Provider Orientation: Virginia Medallion 4.0

Virginia Medicaid and Family Access to Medical Insurance Security (FAMIS) Program

Virginia Medallion 4.0

Virginia Medicaid and Family Access to Medical Insurance Security (FAMIS) Program, Behavioral Health

Go Live Dates by Region

- Tidewater – August 1
- Central – September 1
- Northern / Winchester – October 1
- Charlottesville / Western – November 1
- Southwest / Roanoke / Alleghany – December 1

Thank you so much for joining today!

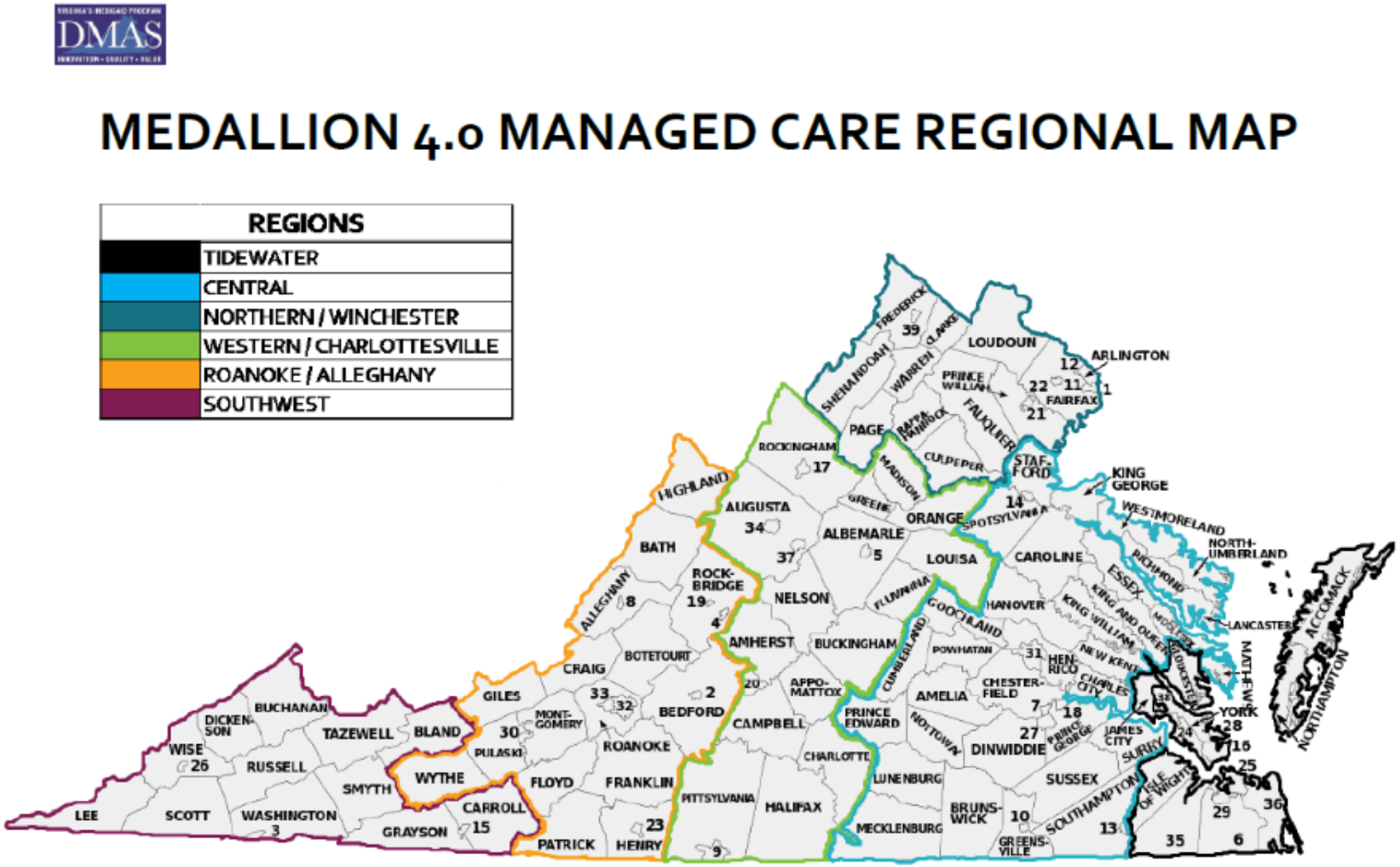
We will be getting started momentarily.

OPTUM®

UnitedHealthcare® Community Plan

Regions

MEDALLION 4.0 MANAGED CARE REGIONAL MAP



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 United Behavioral Health and Optum in our communications to you
- UnitedHealthcare Community Plan of Virginia has contracted with Optum to administer the behavioral health portion of the Virginia Medallion 4.0 Plan to include mental health and substance use disorders

We are dedicated to making 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.

UnitedHealthcare Community Plan (Community Plan)

Community Plan

- Is the largest health benefits company dedicated to providing diversified solutions to states that care for the economically disadvantaged, the medically underserved and those without benefit of employer-funded health care coverage
- Participates in programs in 24 states plus Washington D.C. serving approximately 5 million beneficiaries of acute and long-term care Medicaid plans, the Children's Health Insurance Program (CHIP), Special Needs Plans and other federal and state health care programs
- Health plans and care programs are uniquely designed to address the complex needs of the populations they serve, including the chronically ill, those with disabilities and people with higher risk medical, behavioral and social conditions

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

INTotal Health
A UnitedHealthcare Health Plan

is now

UnitedHealthcare®
Community Plan

At UnitedHealthcare, we help people live healthier lives and help make the health system work better for everyone!

OPTUM®

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Community Plan

Optum Philosophy of Care

Our managed care plan:

- Integrates medical and behavioral health delivery systems
- Focuses on member involvement in identifying his or her 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

Integrated Care

Better care through Integrated Care Delivery System (ICDS)

New Managed Care Contracts:

- Virginia has awarded 6 different Managed Care Organizations contracts to administer their Medicaid and FAMIS benefits

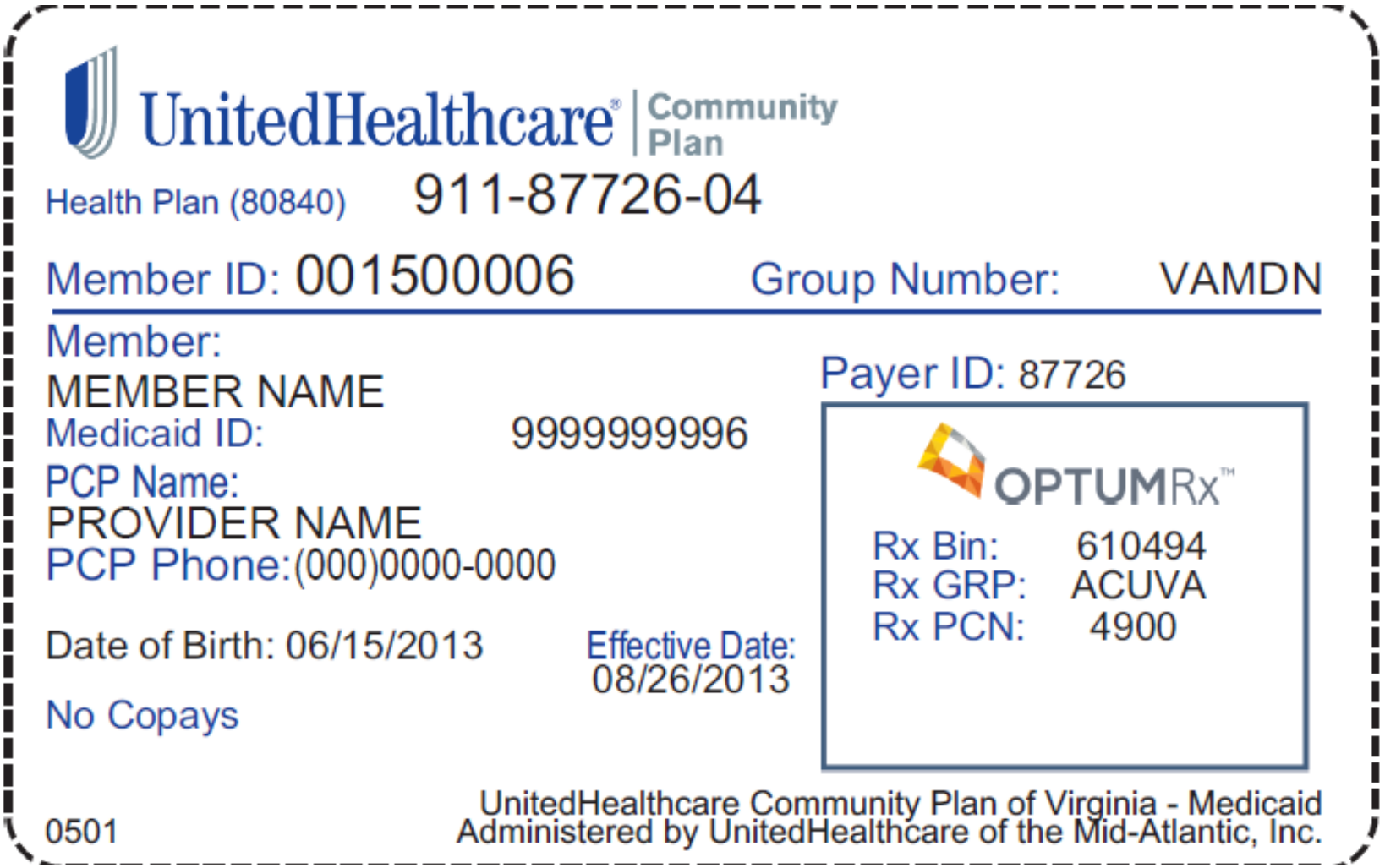
Team Members Are Encouraged to be Involved in Care Coordination:

- Member and their family/caregiver
- Care Advocate
- Member's Primary Care Coordinator
- Primary Care Provider
- Specialists and other providers as applicable

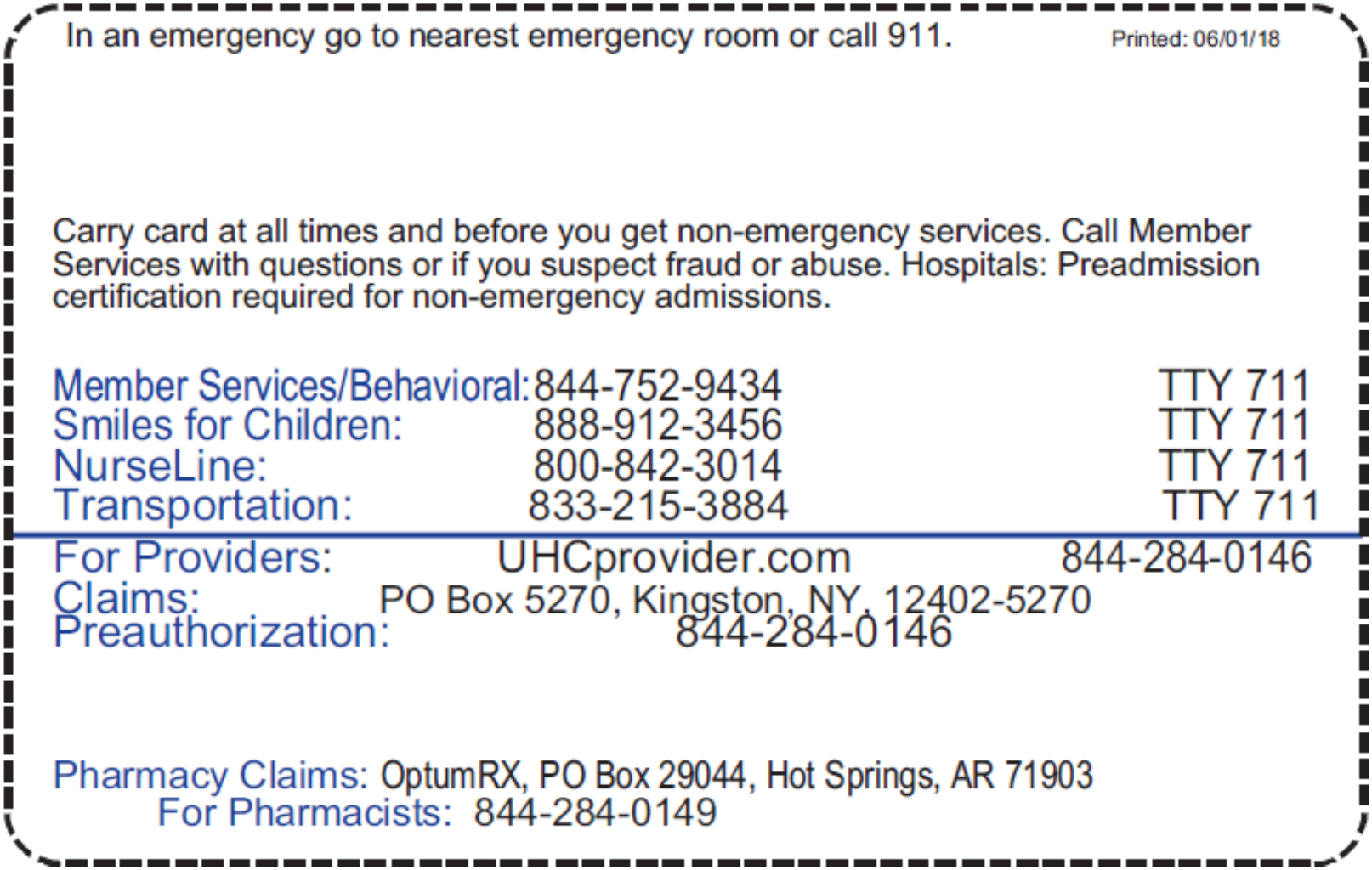
Please note:

It is IMPERATIVE to check the Member's Eligibility Information. Member coverage and covered benefits do vary.

Member Identification Card, front



Member Identification Card, back



In an emergency go to nearest emergency room or call 911.

Printed: 06/01/18

Carry card at all times and before you get non-emergency services. Call Member Services with questions or if you suspect fraud or abuse. Hospitals: Preadmission certification required for non-emergency admissions.

Member Services/Behavioral:	844-752-9434	TTY 711
Smiles for Children:	888-912-3456	TTY 711
NurseLine:	800-842-3014	TTY 711
Transportation:	833-215-3884	TTY 711

For Providers:	UHCprovider.com	844-284-0146
Claims:	PO Box 5270, Kingston, NY, 12402-5270	
Preauthorization:	844-284-0146	

Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903

For Pharmacists: 844-284-0149

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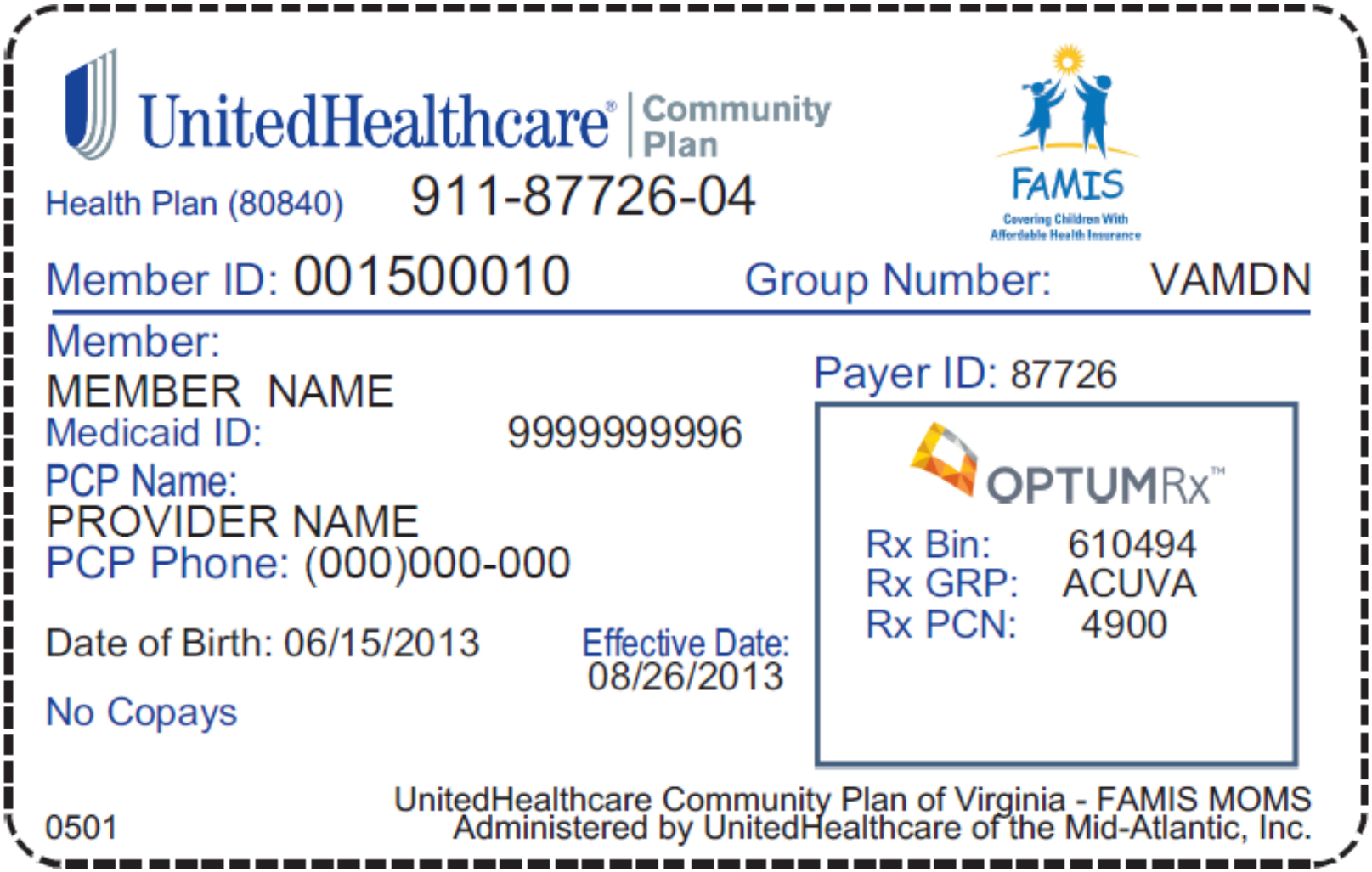
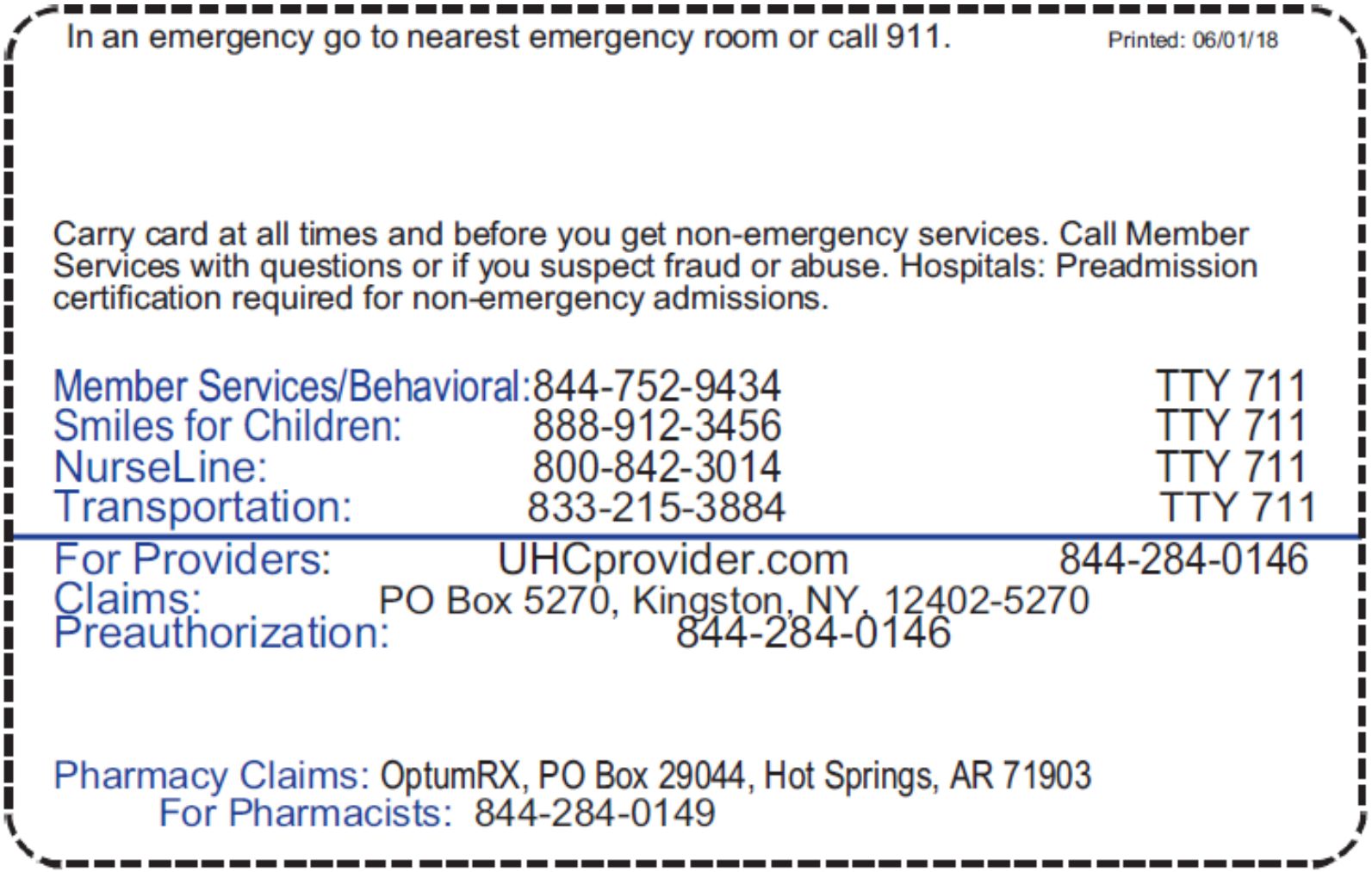
Member Identification Card, FAMIS, front



Member Identification Card, FAMIS, back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Behavioral Health Clinical Model

Six key principles of 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 individuals in a holistic manner by using a single Member-driven treatment plan, including helping each individual access his or her natural community supports based on personal strengths and preferences
3. Use of clinical systems and claim platforms that allow for a seamless coordination of the individual's needs across inter-disciplinary care teams
4. Focusing on multi-morbidities in patients with chronic clinical conditions to improve health outcomes and affordability
5. Improving screening, intervention and treatment for Mental Health and Substance Use Disorder conditions
6. Providing treatment for individuals at the point of care where they are most comfortable

Behavioral and Medical Integration

Our Goal: Increase medical and behavioral health care integration

- Providers are asked to refer Members with known or suspected and untreated physical health problems or disorders to their Primary Care Physician for examination and treatment

Our Goal: Increase integration of treatment for mental health and substance use disorder conditions

- Our care management program assists individuals with complex medical and/or behavioral health needs in the coordination of their care
- All individuals, including high risk/high-service users with complex needs, are expected to be treated from a holistic standpoint

Integration of Physical and Behavioral Health

It is essential to integrate physical and behavioral health services

- We require that coordination of care occur on a routine basis
- Appropriate releases of information should be obtained to support coordination of care activities at the beginning of treatment
- Coordination of care is completed (and documented) with Primary Care Physicians
- Coordination of care is completed (and documented) with other treating providers
- If the member refuses to allow coordination to occur, that is clearly documented in the treatment record

Individuals and, when appropriate, families, should be provided with education regarding coordination of care including the ways in which it may be beneficial to their overall treatment and health.

Care Coordination

Our Care Coordinators:

- **Provide** outreach and comprehensive assessment
- **Support** and educate members
- **Assist** with care coordination, referrals and resources
- **Facilitate** care provider and member relationships
- **Offer** specialty support for foster care, NICU, high-risk pregnancy, behavioral health, substance use disorder, transplant, children with special health care needs and medically complex members

To reach a Member's Care Coordinator, please call 844-284-0146

Importance of caring for the whole person

Today's Medicaid populations include an increasing number of individuals with behavioral health diagnoses and social service needs, in addition to existing chronic health conditions. To effectively serve the needs and improve the health of these populations, we must address the whole person.

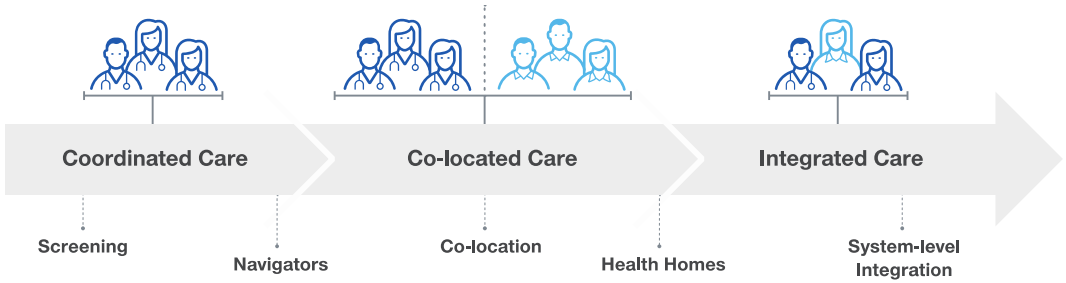
Almost 1/3 of those with medical health conditions also have behavioral health conditions.

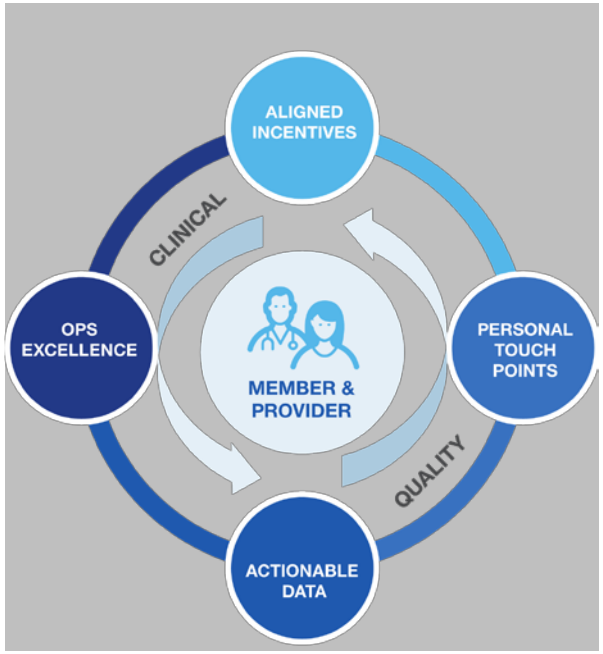
Co-morbid individuals have total expenditures **almost 2x** of those without co-morbid medical and behavioral diagnoses.

Beneficiaries with behavioral health diagnoses account for almost half of total Medicaid expenditures.

Evolving the patient-centered care model

Full integration of medical and behavioral care needs allows for better identification of individuals in need, streamlined touch points for both members and providers, and simplified systems and processes.





Types of Providers in the Behavioral Health Network

Licensed Mental Health Professionals

- Psychiatrist
- Advanced Psychiatric Nurse Practitioner
- Registered Nurse Authorizationto Prescribe
- Clinical Nurse Specialist
- Doctor of Osteopathic Medicine
- Licensed Behavior Analyst
- Licensed Nurse Practitioner
- Medical Doctor
- Physician Assistant
- Registered Nurse
- Licensed Psychologist
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Licensed Addiction Counselor
- Licensed Marriage and Family Therapist

Other Types of Providers

- Peer Support Specialist
- Case Manager

Types of Providers in the Behavioral Health Network

Licensed Mental Health Professionals from:

- FQHCs
- Agencies
- CSBs
- Groups
- Free-Standing Psychiatric Facilities
- ARTS/OBOT/OTP Providers

Link to DMAS Medallion Overview Presentation:

http://www.dmas.virginia.gov/Content_atchs/m4/Medallion%204.0%20Provider%20Stakeholder%20Slide%20Deck_06202018.pdf

Covered Behavioral Services

- Psychological Testing
- Neurobehavioral Status Exam
- Office Emergency Services
- Observation Care Discharge
- Initial Observation Care
- Subsequent Hospital Care
- Observation or Inpatient Care
- ER Consultation
- Smoking and Tobacco Cessation Counseling
- ARTS/ASAM Levels 0.5 – 4.0
- (OBOT) Medication Assisted Treatment (MAT) care coordination
- Opioid Treatment
- Temporary Detention Orders
- Partial Hospitalization
- Case Management Substance Abuse
- Crisis Intervention Substance Abuse
- Medication Assisted Treatment (MAT)
- Residential Substance Abuse
- Alcohol and/or Drug Training
- Intensive Outpatient, Substance Abuse
- Telemental Health
- Peer Support Services
- Inpatient Psychiatric Hospitalization in Freestanding Psychiatric Hospital
- Inpatient Psychiatric Hospitalization in General Hospital
- Peer Support Services, Individual
- SUD Crisis Intervention
- Day Treatment

Link to DMAS Covered Services Manual:

http://www.dmas.virginia.gov/Content_atchs/m4/Medallion%204.0%20Provider%20Stakeholder%20Slide%20Deck_06202018.pdf

Medallion 4.0/ FAMIS MOMS CMHRS Services

CMHRS will be part of the Medallion 4.0 program beginning August 1, 2018

SERVICES

Intensive In Home (IIH)
Therapeutic Day Treatment (TDT)
MH Case Management
MH Family Support Partners
MH Peer Support Services
Behavioral Therapy
Day Treatment/Partial Hosp.
Psychosocial Rehabilitation
Intensive Community Treatment
Mental Health Skill Building
Crisis Intervention
Crisis Stabilization

No changes made to program regulations, medical necessity, criteria, procedure codes, unit values, etc.

Core Service Authorization processes will be standardized across health plans.

DMAS

*Courtesy of DMAS Medallion 4.0 CMHRS & Behavioral Therapy Provider Training

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Excluded Services

Services continued to be covered as FFS through Magellan (not carved in to the MCO's)

- Level A and B Group Home
- School Health Services
- Dental Services
- Home and Community-Based Medicaid Waivers

The following services will be carved in Fall, 2019

- Treatment Foster Care Case Management
- Residential Treatment Services (which consists of Psychiatric Residential Treatment Facility (PRTF) and Therapeutic Group Home Services (TGH) for Medallion 4.0

Registration vs. Authorization

Community Mental Health Rehabilitation Services (CMHRS)	Procedure Code	Registration vs. Authorization INITIAL REQUEST	Registration vs. Authorization CONTINUED STAY
Mental Health Case Management	H0023	R	R
Mental Health Peer Support Services-Individual	H0025	R	A
Mental Health Peer Support Services-Group	H0024	R	A
Crisis Intervention	H0036	R	A
Crisis Stabilization	H2019	R	A
Intensive Community Treatment	H0039	A	R
Intensive In-Home	H2012	A	A
Therapeutic Day Treatment (TDT) for Children *TDT School Day	H0035 *HA	A	A
Therapeutic Day Treatment (TDT) for Children *TDT After School	H0035 *HA *UG	A	A
Therapeutic Day Treatment (TDT) for Children *TDT Summer	H0035 *HA *U7	A	A
Day Treatment / Partial Hospitalization *Adults	H0035 *HB	A	A
Mental Health Skill Building Services (MHSS)	H0046	A	A
Psychosocial Rehab	H2017	A	A
EPSDT Behavioral Therapy (ABA)	H2033	A	A
Addiction & Recovery Treatment Services (ARTS)	Procedure Code	Registration vs. Authorization INITIAL REQUEST	Registration vs. Authorization CONTINUED STAY
Substance Abuse Case Management	H0006	R	R
Substance Abuse	ASAM Levels 2.1/2.5/3.1/3.3/3.5/3.7/4.0	A	A
Substance Abuse	ASAM Levels 0.5/1.0/OTP/OBOT	None	None
ARTS Peer Support Services	T1012 S9445	R	R

Registration vs. Authorization, cont.

Registration: notification process
Authorization: formal request with clinical review

- **Link to CMHRS Authorization and Registration Forms:**
  - http://www.dmas.virginia.gov/#/cmhrs **(old forms will not be accepted, eff. 11/1/18)**
  - Provider Express > Clinical Resources > Forms > Optum Forms – Authorization > Virginia
- **Link to ARTS Forms:**
  - http://www.dmas.virginia.gov/#/artsregistration
- **Optum Provider Website**
  - **www.providerexpress.com**
- **UnitedHealthcare Provider Website**
  - **www.uhcprovider.com**

CONTACT INFORMATION: UnitedHealthcare			
Plan	**Phone Number**	**Fax Number**	**Web Portal**
Virginia Medallion 4.0	**(844) 284-0146**	**(855) 368-1542**	**www.providerexpress.com**

Registration vs. Authorization, cont.

All registration and authorization requests must be submitted on a DMAS ARTS or CHMRS form via Fax or Online.

For online submissions, you will need to attach the DMAS form to your online request. Online submissions without the DMAS form attached will not be processed.

To submit a request online, you will need to:

- Create an Optum ID
- Download the PAAN application www.uhcprovider.com/paan
- Review the resources for learning how to submit your request online
  - Quick Reference Guides
  - Video tutorials
  - Register for a free, live online training session

Once you have your Optum ID and have downloaded and registered the PAAN application, you will be able to submit your requests online, and ***check on the status of your requests, even those submitted by fax*** (allow 3 business days for status after submission).

Whether you submit a request online or by fax, you will still receive a letter confirmation in the mail.

Utilization Management Statement

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

- Optum Level of Care Guidelines
- Optum Psychological and Neuropsychological Testing 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

DMAS website DBHDS Licensing and ASAM Level of Care Crosswalk

Outpatient Management

Reduced administrative burden

- We have removed precertification requirements for in-scope services

Management strategy

- Algorithms for Effective Reporting and Treatment (ALERT)
- Practice Management

In-scope services

- Individual/Group/Family Therapy
- Psychosocial Rehabilitation
- Community Psychiatric Supportive Treatment
- Homebuilders
- Multi-Systemic Therapy
- Functional Family Therapy
- Outpatient Addiction Services (ASAM level 1)

ALERT Program

Member identification

- Claims data
- Service combinations
- Frequency and/or duration that is higher than expected

Licensed care advocates reach out telephonically to treating provider to:

- Review eligibility for the service(s)
- Review the treatment plan/plan of care
- Review the case against applicable medical necessity guidelines

Potential outcome of review:

- Close case (member is eligible, treatment plan/plan of care is appropriate, care is medically necessary)
- Modification to plan (e.g., current care is not evidence- based but there is agreement to correct)
- Referral to Peer Review (e.g., member appears ineligible for service; treatment does not appear to be evidence based; duration/frequency of care does not appear to be medically necessary)

Practice Management Program

As an alternative to requiring precertification for routine and community-based outpatient services, we will provide oversight of service provision through our practice management program.

Program Components

- Regular and comprehensive analysis of claims data by provider/provider group
  - Service/diagnostic/age distribution
  - Proper application of eligibility criteria
  - Appropriate frequency of service/duration of service
- Outreach to provider group when appropriate to discuss any potential concerns that arose from the claim analysis
- Potential outcomes from discussion
  - No additional action necessary
  - Program audit including record review
  - Corrective Action Plan (CAP)
  - Targeted precertification as part of CAP

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:
  - Members discharged from an acute inpatient program must have a follow-up appointment scheduled prior to discharge for a date that is within **seven (7) days of the date of 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

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 Resource

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 and health care 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:

- www.cms.hhs.gov/ocr – Office of Civil Rights
- www.LEP.gov – Limited English Proficiency (LEP): Site promotes importance of language access to federal programs and federally assisted programs
- www.diversityrx.org – Promotes language and cultural competency to improve the quality of health care for minorities
- www.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 Virginia, 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 abuse 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 Quality Audits

- Provider audits are completed for a variety of reasons:
  - High volume Licensed Mental Health Professional (LMHP) office and agency treatment record reviews
  - At the time of Credentialing and Recredentialing for providers without a national accreditation (for example, The Joint Commission or CARF)
  - Quality of Care (QOC) investigation
  - Investigation of member complaints regarding the physical environment of an office or agency

Provider Quality Audits, (continued)

Elements reviewed during audits

- Physical environment
- Policies and procedures
- Member treatment records
- Personnel files

Scoring of audits

- 85% and higher is passing
- Scores between 80 – 84% require a Corrective Action Plan (CAP)
- Scores below 79% require a CAP and re-audit

Provider Quality Audits, (continued)

Feedback to providers:

- Feedback is provided verbally at the conclusion of the audit
- A written feedback letter is mailed within 30 days for routine audits; for Quality of Care audits, the feedback letter is mailed after the requesting committee reviews the audit results
- When a Corrective Action Plan is required, it must be submitted within 30 days of the request
- Re-audits are completed within 3-6 months of acceptance of the Corrective Action Plan

Audit Tools

- There are five (5) audit tools for Medicaid:
  - Case Management Record Audit Tool
  - Clinician Site Audit Tool
  - Organizational Provider Site Tool
  - Psychosocial Rehab Record Audit Tool
  - Treatment Record Audit Tool

- The current audit tools are posted to providerexpress.com: from the home page, choose Our Network > Welcome to the Network > Virginia > Audit Tools

Documentation Standards

- Information regarding documentation standards for behavioral health providers can be located in 3 places:
  - Optum Network Manual (located on providerexpress.com): from the home page, choose Clinical Resources > Guidelines/Policies & Manuals > National Network Manual
  - Coming soon: Virginia Medallion 4.0 Provider Manual (located on providerexpress.com): from the home page choose Clinical Resources > Guidelines/Policies & Manuals > Manuals > State-Specific Manuals and Addendums
  - Audit tools

Documentation Standards, (continued)

Highlights of documentation standards

- A psychiatric history, including the presenting problem, is documented
- A medical history, including the presenting problem, is documented
- Risk assessments (initial and on-going), including safety planning when applicable, are present
- A substance abuse screening is completed
- For children and adolescents, a complete developmental history is documented

Documentation Standards, (continued)

- Treatment planning documentation includes:
  - Short-term and long-term goals that are objective and measurable
  - Time frames for goal attainment
  - Updates to the plan when goals are achieved or new issues are identified
  - Modifications to goals if goals are not achieved

- For members that are prescribed medications documentation includes:
  - The date of the prescription, along with dosage and frequency
  - Rationale for medication adjustments
  - Informed consent for medications
  - Education regarding the risks/benefits/side-effects/alternatives

Documentation Standards, (continued)

- Discharge planning should be on-going and a discharge summary is documented when services are completed
- Record must be legible
- All entries must be signed by the rendering provider
- Entries must include the start and stop time or length of time spent in the session (for timed sessions)
- Medical necessity for services that are rendered is clearly documented

Documentation Standards, (continued)

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)

Optum expects that all state and federal guidelines related to confidentiality are followed. For more information regarding documentation and storage of records, refer to the Optum *National Network Manual* and the state-specific Virginia Medallion 4.0.

Claims Submission Option 1 – **Online**

Entry through UHCprovider.com:

- Secure HIPAA-compliant transaction features streamline the claim submission process
- Performs well on all connection speeds
- Submitting claims closely mirrors the process of manually completing a CMS-1500 form
- Allows claims to be paid quickly and accurately

You must have a registered user ID and password to gain access to the online claim submission function:

- To obtain a user ID, call toll-free **(866) 842-3278**

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; provides claim error reports for claims that fail submission
  - **It's cost-efficient** - you eliminate mailing costs, the solutions are free or low-cost

Claims Submission Option 2 – **EDI/ Electronically**, (continued)

- You may use any clearinghouse vendor to submit claims
  - Eff 4/1/18, Availity can only be used for claims submission, but cannot be used for member eligibility checks
- Payer ID for submitting claims is 87726
- Additional information regarding EDI is available on

  http://www.uhccommunityplan.com/content/communityplan/homepage/_health-professionals/va.html

  and UHCprovider.com

Claims Submission Option 3 – **Paper**

- **Use the CMS Form 1500 claim form:**
  - Claim elements include but are not limited to diagnosis (**DSM-5**)
  - Member name, Member date of birth, Member identification number, dates of service, type and duration of service, name of clinician (e.g., individual who actually provided the service), provider credentials, tax ID and NPI numbers
  - Paper claims submitted via U.S. Postal Service should be mailed to:

    United Healthcare Community Plan
    P.O. Box 5270
    Kingston, NY 12402

- Use DSM-5 for assessment and the associated ICD-10-CM code for billing
- Institutional claims must be submitted using the UB-04 claim form

Appeals

UnitedHealthcare Community Plan (UHCCCP)is responsible for member appeals and Optum is responsible for PAR Provider post-service appeals.

For Urgent Appeals providers can submit their request to C&S:

UHCCCP Appeals
Phone # 1-888-650-3462
Urgent Appeal Fax # 1-801-994-1082
Fax # for misdirected appeals: 1-801-994-1082

For Non-Urgent Post Service Appeals Network Providers can submit to:

Optum Appeals & Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512
Fax: 1-855-312-1470
Phone: 1-866-556-8166

Appeals

Non-Urgent (Standard)	Urgent (Expedited)
• Must be requested within 60 days from receipt of the Notice of Action letter • When an appeal is requested, Community Plan will make an appeal determination and notify the provider, facility, Member or authorized Member representative in writing within 30 calendar days of receipt of request.	• 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, within two (2) business days, unless the appeal is pertaining to an ongoing emergency or denial of continued hospitalization, which we will complete investigation and resolution of no later than one (1) business day after receiving the request

Appeal requests can be made verbally or in writing.
Verbal requests must be followed with a written and signed appeal.

Services While in Appeal

- You may continue to provide service following an adverse determination if the following are met:
  - The Member is informed of the adverse determination
  - The Member is informed that the care will become the financial responsibility of the Member from the date of the adverse determination forward
  - The Member agrees in writing to these continued terms of care and acceptance of financial responsibility
  - You charge no more than your contracted fee for such services, although a lower fee may be charged

- If, subsequent to the adverse benefit determination and in advance of receiving continued services, the Member does not consent in writing to continue to receive such care and we uphold the determination regarding the cessation of coverage for such care, you cannot collect reimbursement from the Member pursuant to the terms of your Agreement

Electronic Payment & Statements (EPS)

With EPS, you receive electronic funds transfer (EFT) for claim payments, plus your Provider Remittance Advice (PRA) is delivered online

- Reduce administrative costs and simply bookkeeping
- Decrease reimbursement turnaround time
- Funds are available as soon as they are posted to your account

To enroll:

myservices.optumhealthpaymentservices.com

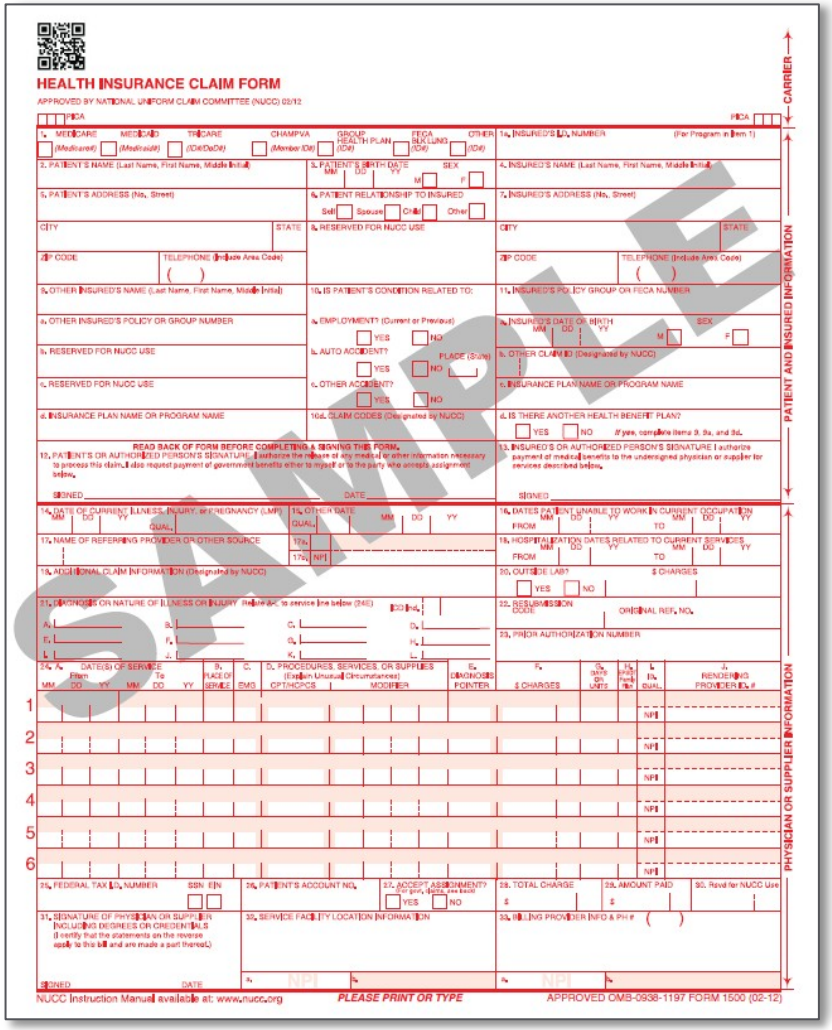
Here's what you'll need:

- 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

Already signed up for EPS with UnitedHealthcare Commercial or UnitedHealthcare Medicare Solutions? You will automatically receive direct deposit and electronic statements through EPS for Virginia Medallion 4.0 when the program is deployed.

*Note: For more information, please call **(866) 842-3278**, option 5, or go to **UnitedHealthcareOnline.com** > Quick Links > Electronic Payments and Statements.*

Claim form – CMS Form 1500 (v02/12)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED DATE

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE MM DD YY QUAL.

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind.

A. B. C. D. E. F. G. H. I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

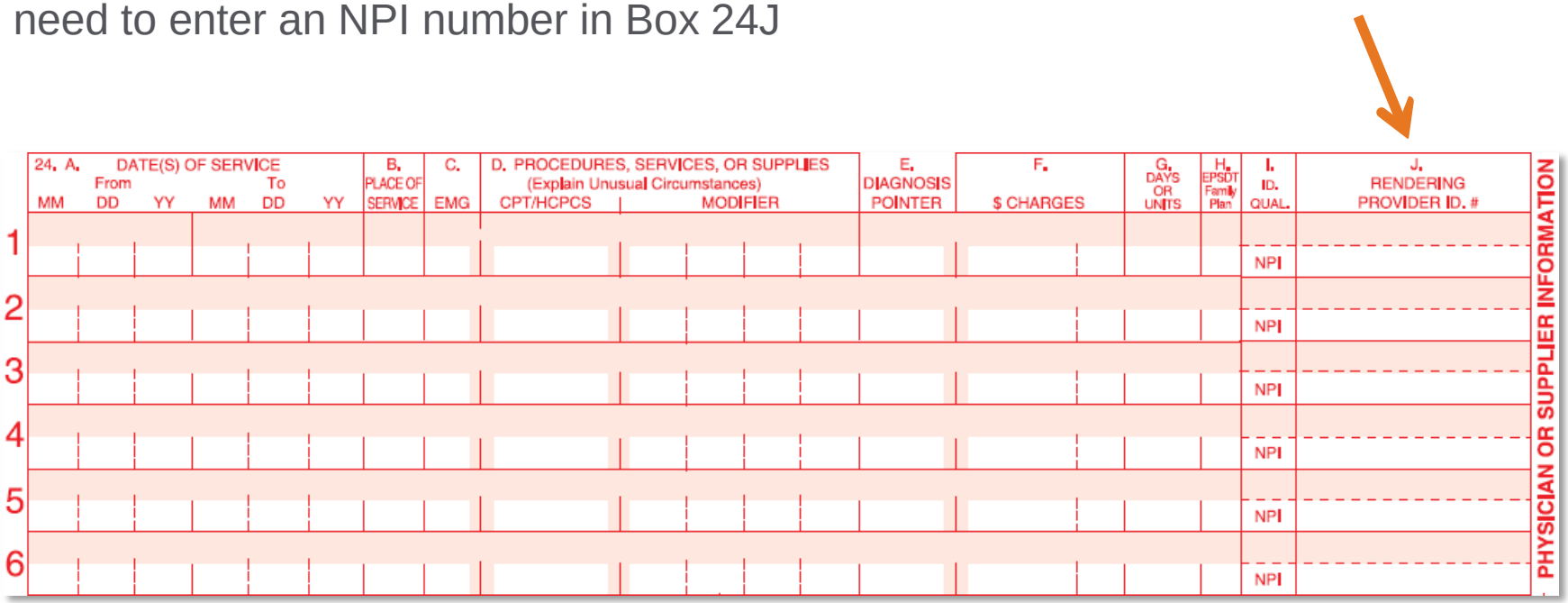
PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

SAMPLE

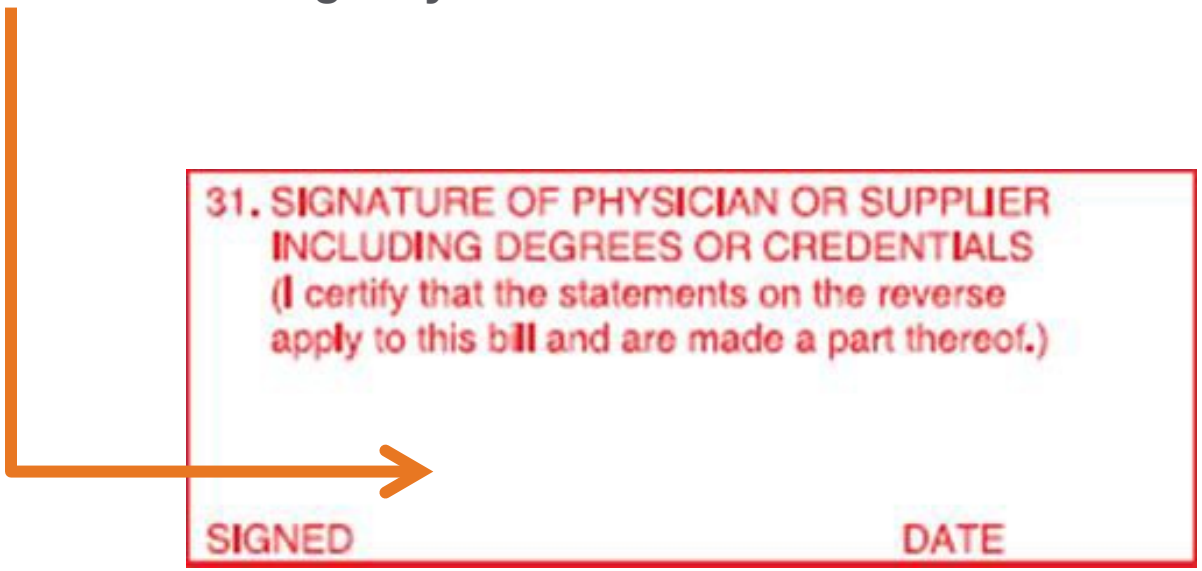
Claim form – CMS Form 1500 provider section, (continued)

- **Box 24J:** Independently licensed clinicians who render services enter their **NPI number** in the non-shaded portion
- **Box 24J:** Non-independently licensed clinicians who render services do not need to enter an NPI number in Box 24J



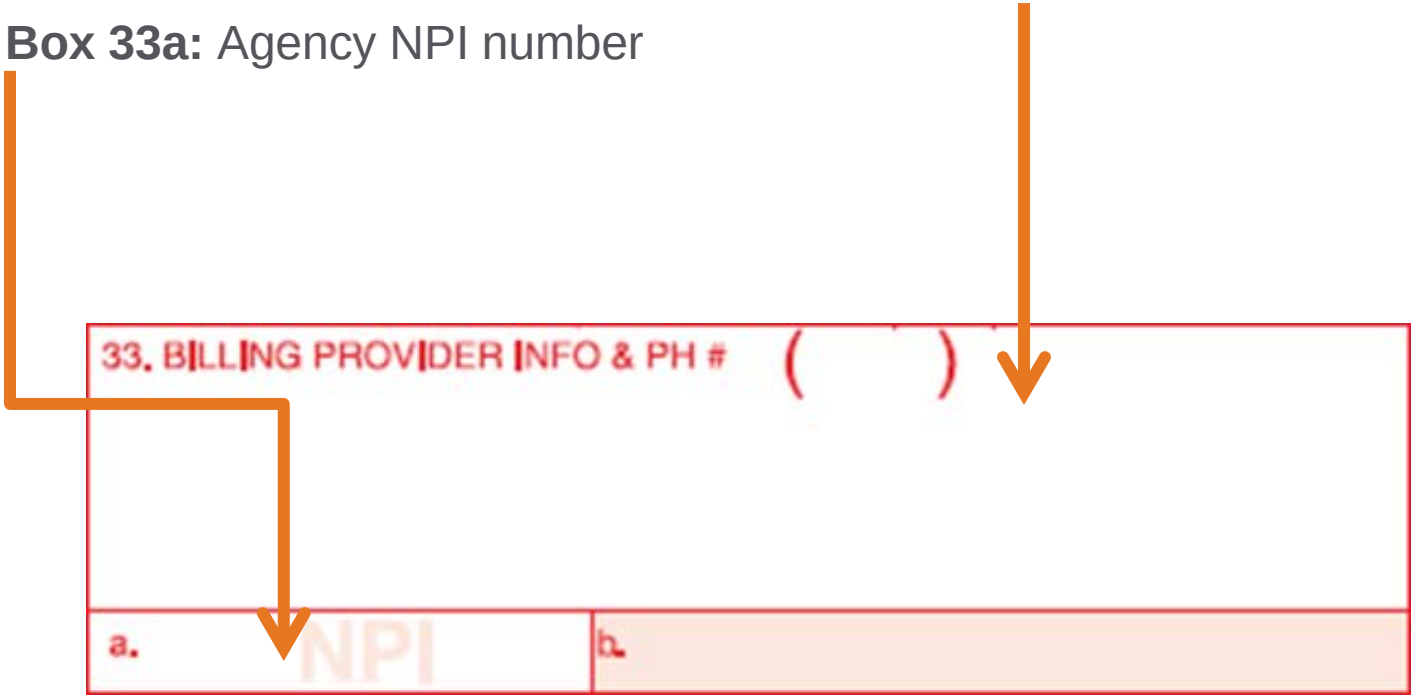
Claim form – CMS Form 1500 provider section, (continued)

- **Box 31: Independently licensed clinicians who render services enter their name and licensure in Box 31**
- **Box 31: Non-independently licensed clinicians who render services enter the name of the agency in Box 31**



Claims form – CMS Form 1500 provider section, (continued)

- **Box 33:** Agency name, address, and phone number
- **Box 33a:** Agency NPI number



Claim Tips

To support clean claim submissions remember:

- NPI numbers are always required on all claims
- A complete diagnosis is required on all claims

Claims filing deadline:

- Virginia Medallion 4.0 allows claim submissions up to 365 days from the date of service

Claims Processing:

- Clean claims, including adjustments, will be adjudicated within 30 days of receipt
- The following exceptions shall apply:

  The Contractor shall ensure clean claims from NFs, community LTSS providers (including providers who provide community LTSS services when covered under EPSDT) and community behavioral health and SUD providers are processed within fourteen (14) days of receipt of the clean 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 unitedhealthcareonline.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)

Overview of Fraud, Waste, Abuse, and Error (FWAE)

Working together to meet the goal of every individual receiving the right care, at the right time and the right place across the full system of care

- **Difficult, necessary and valuable program**: We are all charged with applying the most appropriate use of resources to support necessary care
- The Program and Network Integrity (PNI) Team identifies potential FWAE through tips and standardized review processes
- Appropriate corrective action, when necessary, occurs on a continuum commensurate with the range of questionable activity; actions may include addressing simple mistakes through education to referral to law enforcement when required
- **How we do it is key**: It is essential to strike a balance between the rare fraudulent practice and the vast majority of other cases reviewed. We must be vigilant and work together to improve any practice that impedes care and/or wastes valuable dollars anywhere within the system of care

Definitions

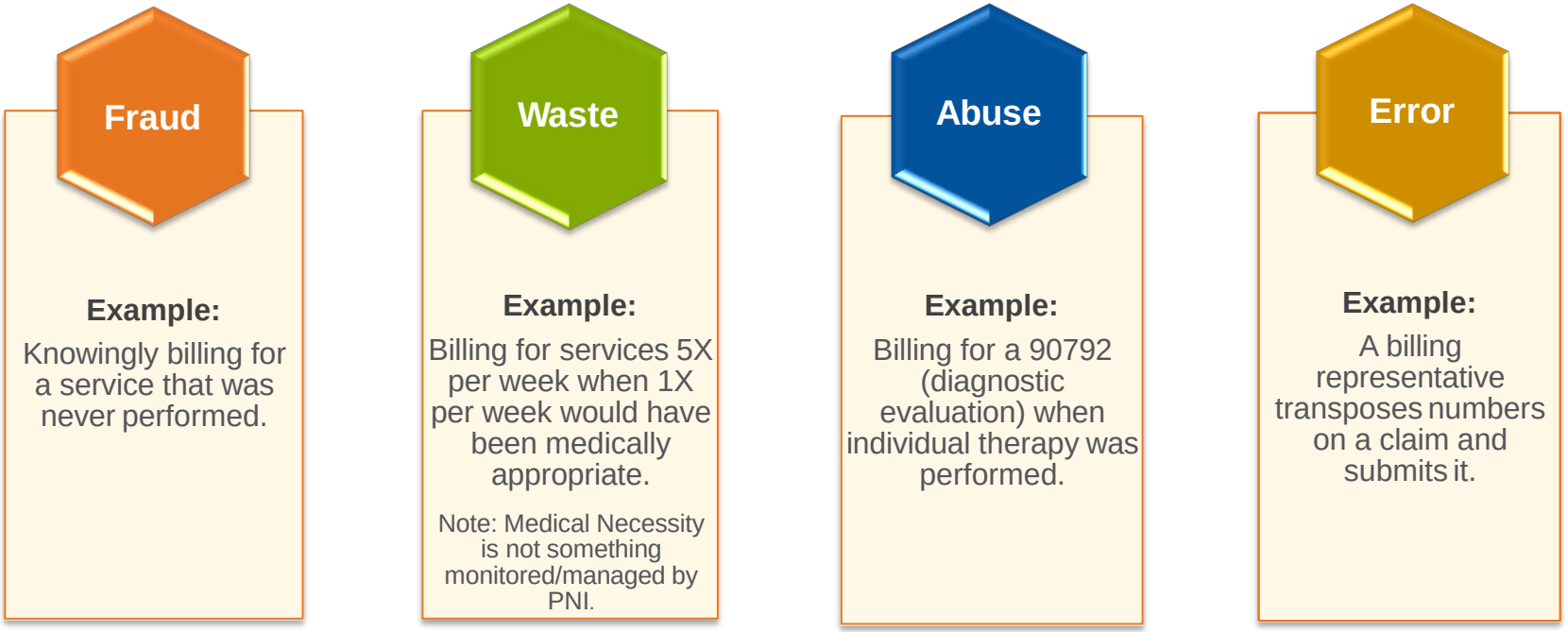
Intentional misrepresentation to gain a benefit

Any unnecessary consumption of health care resources

Unsound business practice that can include inappropriate utilization and/or inefficient use of resources

Mistakes, inaccuracies or misunderstandings that can usually be identified and quickly corrected

Examples of FWAE



PNI will:

- Carefully monitor for and take action to prevent FWAE
- Appropriately & consistently evaluate suspected FWAE
- Tailor corrective action to effectively stop/change the outlier behavior
- Offer a robust education program that engages the provider in changing outlier billing and coding behavior to accurately reflect the services rendered

Member Website and Resources

www.myuhc.com/communityplan makes it simple for members to:

- Identify participating providers
  - Geographic location
  - Provider specialty type/areas of expertise
  - License type
- Locate community resources
- Find articles on a variety of wellness and work topics
- Complete self-assessments

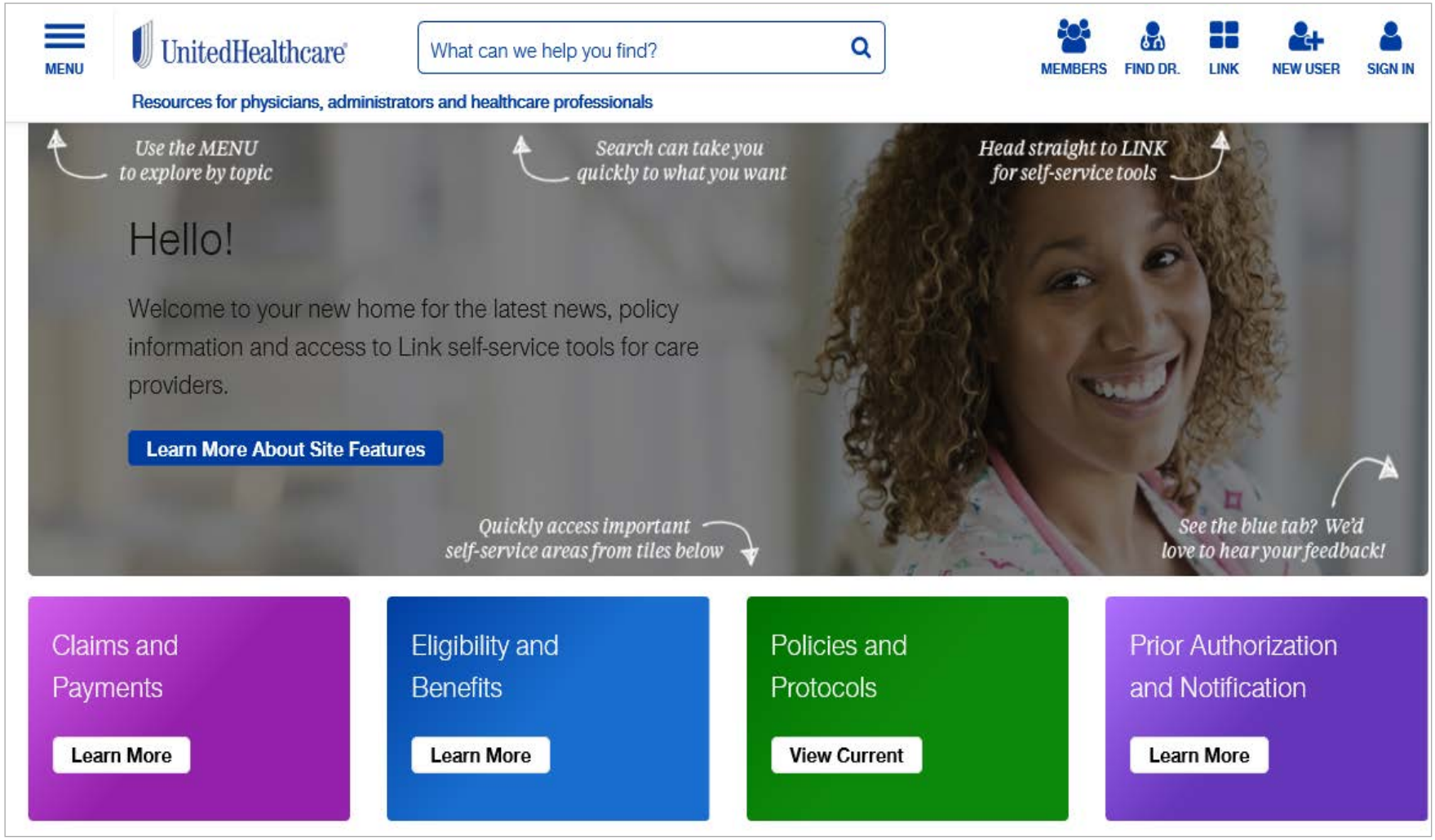
- The website has an area designed to help members manage and take control of life challenges

UnitedHealthcare Provider Website

www.uhcprovider.com

- **Secure transactions for Medicaid include:**
  - Check eligibility and authorization or notification of benefits requirements
  - Submit professional claims and view claim status
  - Make claim adjustment requests
  - Register for Electronic Payments and Statements (EPS)
  - To request a user ID to the secure transactions on the www.uhcprovider.com, select New User from the Home Page; you may obtain additional information through the Help Desk at **(866) 842-3278**
- For member eligibility, claim status, and reference materials, go to UnitedHealthcareOnline.com > Tools and Resources > UnitedHealthcare Community Plan Resources
- Customer Service for website support: **(800) 600-9007**

UHCProvider.com – Login 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
  - Behavioral Health Toolkit for Medical Providers
- Secure pages
  - Require registration
  - Available only to network providers
  - The password-protected “secure transactions” offers Virginia Medicaid providers access to provider-specific information including the ability to update your practice information

Provider Resources, (continued)

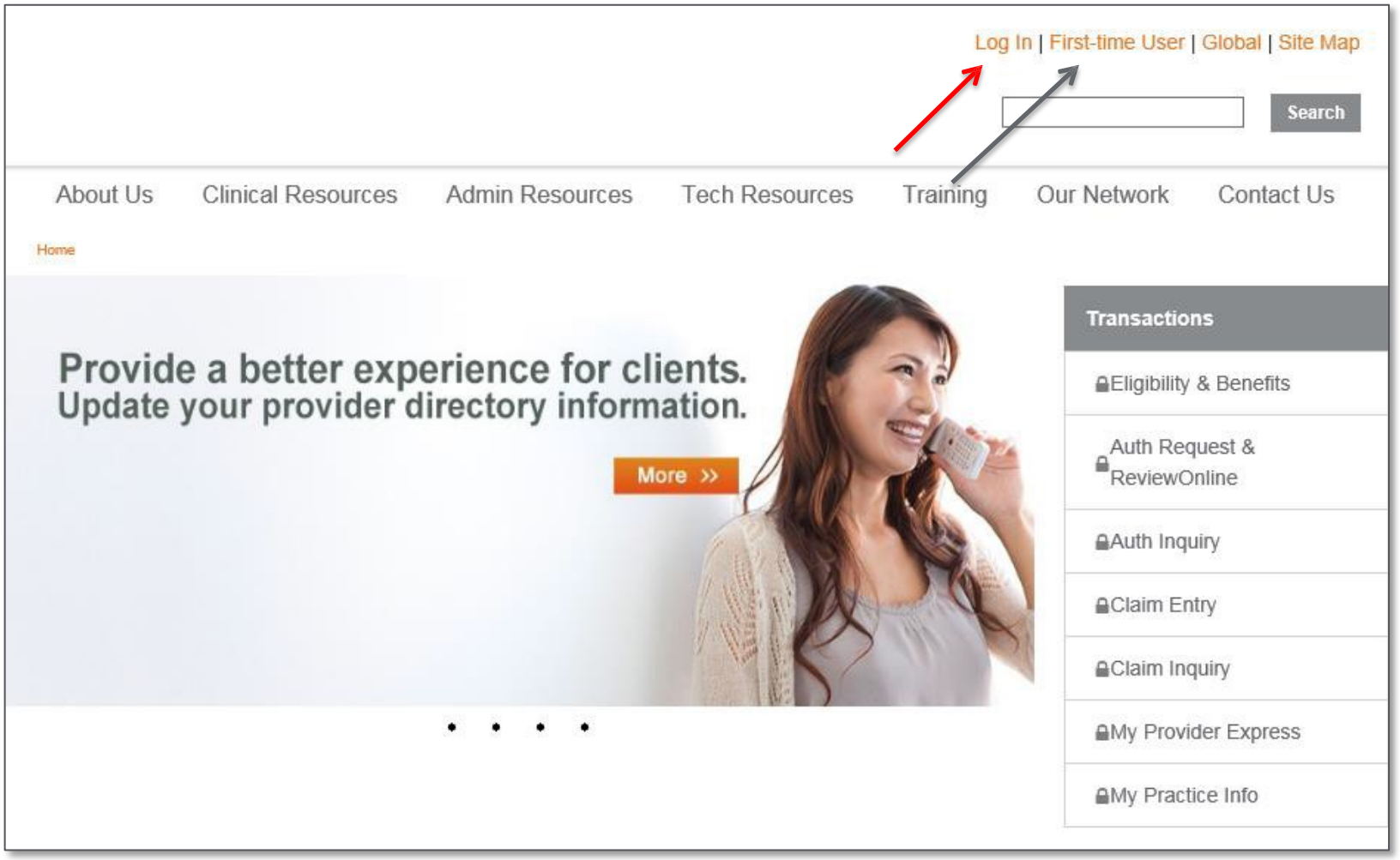
Public Pages: general updates and other useful information

- Access forms library
- Find network contacts
- Review clinical guidelines
- Access *Network Notes*, the provider newsletter
- Level of Care Guidelines
- Training/Webinar offerings
- Virginia pages
  - Audit tools (coming soon) from the Home Page, choose Our Network > Welcome to the Network > Virginia
  - Authorizations (online or paper) from Home Page, choose > Clinical Resources > Forms > Optum Forms – Authorization > Virginia

Provider Resources, (continued)

- Secure pages are available only to Optum in-network providers and require registration
- Providers will be able to update their practice information using the "My Practice Info" feature
- To request a User 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, call the Provider Express Support Center at **(866) 209-9320** (toll-free) between 8 a.m. to 10 p.m. Eastern time, or chat with a tech support representative online 9 a.m. to 6 p.m. Eastern time

Provider Express Home Page – Log In



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
  - Support Members in ways that are culturally and linguistically appropriate
- Determine if Members have benefits through other insurance coverage
- Advocate for Members as needed
- 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

Provider Responsibilities – Mandated State Reporting

- Follow State mandates and requirements for Reporting Child Abuse and Neglect
  - Virginia law specifies certain professionals MUST report suspected child abuse or neglect
    - Examples of mandatory reporters are:
      - Hospital Residents or interns
      - Persons employed in the nursing profession
      - Social workers
      - Mental Health professionals
- The Child Abuse and Neglect Hotline number is: 1-800-552-7096

For more details please review:
https://www.dss.virginia.gov/files/division/dfs/mandated_reporters/cps/resources_guidance/B032-02-0280-00-eng.pdf

Access to Care Standards

Urgent If not addressed in a timely way could escalate to an emergency situation	Members will be offered an appointment within 24 hours
Life threatening emergencies Imminent risk of harm or death to self or others due to a medical or psychiatric condition	Referral is Immediate

Join Our Network – Clinicians

- The participation process begins with submission of the provider application
  - Clinicians contracting on an individual basis complete the CAQH universal application online at www.caqh.org
  - Providers complete Network Request form
  - Agencies pursuing group contracts complete the Optum Agency application
- Additional required application materials include
  - Signed Optum Provider Agreement
  - State required credentialing documents (attestation forms, licensures)
  - Signed Virginia Medicaid Addendum
    - One per clinician pursuing individual contracting
    - One per agency/group if pursuing a group contract
- Approval by Optum Credentialing Committee
- Credentialing requirements can be found at providerexpress.com under "Join Our Network"
- Orientation to Optum clinical and administrative protocols via webinars or review of provider resources posted on providerexpress.com

Join Our Network, (continued)

FQHCs, CSBs, Agencies and Groups:

- For FQHC agencies that employ licensed professional staff to render services under the umbrella of the agency, Optum will execute group contracts with the agency as the contracting entity
- Agencies must submit the Optum agency application, indicating the services being provided and the licensed clinical professionals on the staff roster
- The individual licensed clinicians on staff do not need to submit CAQH applications or be individually credentialed when they work for the agency under an Optum group contract

Supervisory Protocol Addendum

The **Supervisory Protocol Addendum** allows non-credentialed clinicians to render services while under the supervision of an independently licensed clinician.

- Clinicians rendering psychotherapy services must have a minimum of a master's degree
- All services that are rendered must be within the scope of the clinician's training
- Supervision must:
  - Occur regularly on a one-to-one basis
  - Be documented

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

Contact Information

Important Phone Numbers, Emails, and Fax Numbers:

- Virginia Provider Services: (844) 284-0146
- Pharmacy Help Line (OptumRx): (844) 284-0149
- For BH Authorizations: (877) 843-4366 or Fax: (844) 881-4926
- Psychological Testing Request Form:
  https://optumpeeraccess.secure.force.com/psych/
- Claims: (844) 284-0146 and UHCprovider.com

Important Addresses:

- Behavioral Health or Medical Claims:
  P.O. Box 5270, Kingston, NY 12402
- Pharmacy Claims:
  OptumRx P.O. Box 29044, Hot Springs, AR 71903
- Website – UHCprovider.com
- Website – providerexpress.com

Behavioral Network Services, Virginia Contact Information

Tidewater and Central
Taylor Fink
Phone: (763) 361- 6233
Email: taylor.fink@optum.com

Charlottesville / Western
Roanoke / Alleghany
Southwest
Brittany Meadows
Phone: (952) 202-6601
Email: brittany_e_meadows@optum.com

Escalation Contact
Karen Friesz, Director, Behavioral Health
kfriesz@uhc.com

Northern / Winchester
Frank Rizio
Phone: (763) 321-2562
Email: frank.rizio@optum.com

ABA/EPSDT All Regions
Pamela Lewis
Phone: (651) 495-5397
Email: pamela.lewis@optum.com

EPSDT ABA Program Services

VA Medicaid EPSDT ABA Provider Credentialing Criteria

Individual Board Certified Behavior Analysts - Solo Practitioner

- Board Certified Behavior Analyst (BCBA) with active certification from the national Behavior Analyst Certification Board, ***and***
- State licensure
- State Medicaid certification in good standing
- Compliance with all state/autism mandate requirements as applicable to behavior analysts
- Minimum professional liability coverage of $1 million per occurrence/ $1 million aggregate

VA Medicaid EPSDT ABA Provider
Credentialing Criteria

ASD Groups

- BCBAs must meet standards above and hold supervisory certification from the national Behavior Analyst Certification Board if in supervisory role
- Compliance with all state/autism mandate requirements as applicable to behavior analysts
- BCaBAs must have active certification from the national Behavior Analyst Certification Board and appropriate state licensure
- Behavior Technicians must have RBT certification from the national Behavior Analyst Certification Board, or alternative national board certification, and receive appropriate training and supervision by BCBAs
- BCBA on staff providing program oversight
- BCBA performs skills assessments and provides direct supervision of paraprofessionals in joint sessions with client and family
- $1 million/occurrence and $3 million/aggregate of professional liability and $1m/$1m of general liability if services are provided in a clinic setting
- $1 million/occurrence and $3 million/aggregate of professional liability and $1m/$1m of supplemental insurance if the agency provides ambulatory services only (in the patient's home)

VA Medicaid EPSDT ABA Program Provider Fee Schedule

UNITED BEHAVIORAL HEALTH VA Medicaid EPSDT ABA Fee Schedule			
Billing Code	**Modifier**	**Service Description**	**Reimbursement**
H0032	UA	EPSDT Behavioral Therapy Assessment – 1 hour unit	$60.00
H2033		EPSDT Behavioral Therapy – 15 minute unit	$15.00
1) Per 15 Minute Payment: The Reimbursement Rate made to Provider for each unit of service provided to a Member as defined by the definition of the Billing Code. Such payment shall be considered payment in full for all MH Services provided to the Member, included but not limited to nursing care, diagnostic and therapeutic services, and supplies. Such payment is exclusive of physician fees. If physician services are rendered, such services are included in the rate of reimbursement.			
2) The MH Services authorized by UBH and provided to a Member on an outpatient basis of the diagnosis, testing, and/or treatment of a mental health condition, other than Emergency MH Services or as part of a partial hospitalization or day treatment program, Provider shall be paid by Payor the lesser of (a) Provider's Customary Charge for such MH Services, less any applicable Member Expenses; or (b) the Method of Payment set forth above, less any applicable Member Expense(s).			
3) Proper billing form: CMS 1500			

VA Medicaid EPSDT ABA Program Page

OPTUM® Provider Express

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Home | About Us | Clinical Resources | Admin Resources | Video Channel | Training | Our Network | Contact Us

Home > Clinical Resources > Autism/Applied Behavior Analysis > Virginia CCC ABA Program

Virginia Medicaid EPSDT ABA Program

UnitedHealthcare Insurance Company, doing business as UnitedHealthcare Community Plan of Virginia, is one of the selected managed care plans within the state of Virginia providing coverage to the Commonwealth Coordinated Care Plus (CCC) membership effective 1/1/2018, and the Medallion membership effective 8/1/2018.

Optum collaborates with UnitedHealthcare Community Plan of Virginia and is responsible for securing the Autism/ABA Network for this initiative. Your participation in our network helps to ensure access to comprehensive quality care for covered behavioral health services for enrolled members.

- VA Medicaid EPSDT ABA Provider Orientation
- VA Medicaid EPSDT ABA Provider Quick Reference Guide
- VA Medicaid ABA Initial Authorization Form
- VA Medicaid ABA Ongoing Authorization Form

Please contact Pamela Lewis, Specialty Network Manager, at pamela.lewis@optum.com to learn more about this network.

Behavioral Network Services, Virginia Contact Information

Tidewater and Central
Taylor Fink
Phone: (763) 361- 6233
Email: taylor.fink@optum.com

Charlottesville / Western
Roanoke / Alleghany
Southwest
Brittany Meadows
Phone: (952) 202-6601
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Escalation Contact
Karen Friesz, Director, Behavioral Health
kfriesz@uhc.com

Northern / Winchester
Frank Rizio
Phone: (763) 321-2562
Email: frank.rizio@optum.com

ABA/EPSDT All Regions
Pamela Lewis
Phone: (651) 495-5397
Email: pamela.lewis@optum.com

Thank you.

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UnitedHealthcare®
Community Plan