Post Go Live Behavioral Health Carve-In Ohio Medicaid Provider Training

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Community Plan

Post Go Live Behavioral Health Carve-In

- Today: Post Go Live Behavioral Health Carve-In
  - Overview of Behavioral Health Carve-In
  - Prior Authorization
  - Claims
  - Provider Resources
  - Q & A
- Past: Behavioral Health Carve-In 7/1/2018

Please note the ODM material in this presentation is current as of ODM's Behavioral Health Provider Manual published on 1/30/18.

Prior Authorization

Authorization Requirements

Description and Code	Benefit Period	Authorization Requirement
Assertive Community Treatment (ACT) H0040	Based on prior authorization approval	ACT must be prior authorized and all SUD services must be prior authorized for ACT enrollees.
Intensive Home Based Treatment (IHBT) H2015	Based on prior authorization approval	IHBT must be prior authorized.
SUD Partial Hospitalization (20 or more hours per week)	Calendar year	Prior authorization is required for this level of care for adults and adolescents.
Psychiatric Diagnostic Evaluations 90791, 90792	Calendar year	1 encounter per person per calendar year per code per billing agency for 90791 and 90792. Prior authorization once limit is reached.
Psychological Testing 96101, 96111, 96116, 96118	Calendar year	Up to 12 hours/encounters per patient per calendar year for 96101, 96111, and 96116, and 8 hours of 96118. Prior authorization once limit is reached
Screening Brief Intervention and Referral to Treatment (SBIRT) G0396, G0397	Calendar year	One of each code (G0396 and G0397), per billing agency, per patient, per year. Cannot be billed by provider type 95. Prior authorization once limit is reached.

Authorization Requirements Continued

Alcohol or Drug Assessment H0001	Calendar year	2 hours per patient per calendar year per billing agency. Does not count toward ASAM level of care benefit limit. Prior authorization once limit is reached.
SUD Residential H2034, H2036	Calendar year	Up to 30 consecutive days without prior authorization. Prior authorization then must support the medical necessity of continued stay, if not, only the initial 30 consecutive days are reimbursed. Applies to first two stays; any stays after that would be subject to full prior authorization.
Any service or ASAM level of care not listed in this table is not subject to prior authorization.		

Authorization

Non-emergent situations	Emergent situations
• Prior authorization can be obtained by a member, family member, or a provider. When calling UHC, be prepared to provide demographic information and a brief description of the presenting problem. UHC will explain the services available under their benefit plan.	• A medical professional, a member, or a lay person in an emergency situation can identify the need for behavioral health services. Conditions that warrant an emergency admission are situations in which there is a clear and immediate risk to the safety of the member or another person as a direct result of mental illness or substance abuse. • Contact UHC for prior authorization of continued stay or additional care.

Authorization phone number: 1-866-261-7692

Prior Authorization Process

Request Via Phone	Request Via Portal (M-F 8 a.m. - 5 p.m. CST only)
• Provider calls **1-866-261-7692** • Provider selects the Mental Health/Substance use option • Provider services representative confirms eligibility/benefit questions • Call is transferred to Behavioral Health Care Advocate to complete the prior authorization	• Provider logs in to **www.unitedhealthcareonline.com** • Provider verifies member eligibility through the portal • Provider enters authorization request on the portal • Authorization request information received by a Behavioral Health Care Advocate • Behavioral Health Care Advocate calls provider back to complete authorization process

Prior Authorization Continued

- Uniform prior authorization form created for community BH services across all MCO's

- http://bh.medicaid.ohio.gov/manuals > Provider > Medicaid Managed Care Plans > Medicaid/MyCare Uniform Prior Authorization Form

Authorization fax number: 1-866-839-6454

Claims

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Claims Submission

- Providers must submit claims using the current 1500 Claim Form or UB-04 with appropriate coding including, but not limited to ICD-10, CPT, and HCPCS coding
- **Please refer to your provider agreement related to timely filing of claims***
- 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) (unique NPI's for rostered clinicians)
  - Providers are responsible for billing in accordance with nationally recognized CMS Correct National Coding Initiative (NCCI) standards. Additional information is available at www.cms.gov
  - When a provider is contracted as a group or facility, the payment is made to the group/facility and not to the individual clinician

Claims Submission Process

- How to submit:
  - Submit electronically
    - Accepting a wide variety of clearinghouses
  - **www.UnitedHealthcareOnline.com**
    - Secure portal to view eligibility, submit prior authorization request and submit claims for Medicaid members
  - Paper claims may be submitted to the following address:
    United Healthcare Community Plan, PO Box 8207
    Kingston, NY 12402-8207

- What to include:
  - Submit claims with member's subscriber ID number **OR** ODM's MMIS ID number
  - Use Payer ID number **87726** for all UnitedHealthcare Community Plan claims

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.

*Note: For more information, please call **866-842-3278**, option 5, or go to **UHCProvider.com**> Help> Electronic Solutions > Electronic Payments and Statements*

Claims Tips

To ensure clean claims remember:

- NPI numbers are always required for both rendering/billing provider on all claims
- Obtain an NPI and enroll rendering clinicians in the Ohio Medicaid program and affiliate the clinician with the agency's Medicaid ID number(s) in MITS
- Modifiers, in addition to the NPI, are and will continue to be used for non-licensed/paraprofessional and non-independently licensed providers in order to differentiate service level by licensure and training for claims payment purposes*
- A complete diagnosis is also required on all claims
- Providers must accurately identify and report on each claim detail line where a service took place using the most appropriate CMS place of service code.

Claims Processing

- Clean claims, including adjustments, will be adjudicated within 30 days of receipt*

Common Provider Claim Errors

- J Codes NDC codes must be included. Reference MitsBits
- Add on codes must be connected to the claim with the primary code…not separate
- NPI must be on the claim in a specific loop 2420A line level rendering
- Ensure correct modifier and modifier mixes. Refer to provider manual with what is allowed.

Required Modifiers

Practitioner Providing the Service:	Professional Abbreviation	Practitioner Modifier
Licensed professional counselor	LPC	U2
Licensed chemical dependency counselor III	LCDC III	U3
Licensed chemical dependency counselor II	LCDC II	U3
Licensed social worker	LSW	U4
Licensed marriage and family therapist	LMFT	U5
Psychology assistant, intern, trainee	PSY assistant	U1
Chemical dependency counselor assistant	CDC-A	U6
Counselor trainee	C-T	U7
Social worker assistant	SW-A	U8
Social worker trainee	SW-T	U9
Marriage and family therapist trainee	MFT-T	UA
QMHS – high school	QMHS	HM
QMHS – Associate's	QMHS	HM
QMHS – Bachelor's	QMHS	HN
QMHS – Master's	QMHS	HO
QMHS – 3 years' experience	QMHS	UK
Care management specialist – high school	CMS	HM
Care management specialist – Associate's	CMS	HM
Care management specialist – Bachelor's	CMS	HN
Care management specialist – Master's	CMS	HO
Peer recovery supporter – high school	PRS	HM
Peer recovery supporter – Associate's	PRS	HM
Peer recovery supporter – Bachelor's	PRS	HN
Peer recovery supporter – Master's	PRS	HO

Procedure Modifiers

Service Circumstance	Modifier
Group service	HQ
Physician, team member (ACT)	AM
CNP team member (ACT)	UC
PA or CNS, team member (ACT)	SA
Master's level, RN, LPN, team member (ACT)	HO
Bachelor's level, team member (ACT)	HN
Peer recovery supporter, team member (ACT)	HM
Pregnant/parenting women's program	HD
Complex/high tech level of care	TG
Cognitive Impairment	HI
Licensed practitioners providing TBS Group Hourly/Per Diem (day treatment) or SUD group counseling	HK
OTP Daily Administration	HF
OTP One Week Administration (2 – 7 Days)	TV
OTP Two Week Administration (8 – 14 Days)	TU
OTP Three Week Administration (15 – 21 Days)	TS
OTP Four Week Administration (22 – 28 Days)	HG
Significant, separately identifiable Evaluation & Management (E/M) service by physician or other qualified health professional on the same day of the procedure or other service	25
NCCI modifiers (See NCCI Section)	59, XS, XE, XU and XP
CLIA waived test- certificate of waiver – CMS certificate type code 2 or higher required	QW
Crisis modifier used on T1002, H2017 (PSR only, not LPN nursing service), H2019, H0004 and 90832	KX
Physician delivering SUD group counseling	AF
Secured video-conferencing (See code charts for allowable services)	GT

Provider Resources

Claims Contact Information

Prior Authorization	UnitedHealthcare at 1-866-261-7692
Paper Claim Submission	Mail paper claims to: United Healthcare Community Plan PO Box 8207 Kingston, NY 12402-8207
Electronic Claim Submission	Through Link or via EDI clearing house Payor ID 87726
Claims Status	Web portal at Link on UHCprovider.com
Claims Appeals	United Healthcare Community Plan Appeals and Grievances PO Box 31364 Salt Lake City, UT 84131-0364
Eligibility Verification	View eligibility online at Link on UHCprovider.com
Provider Service Center	800-600-9007 for Community Plan Customer Service
Update Practice Information	**providerexpress.com** or via 877-614-0484

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Appeals and Grievances

- Claims reconsideration through:

  UHCprovider.com > Claims & Payments > Claim Reconsideration

- Corrected claims or any paper attachments to be submitted via Optum Cloud.

- Appeals & Grievances mailing address

  UnitedHealthcare Community Plan
  UnitedHealthcare Community Plan of Ohio
  P.O. Box 31364
  Salt Lake City, UT 84131-0364

- Call **800-600-9007** for Community Plan Customer Service

Link

- Link is the new gateway to our 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 Members

- To register for Link, sign in to UHCprovider.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 UHCprovider.com > For Health Care Professionals > Ohio to see:

- Provider Directory
- Claims and Member information
- Clinical Practice Guidelines
- Provider Forms
- Reimbursement Policies
- Provider News, Alerts and Trainings
- Pharmacy and Drug information

Other Online Tools & Resources

Liveandworkwell.com

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

providerexpress.com

- Level of Care, Best Practice and Coverage Determination Guidelines
- Provider demographic changes / Roster management
- Welcome to our network – MyCare Ohio and Medicaid specific news, trainings, notifications

http://bh.medicaid.ohio.gov/manuals*

- Medicaid Managed Care Plans Information
- Medicaid/MyCare Uniform Prior Authorization Form

Agency Maintenance and Roster Updates

- All ODM rendering clinicians should be listed on the agency's roster included in the agency's initial credentialing application
- Optum will be responsible for maintaining Medicaid and MyCare rosters for participating agencies using data provided by ODM*
- It is critical that MITS is updated with rendering clinicians and that clinicians are affiliated with the agency's Medicaid ID number(s) so Optum can ensure accurate roster maintenance for claims payment purposes
- Optum Network Management may contact agencies for clarity and verification in the event roster discrepancies are found, but agency's must take action in MITS with regard to their affiliated clinicians
- Proactive submission of rosters is not required for Medicaid and MyCare, but will be accepted and reviewed via the Agency Roster Update Form or through your secure account on www.providerexpress.com*
- The provider must be found in and affiliated with the agency in MITS

Optum Network Manager Contact Information

Karen Argabrite, Network Manager

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Nanna Horton, Network Manager

- Phone: 763-599-5502
- Email: Nanna.Horton@optum.com

Urgent Post Go Live Issues:
OhioNetworkManagement@Optum.com

Thank you