum

Appeals & Grievances

P.O. Box 30512

Salt Lake City, UT 84130-0512

Fax: 855-312-1470

Phone: 866-556-8166

Fraud, Waste, Abuse and Error (FWAE)

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:

Prospective (Pre-Pay)	Retrospective (Post Pay)	Intelligence
• **Analyze member, provider and claims data**	• Analyze member, provider and claims data	• Anonymous TIP line
• **Identify trends, current/ upcoming schemes or unusual behavior**	• Identify trends, schemes or unusual behavior, then investigate	• Email / PO Box
• **Stop potentially fraudulent or defective claims from being paid**	• Work with state and federal agencies to stop fraud, waste and abuse consistently across the industry	• Internal and external training
		• Provider Education

Websites

Member Website: Live and Work Well (LAWW)

Self-help programs and tools

- Cognitive therapy-based programs
- Self-assessments with immediate feedback
- Quick-search databases
- Caring eCards
- Financial tools and legal templates

Educational information

- Over 100 specially-designed Centers of information to address all aspects of life
- More than 5,000 clinician-reviewed articles, discussion boards, videos, webinars and newsletters in English and Spanish
- Kid and teen wellness-related tools, articles, stories, movies and games

Access to professional services

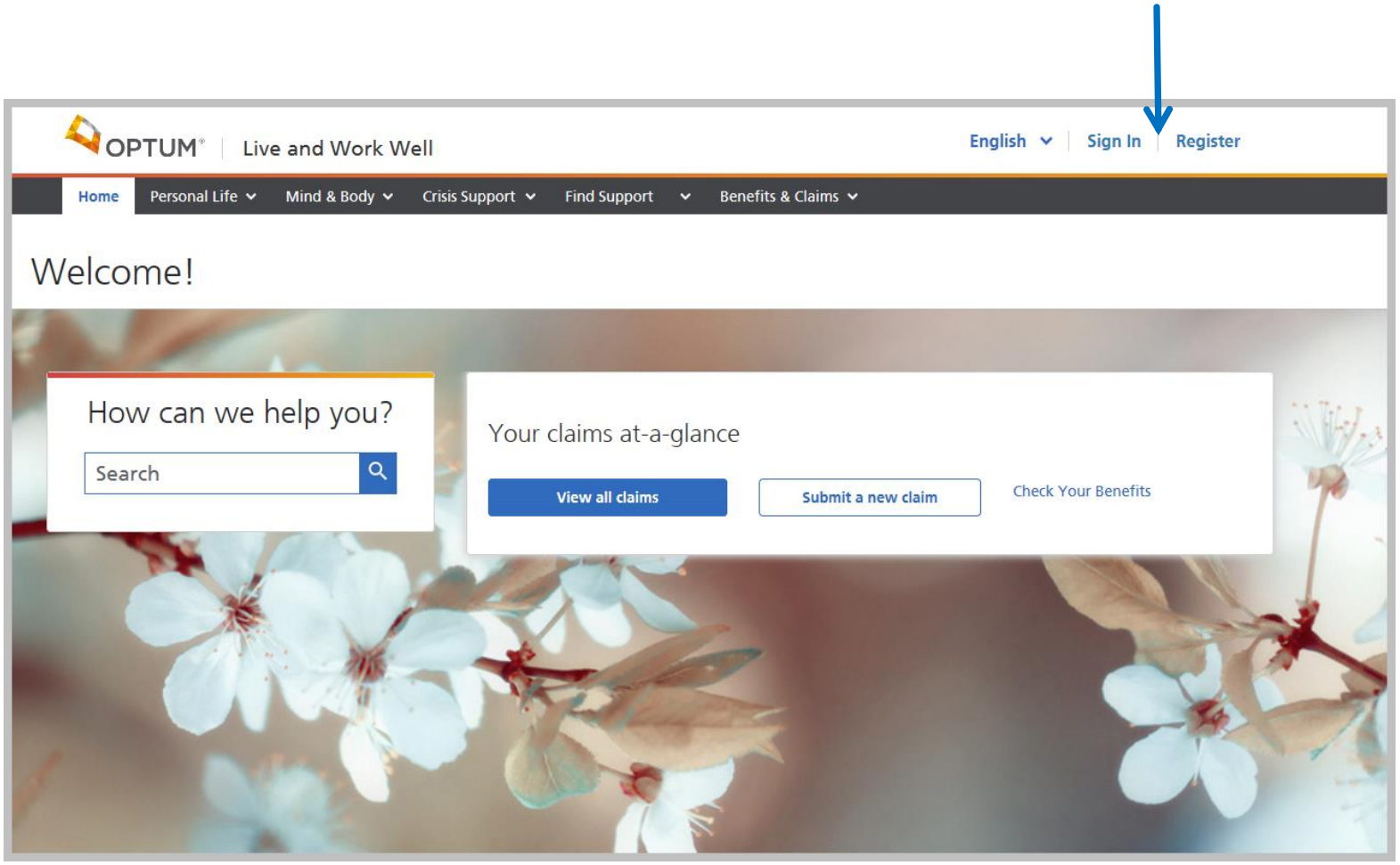
- Clinician search tool (web and mobile)
- Benefit coverage toolkit
- Legal and financial consultation

URAC accredited and global

- 1 of only 10 URAC accredited health websites and the only accredited behavioral site
- Global versions available in sixteen languages

OPTUM®

LAWW home page



Provider resources

Provider Express - providerexpress.com

Our industry-leading provider website

- Includes both public and secure pages for behavioral health providers
- Public pages
  - General updates and useful information
- Secure pages
  - Require registration
  - The password-protected “secure transactions” offers providers access to provider-specific information including the ability to update your practice information

Provider resources, (continued)

Public Pages: general updates and other useful information

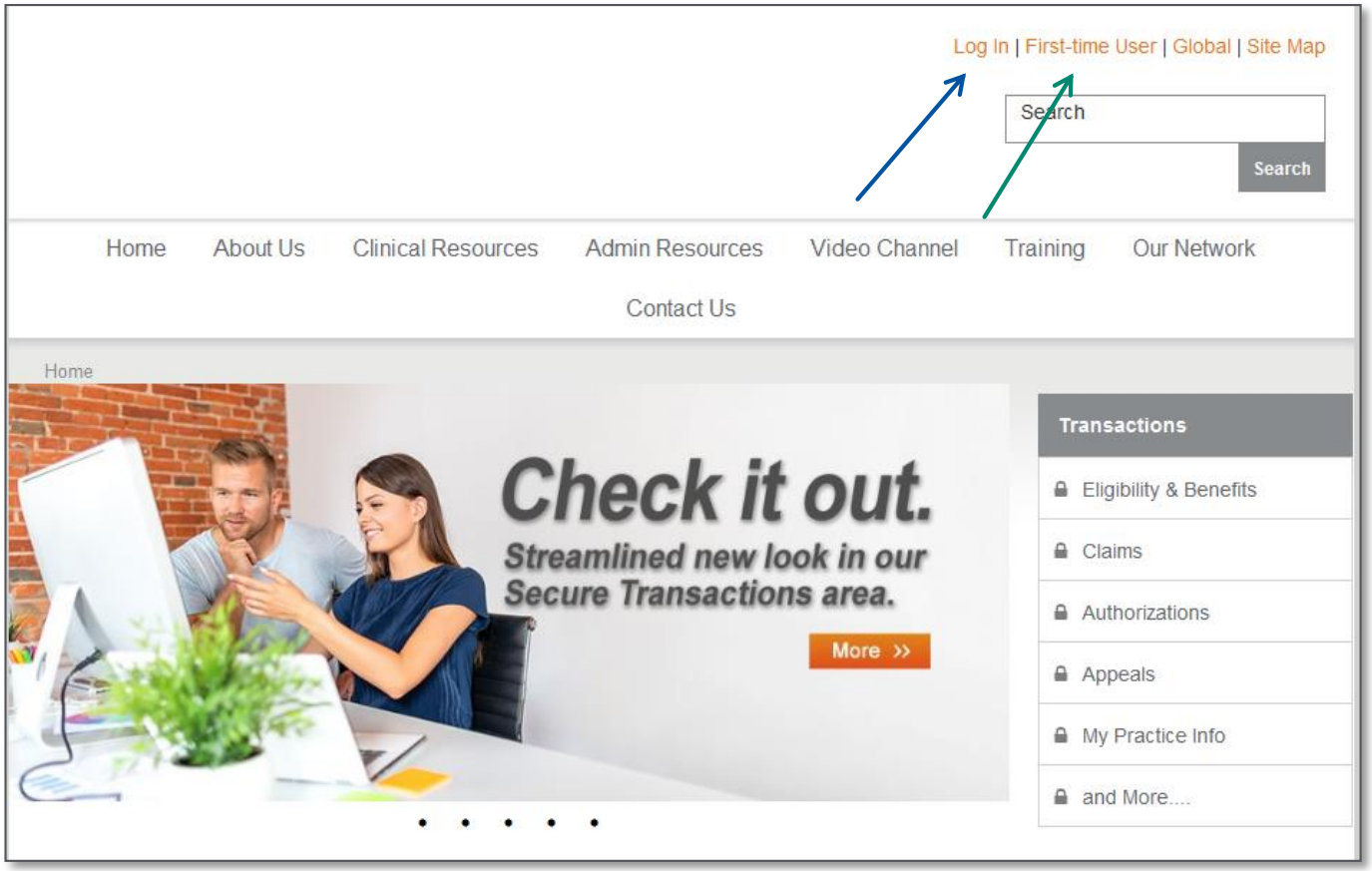
- Access forms library
- Find network contacts
- Review clinical guidelines
- Access *Network Notes*, the provider newsletter
- Level of Care Guidelines
- Training/Webinar offerings
- AllWays Health Partners page: from the home page, Our Network > Welcome to the Network > Massachusetts
  - Information for AllWays Health Partners is on the right side of the screen

AllWays Health Partners Provider Express page

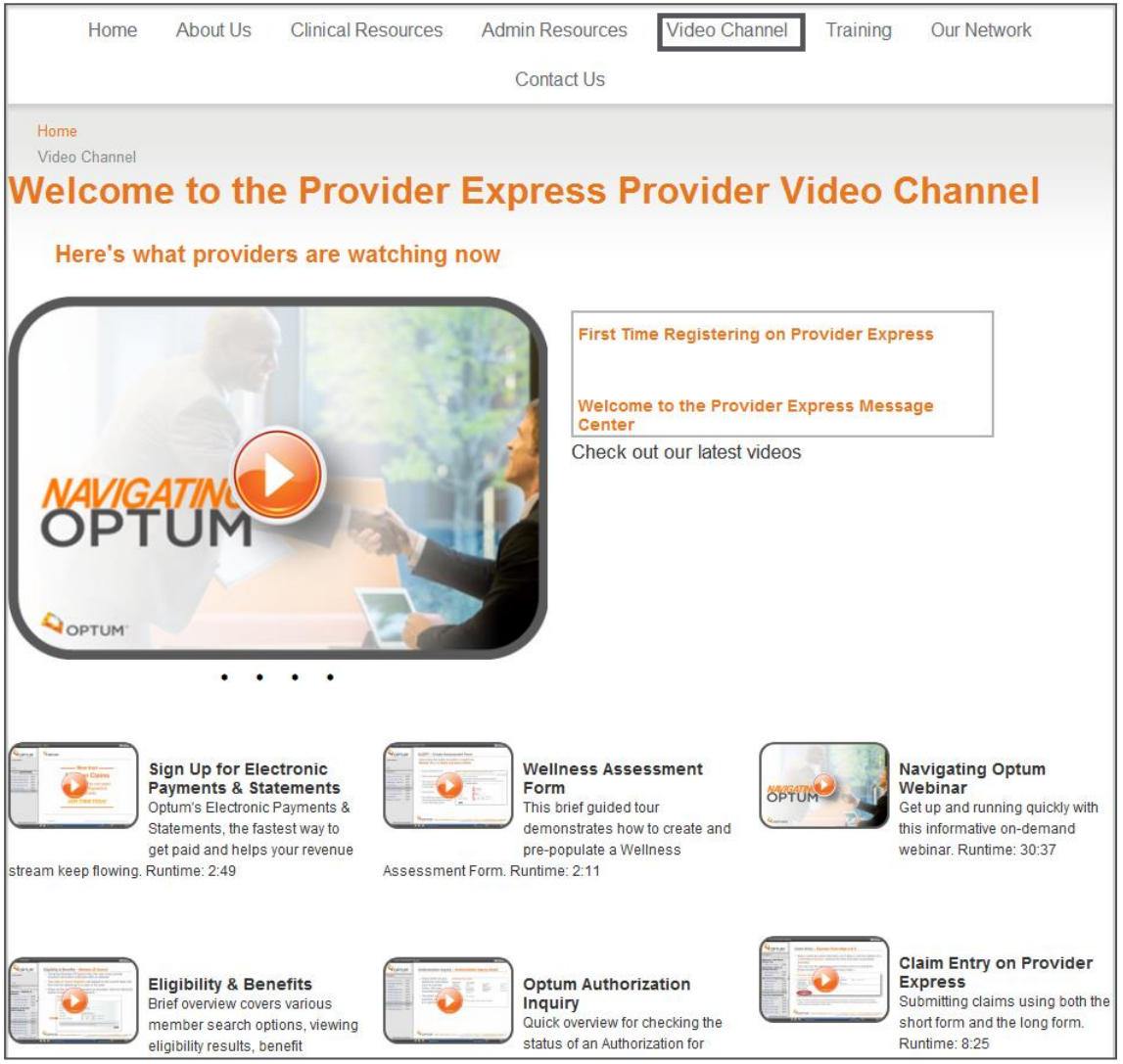
Provider resources, (continued)

- Secure pages require registration
- Providers will be able to update their practice information using the “My Practice Info” feature
- To request an Optum ID, select the “First-time User” link in the upper right corner of the home page
- If you need assistance or have questions about the registration process, click on “Contact Us” and refer to the Website Technical Support section
- The Video Channel includes multiple brief videos on the various functions in the secure transactions area of Provider Express

Provider Express



Provider Express Video Channel



Provider Relations

Provider Responsibilities

- Render services to Members in a non-discriminatory manner:
  - Maintain availability for a routine level of need for services
  - Provide after-hours coverage
- Determine if Members have benefits through other insurance coverage
- Advocate for Members as needed
- Respond in a timely manner to requests from Optum (this includes requests for record submissions and requests for information relation to a member complaint)
- Notify us at 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)
  - Time line is established by NCQA
- 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

Provider Customer Service

The customer service phone number dedicated to the AllWays Mass/Health

ACO (Medicaid), My Care Family line of business is: 844-451-3519

Provider Relations Contact Information

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Thank you.

Contact information:

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Gabriel Nathan, Senior Network Manager

Janet Choup, Network Manager

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