Washington Integrated Managed Care New Provider Training

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan

BH2282_08/2019

UnitedHealth Group Structure

Helping make 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

Helping people live healthier lives

Health care coverage and benefits:

- Employer & Individual
- Medicare & Retirement
- Community & State
- Military & Veterans
- Global

UnitedHealthcare and You

Achieving our Mission:

- Starts with Providers
- Serves Members
- Applies global solutions to support sustainable local health care needs

From risk identification to integrated therapies, our mental health and substance abuse solutions help to ensure that people receive the right care at the right time from the right providers.

Specialty Network Services

Customers we serve:

- 50% of the Fortune 100 and 34% of the Fortune 500
- Largest provider of global Employee Assistance Programs (EAP), covering more than 19 million lives in over 140 countries
- Local, state and federal government contracts (Public Sector)

Simultaneous NCQA and URAC accreditation

URAC
ACCREDITED
HEALTH UTILIZATION
MANAGEMENT

MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION
NCQA
ACCREDITATION
FULL

Serving almost 43 million Members:

- 1 in 6 insured Americans
- The largest network in the nation, delivering best in class density, discounts and quality segmentation
- More than 140,000 practitioners; 4,200 facilities with 9,000 facility locations

Staff expertise:

- Multi-disciplinary team of 50 staff Medical Directors, including child and adolescent, medical/psychiatric, Board Certified Behavior Analysts, and addiction specialists, just to name a few

Integrated Managed Care Overview

UnitedHealthcare® Community Plan

What is Integrated Managed Care (IMC)?

- Integrating Behavioral Health (BH) measures, such as outcomes management for depression, with the full complement of physical health measures in our contracts with PCPs
- Applying Mental Health and Substance Use Disorder (MH/SUD) treatment measures to contracts with BH providers
- Promoting PCP and BH provider collaboration by distributing incentives to both for improving quality outcomes of Members that they share
- Total cost of care Value-based Purchasing (VBP) agreements, including gain share, risk share and capitation, analyzing total spend for both physical and behavioral health care

WA IMC Provider Participation Requirements

State Requirements:

- Valid Washington State License
- Registered with State
- Medicaid ID
- Enroll as Billing Provider for Managed Care
- NPI

MCO Requirements:

- Completed CAQH
- Completed Optum National Provider Registration Form

IMC Credentialing

Important Notes about credentialing:

- **Time sensitive**: Credentialing is the one of the first and most critical steps to ensuring IMC go-live readiness. Failure to complete credentialing early enough can result in downstream delays to: portal access, loading providers into MCO systems, claims testing, and payment.
- **Multiple Locations**: Credentialing applications must include *each* licensed location.
- **New locations**: New locations must be credentialed with MCOs. MCOs should also be notified of location closures.

Rosters

- When agencies are credentialed at the facility level, we are reliant on provider rosters to ensure our systems are up-to-date.
- MCOs have established a common roster template for all providers to use in order to streamline processes.
- Updated rosters should be sent to MCOs on a regular basis to ensure systems are up-to-date. Failure to send timely roster updates can result in incorrect payments or denials.
- Allow approximately 30-45 days for roster updates to be processed, prior to submitting claims, to avoid denials and re-work.

Reporting Provider Changes/Updates

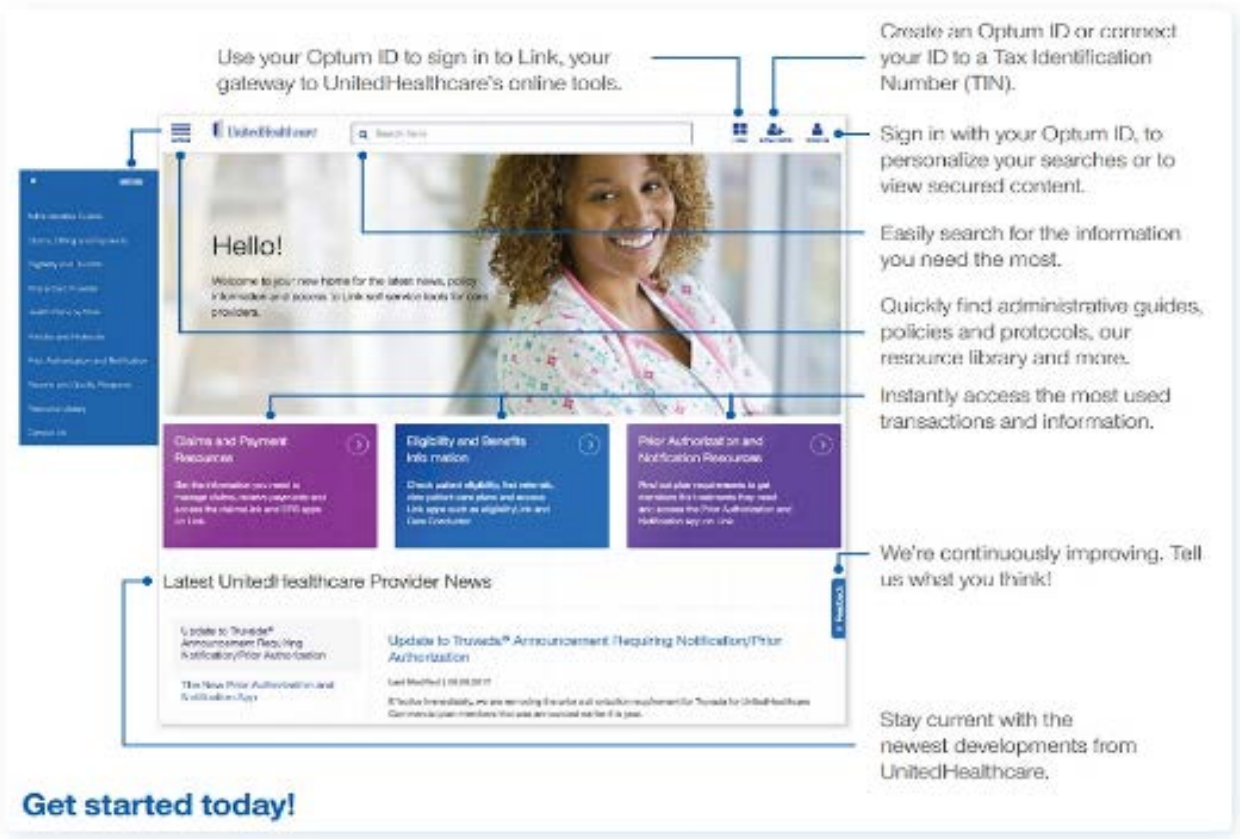
Providers must give notice at least 60 days in advance of any provider changes such as:

- Provider Terms
- Provider Adds/Updates
- Tax ID Changes
- Group and/or Individual NPI
- Billing and/or Pay to addresses
- Clinic locations (where services are rendered)

Updates may be submitted on Provider Express or by emailing WAIMC@Optum.com

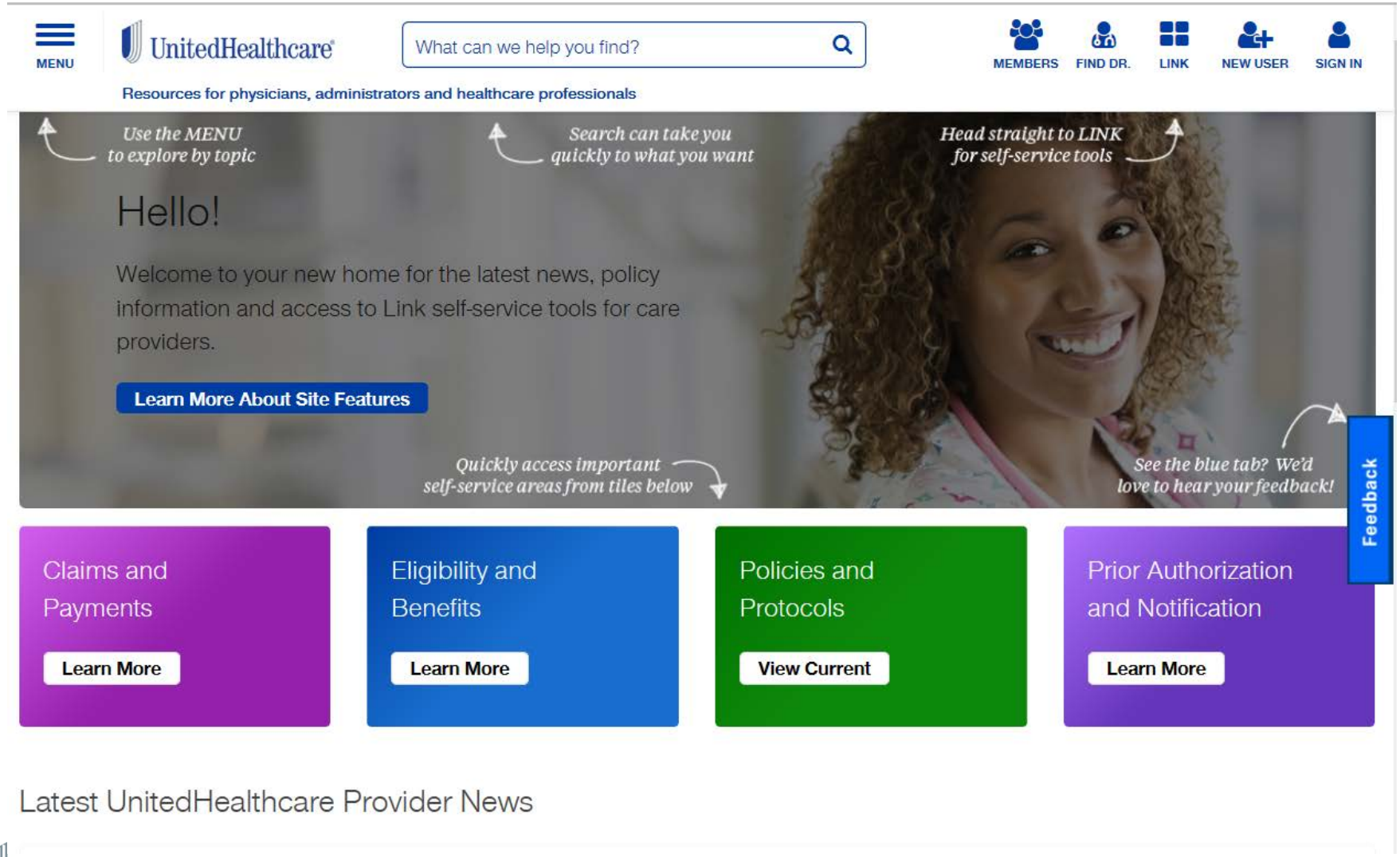
UnitedHealthcare Online – Login Page

Features | Details | Screens

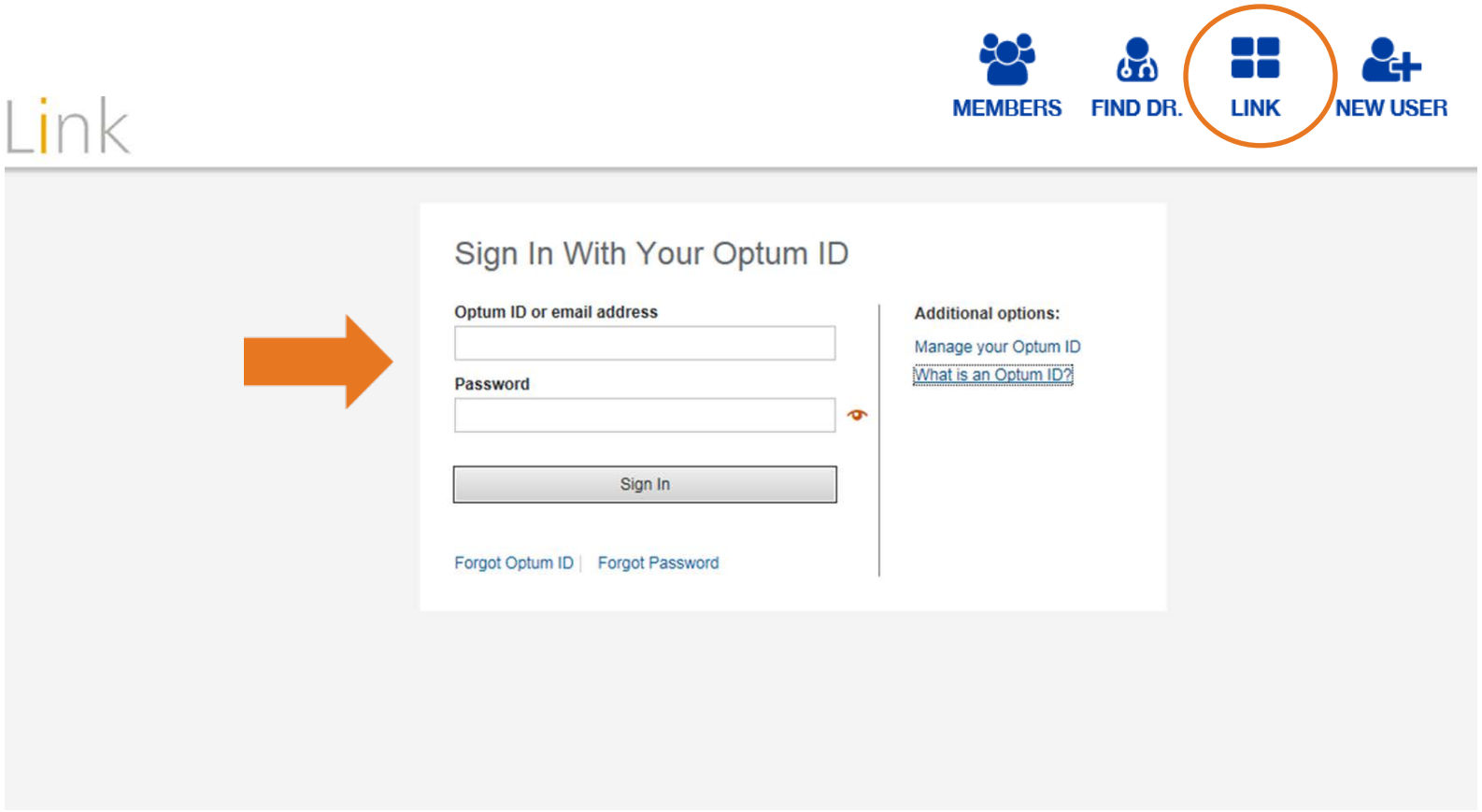


UnitedHealthcare Community Plan

UnitedHealthcare Online – Login Page (continued)



About Link and Optum IDs



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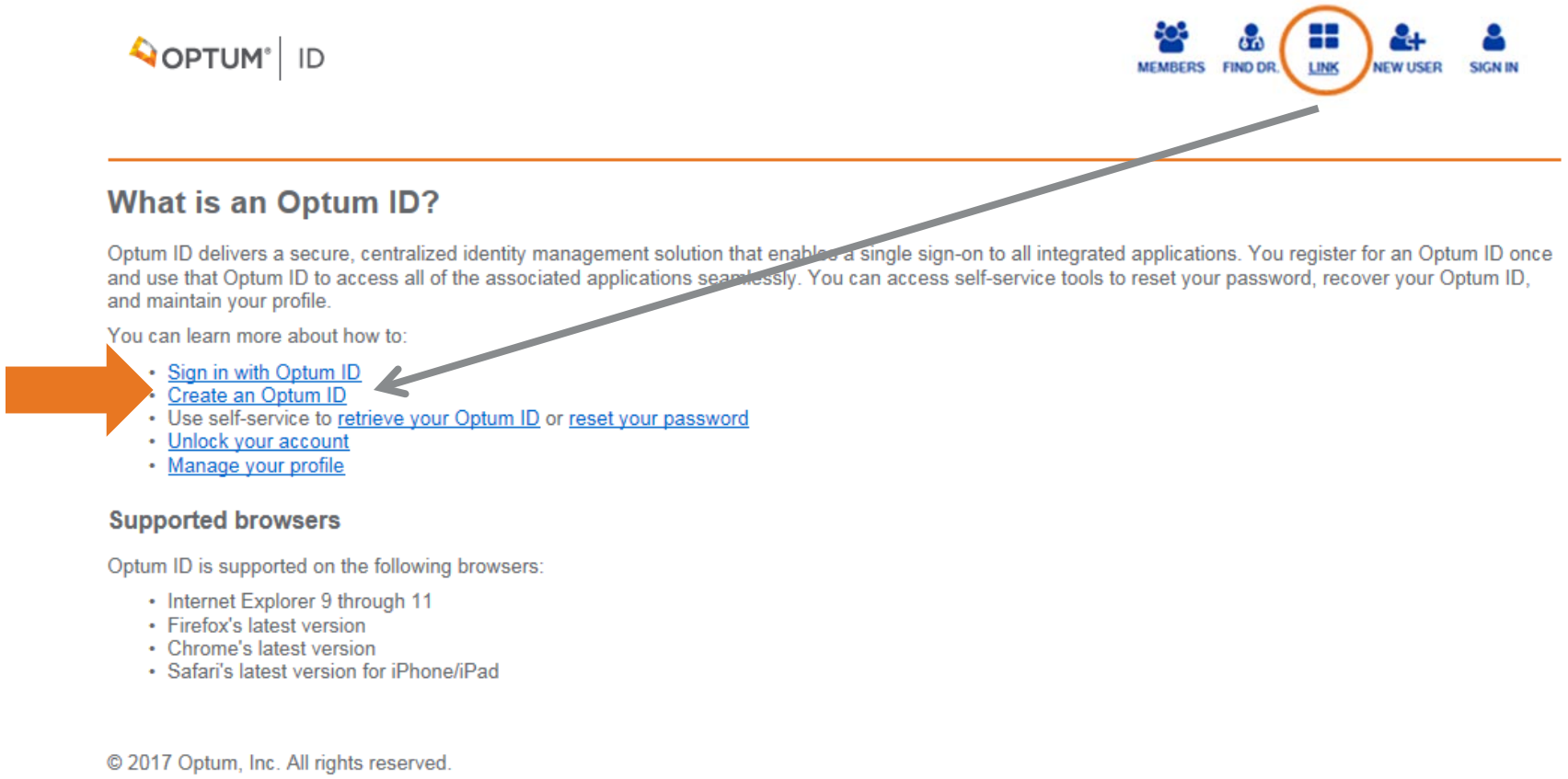


Website and Portal

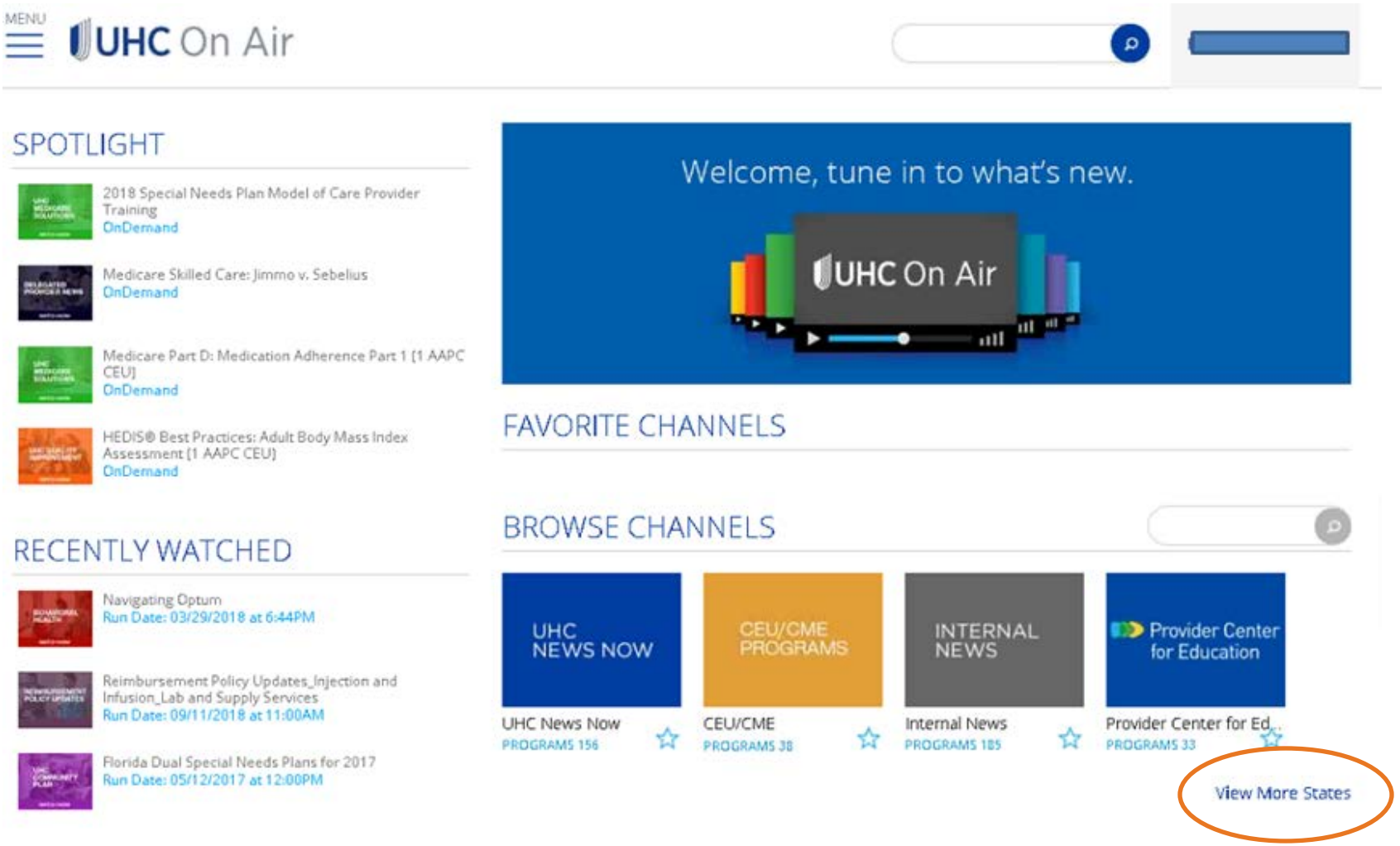
Website Content

- Clinical and Payment Policies
- Clinical Practice Guidelines
- Frequently Used Forms
- HEDIS Guides
- Preferred Drug List
- Provider Manuals
- Provider Newsletters & Announcements
- Provider Portal Link
- Provider Training and Resource Materials
- Verify Prior Auth requirements

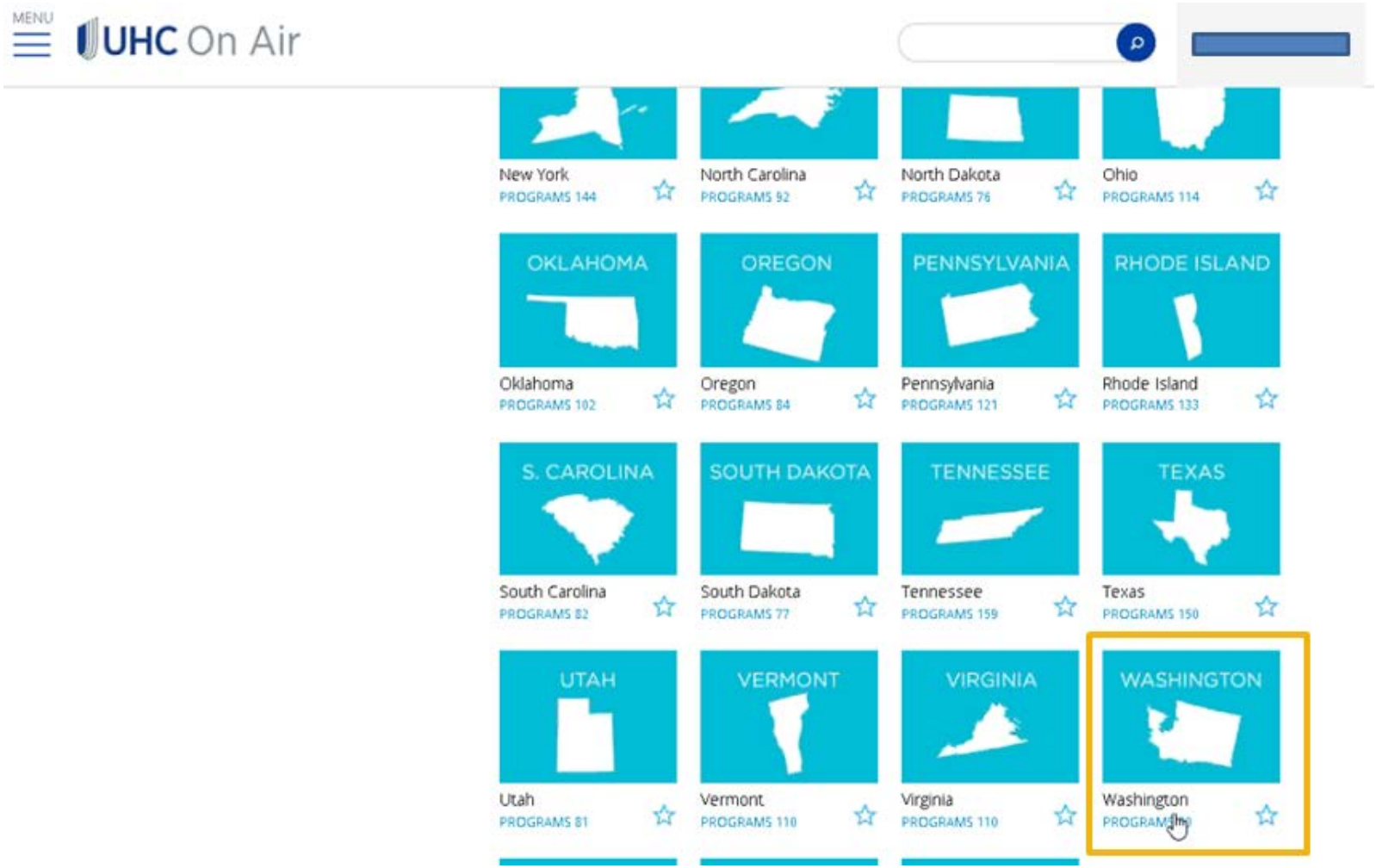
Portal Content

- Authorization status and submission
- Case management referrals
- Check member eligibility and benefits
- Claim audit tool
- Claim submission and status
- Claim correction and resubmission
- Secure transactions
- Update practice information

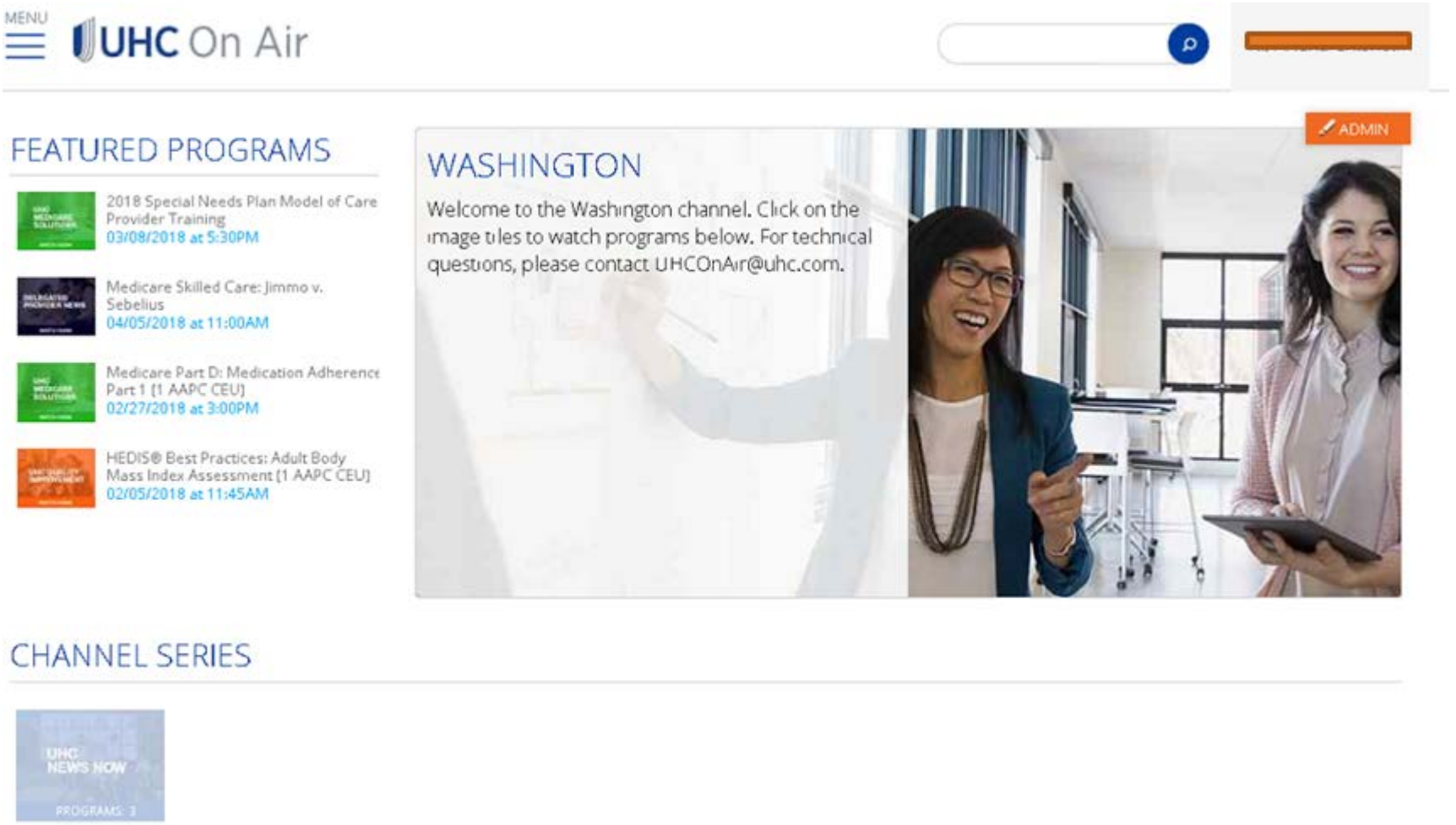
Cultural Competency



Cultural Competency (continued)



Cultural Competency (continued)



Cultural Competency (continued)

As a health care provider, it is important for you to remember to be sensitive to the cultural diversity of the population you serve, as well as state and federal regulations, including Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act:

- All providers must comply with state and federal law to ensure that applicants for employment, employees, and persons to whom they provider service are not discriminated against due to 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

- 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

Cultural Competency (continued)

All services should be conducted in a manner that respects the Member's cultural heritage and appropriately utilizes natural supports in the Member's community

- 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 and 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; however, it cannot be required

Cultural Competency Resources

Additional resources for information on Cultural Competency:

cms.hhs.gov/ocr – Office of Civil Rights

LEP.gov – Promotes importance of language access to federal programs and federally assisted programs

crosshealth.com – Quarterly newsletters on cultural competence topics for staff

diversityrx.org – Promotes language and cultural competence to improve the quality of health care for minorities

ncihc.org – Organization to promote culturally competent health care

focusondiversity.com – Provides statistics

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

Elements reviewed during audits:

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

Provider Quality Audits (continued)

Scoring of audits:

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

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

Here are a few audit tools for Washington Medicaid:

- Case Management Record Audit Tool
- Psychosocial Rehab Record Audit Tool
- Treatment Record Audit Tool

The audit tools can be found on *providerexpress.com*: Home > Admin Resources > Forms > Optum Forms - Administrative

WA IMC Member Information

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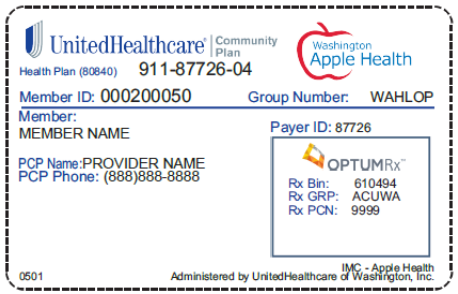
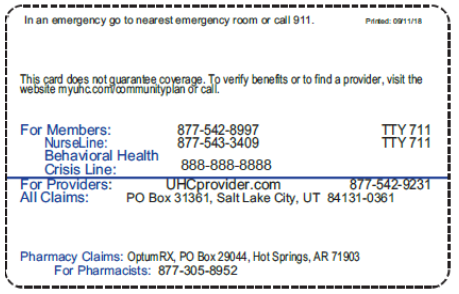
Member ID Card

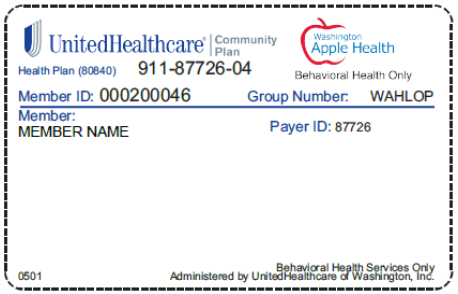
- Sent directly to the Member
- The Member's ID number will be their Medicaid number
- All relevant contact information will be on the back of the card for both medical and behavioral customer service

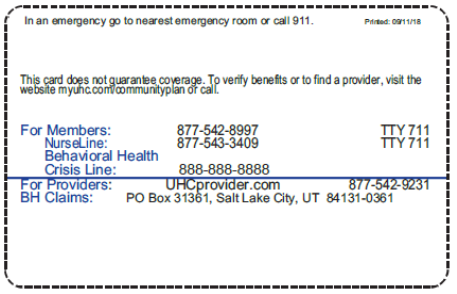
IMC Member ID





BHSO Member ID





Please note this image is for illustrative purposes only.

Member Rights and Responsibilities

- Members have the right to be treated with respect and recognition of his or her dignity, the right to personal privacy, and the right to receive care that is considerate and respectful of his or her personal values and belief system
- Members have the right to disability related access per the Americans with Disabilities Act
- You will find a complete copy of Member Rights and Responsibilities in the Provider Network Manual on *providerexpress.com*
- These rights and responsibilities are in keeping with industry standards. All Members benefit from reviewing these standards in the treatment setting
- We request that you display the Rights and Responsibilities in your waiting room, or have some other means of documenting that these standards have been communicated to the Members

Member Website

- At MyUHC.com, it's simple for Members to:
  - Identify network clinicians and facilities
  - Locate community resources
  - Find articles on a variety of wellness and work topics
  - Take self-assessments
- The search feature allows Members and providers to locate in-network providers for behavioral health and substance use disorder services. Search by:
  - Geographic area
  - Specialty
  - License Type
  - Expertise
- The website has an area designed to help Members manage and take control of life challenges.

Service Requirements

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Intake

At Intake:

- Copy front and back of the Member's insurance card
- Record subscriber's name and date of birth

Suggested information:

- Provide subscriber with your HIPAA policies
- Provide subscriber with consent for billing using protected health information, including signature on file
- Always get a consent for services
- Informed Consent: services, to leave voicemail, email, etc.
- Billing policies and procedures
- Release of Information to communicate with other providers(SUD)

Eligibility and Prior Authorization

- Call the number on the back of the Member's insurance card to see if Member is eligible for your services or verify on provider portal
- Check benefit coverage relating to both the service and the diagnosis on provider portal or by calling the number on the Member's insurance card.
- Make sure all services **receive prior approval before beginning services** (except for crisis stabilization if emergent and inpatient admissions – see below)
- When calling the Optum Care Advocate you must have:
  - Member's Name
  - ID#
  - Date Of Birth
  - Address

[Sign up today for Training on submitting an Authorization]

Prior Authorization

Call

- United HealthCare Call Center: 1-877-542-9231
- IP & Res reviews 24/7
- Non-Routine Outpatient: Call during business hours

Online

- Providerexpress.com:
- Frequently used non-routine services where an authorization can be requested online include: Psychological Testing, Transcranial Magnetic Stimulation (TMS), GFS funded services and ABA/Autism
- For other non-routine services call the number on the back of the Member's ID card to request authorization.

FAX

- WA IMC Fax Form
  Fax the form to : 1-844-747-9828

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Prior Authorization Contacts

Frequently Used Numbers

To request an authorization or check the status of a request:

- Provider Web Portal: Providerexpress.com
- Healthcare Services (Prior Authorization):1-877-542-9231

To fax in a request for services:

- Prior Authorization Fax: 1-844-747-9828

Prior Authorizations are supported by the Optum Assessment and Treatment Team (A&T)

For any escalated prior authorization issues that cannot be resolved through the prior authorization line, contact:

IMC Network Manager:	Danielle Politte
Phone:	1-425-201-7103
Fax:	1-844-233-0243
Email:	Danielle.Politte@optum.com

UnitedHealthcare Community Plan

Clinical Information Requirements for Each Review

- Level of Care (LOC) Guidelines can be located on *providerexpress.com*
- UnitedHealthcare Community Plan of Washington (UHC) home page also available on uhcprovider.com
- Our dedicated Washington Specific provider link can also be used.

Meet Medical Necessity

Goals are:

- Related to the core behavioral difficulties
- Objective
- Individualized
- Measurable

Includes:

- Coordination of care with other treating providers

Clinical Information Requirements (continued)

- Confirmation Member has an ICD-10 diagnosis
- Any medical or other mental health diagnoses
- Must meet medical necessity (see *Provider Express* for the Level of Care Guidelines and Coverage Determination Guidelines) – duplicate – see earlier slide
- Any other mental health or medical services in which Member is engaged
- Length of time Member been in treatment
- Any medications Member is taking
- Reason services are needed now
- Discharge criteria

Prior Authorization Process Information

- **Calls for initial and preauthorization** are answered as quickly as possible. Average response time is 90 seconds.

This call goes through the *Intake Team* where benefits are verified. The call is then routed to the *Assessment and Triage (A&T) team*.

- **Authorization requests coming in through the *Portal*** have their own designated team who will respond within one hour.

- **Faxed authorizations** must be sent out to the A&T team by the *Intake Team*. Once received they are processed within an hour.

- **Notification Only** Some services only require a notification. For example, emergent stabilization services, unplanned admissions to acute inpatient BH facilities, and WISe enrollment. Notification of admissions occurs via electronic file on the portal, a fax or phone call within 24 hours of that admission. Clinical information to determine medical necessity is provided following the notification.

Prior Authorization Process Information (continued)

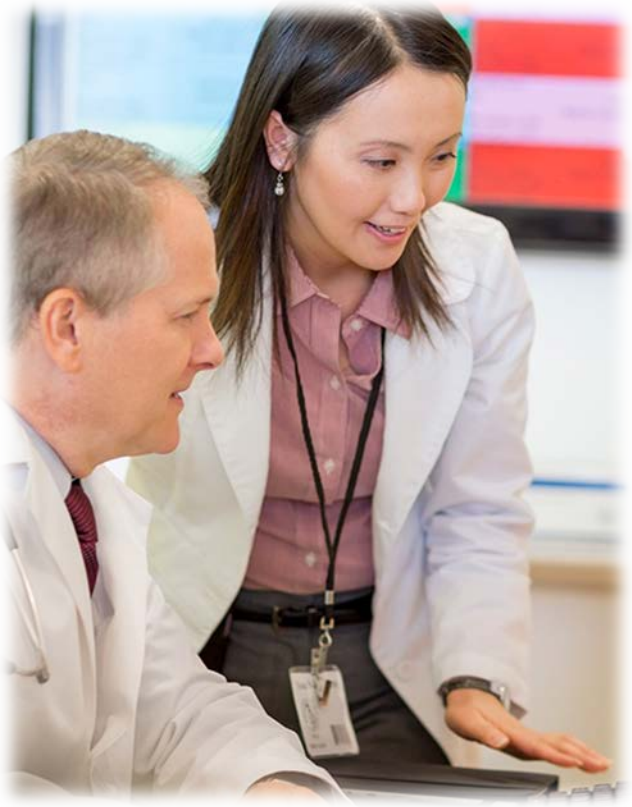
The requesting facility can expect an authorization answer via phone, either immediately if the decision is made by phone, or within an hour if using the portal. Faxed requests can take longer as they have to be assigned by the Intake Team to an A&T Care Advocate. The Care Advocate then has one hour to make a decision. If approved, the A&T Care Advocate staff lets the requesting provider know who the Facility Based Care (FBC) Advocate is who will be assigned to the case to conduct concurrent reviews. The requesting provider will be given that staff's phone number. We refer to this process as a primary review: a licensed BH clinician reviews the clinical documentation against medical necessity criteria, approves and notifies the provider of the authorization number and the number of days or visits that were approved, as well as the next review date if a continuation of the service is expected.

If the authorization request is not meeting medical necessity, the A&T Care Advocate will staff the case with the team lead, manager, or MD. They decide if it will be approved or go to peer review. Peer reviews are assigned to the National Peer Review Team. Turnaround time for inpatient is one business day, for lower levels of care it is four business days. Peer reviews are referred to as secondary reviews: requests that do not appear to meet criteria at the primary level are escalated to a health care provider, such as a psychiatrist, addiction medicine specialist, clinical psychologist or pharmacist.

Concurrent Reviews or Continued Stay Requests

The same information will be needed for each review:

- Any medical or other mental health diagnoses
- Any other mental health or medical services Member is receiving
- Any medications Member is taking
- Progress or lack thereof and must meet medical necessity
- Goals must not be educational or academic in nature – focusing only on the behavioral difficulties
- Discharge criteria



Information about the Concurrent Review/Continued Stay Request Process:

Authorization is valid until last covered day. The *Facility Based Care* Advocate will call for the continued stay review on the last covered day. If the last covered day falls on a Sunday, the *Facility Based Care* Advocate will call for the concurrent review on Monday.

The provider can also call the Care Advocate. However, the provider cannot call the Care Advocate early to get an extension because authorizations can only be reviewed on last covered day.

If the provider is in network, the continued stay review can be submitted by fax or portal instead of a phone call. Out of network providers need to call in for a review.

Turn-around time for these authorization requests are based on the type of request:

Urgent	Standard/Routine
2 calendar days	5 calendar days

We highly recommend that providers not rely on urgent review requests when not indicated. Doing so can create a backlog of urgent requests that does not allow for the identification of requests that are truly of an urgent nature.

If a request does not meet medical necessity, after review by the team leader, the manager, or an MD for inpatient, or a psychologist for other levels of care, the Care Advocate sends the clinical information to the *National Team* to schedule a peer to peer. Turn-around time for inpatient is one business day, for lower levels of care it is four calendar days.

When a determination is made that a level of care is not met or further care is not required, a Partial or Full denial may be issued. The denial will be communicated within 24 hours of the determination. UHC will work closely with the provider to identify a transition plan and assist provider and the member in finding services that meet the member's needs.

The member can appeal a denial within 60 calendar days. We recommend doing so within 48 hours (business hours).

Retrospective Review & Suspended Medicaid

Retrospective Review

This is a review that is conducted after the service has occurred to determine if the services were medically necessary. This may occur when a member retrospectively enrolled or the facility was unable to identify the member's coverage.

After the member was discharged the provider can submit a retro appeal for up to 24 months by calling **877-542-8997.**

Serving Members with Suspended Medicaid

The suspension of Medicaid eligibility while the member is incarcerated or at Western State Hospital should not prevent seamless continuity of care as soon as the person transfers to the community. For example, when the jail provider identifies that an inmate will benefit from SUD residential services upon release, arrangements should be made to ensure immediate transfer from the jail to the treatment facility:

- While the person is still incarcerated, the jail provider will contact UHC to relate the need for SUD residential treatment for this member upon release
- The jail provider will submit clinical documentation to justify the request
- UHC will review the clinical materials and, if accepted, will give a service record/authorization number to the jail provider
- The jail provider will make arrangements for the member's transportation to the RTF upon release
- On the day of admission, the accepting RTF provider will contact UHC to provide the day and time when the member came to their facility. The RTF provider will also submit updated clinical information that further supports the member's need for this level of care.

ALERT Program

UHC created the ALERT program to facilitate clinical risk and utilization management for routine outpatient treatment where no pre-authorization is required.

The goal of the ALERT program is to reduce the administrative burden on providers, while also ensuring quality and efficient treatment for our members.

The ALERT program is designed to identify cases where a clinical discussion between UHC and the treating provider would likely be impactful. Up to 90% of all routine outpatient treatment episodes require no interaction between UHC and the provider.

ALERT works by using clinical and claims data to identify outlier cases where interaction between UHC and the treating provider is likely to add value. The data comes from submitted Wellness Assessments, behavioral claims, and pharmacy claims. This approach allows the vast majority of outpatient cases to proceed without any interaction between UHC and the treating provider.

ALERT interventions are initiated by letter and/or phone call to the treating provider. UHC ALERT intervention staff personnel are licensed clinicians.

Discharge Planning

Must include the following components in every plan

- Anticipated date of discharge
- Objective, measurable goals that would need to be met for the Member to be discharged
- Identify next level of care for the Member, (outpatient therapy)---Include contact info if appropriate
- Member and/or parent agreement with plan
- How to resume services if needed
- Resources in the community for the Member
- How discharge is coordinated with other providers

Evaluation & Treatment Services (E&T)

Evaluation and Treatment Centers (E&T) provide a secure setting for evaluation and short-term psychiatric treatment.

- Involuntary admissions must be initiated by a Designated Mental Health Professional
- Notify UHC at the time of admission; submit clinical for authorization within 24 hours of admissions – even for involuntary.
- There are no self-referrals or direct admits to E&T centers

The primary goals of E&T services are to help stabilize individuals who are:

- Experiencing psychiatric instability
- At risk of harm to themselves or others
- Gravely disabled as a result of their psychiatric condition, and
- At risk of needing psychiatric hospitalization.

Evaluation & Treatment Services (E&T) (continued)

- Per Service Encounter Reporting Instructions (SERI) services include, at a minimum:
  - Evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals
  - Discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care.
- Nursing care includes but is not limited to:
  - Performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness.
- Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology.
- The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented

Freestanding E&T services in a facility meeting the definition of an Institution for Mental Disease (IMD) are funded by Non-Medicaid resources. This includes E&T services provided to individuals with Medicaid as the pay source.

WISe Provider Participation Requirements

Washington's Wraparound with Intensive Services (WISe)

The core elements of WISe include:

- **Engagement**
- **Assessing**
- **Teaming**
- **Service planning and implementation**
- **Monitoring and adapting**
- **Transition**

Implementation of WISe, utilizing the Washington State Children's Behavioral Health

Principles will:

- Reduce the impact of mental health symptoms on youth and families, increase resilience, and promote recovery;
- Keep youth safe, at home, and making progress in school;
- Help youth to avoid delinquency; and
- Promote youth development, maximize their potential to grown into healthy and independent adults

WISe Notification

WISe Notification Form, completed when:

- Member is enrolled in WISe program
- Member exits WISe
- Adverse Benefit Determination
  - Denial
  - Termination
  - Reduction in services
  - Suspension of services

Send by Fax: 1-844-747-9828

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WISe Tracker

- One form utilized for monthly report and invoice/roster to MCOs
  - Report data: Due by 5th of the month, each month
    - Capacity information, average service hours, and interest list
  - Invoice and Roster: Due when contract indicates

*WISe providers can choose to send in both the report and invoice by the 5th

Evidence-Based Practice Codes

What are Evidence-Based Practice (EBP) codes and how are they used?

EBP codes are specially designated identifiers on a claim or encounter that are used to report specific research, or evidence-based practices for children's public mental health care provided by licensed or certified mental health providers to children 18 and under in Washington State. EBP encounter data is used for reporting to the legislature and other reporting requirements related to the provision of mental health services to children.

How should providers report EBPs under IMC?

- The rules for coding and submitting EBPs under IMC are slightly different:
  - The EBP code must be reported as a nine-digit number beginning with '860'. The next three digits must represent the appropriate EBP code as outlined in the Evidence-Based Practices Reporting Guide. The last three digits must be reported as '000'.

    Example: 860163000 should be used when reporting Child-Parent Psychotherapy
- Report one EBP code per encounter in the 2300 REF02 Prior Authorization field of the standard 837 file submission.
- The REF01 field should contain the 'G1' qualifier (prior authorization).
- The REF02 field should contain the nine-digit EBP code.

  Example: REF*G1*860163000

Evidence-Based Practice Codes (continued)

Will MCOs validate EBP codes on encounters and claims?

Yes. You should check with each MCO for specific validations that might apply. In general you should be ensuring the following:

- The value must match a valid 9 digit EBP code: Begins with an 860, followed by a valid 3 digit EBP code and ending with 000.
- The EBP code should only be used in conjunction with a valid CPT code per the Evidence-Based Practices Reporting Guide (under the “Eligible Encounter Codes” section).

Evidence-Based Practice Reporting Guides and additional information about EBPs can be found at:

dshs.wa.gov/ > Search for Evidence-Based and Research-Based Practices

PACT Provider Participation Requirements

What is Program of Assertive Community Treatment (PACT)?

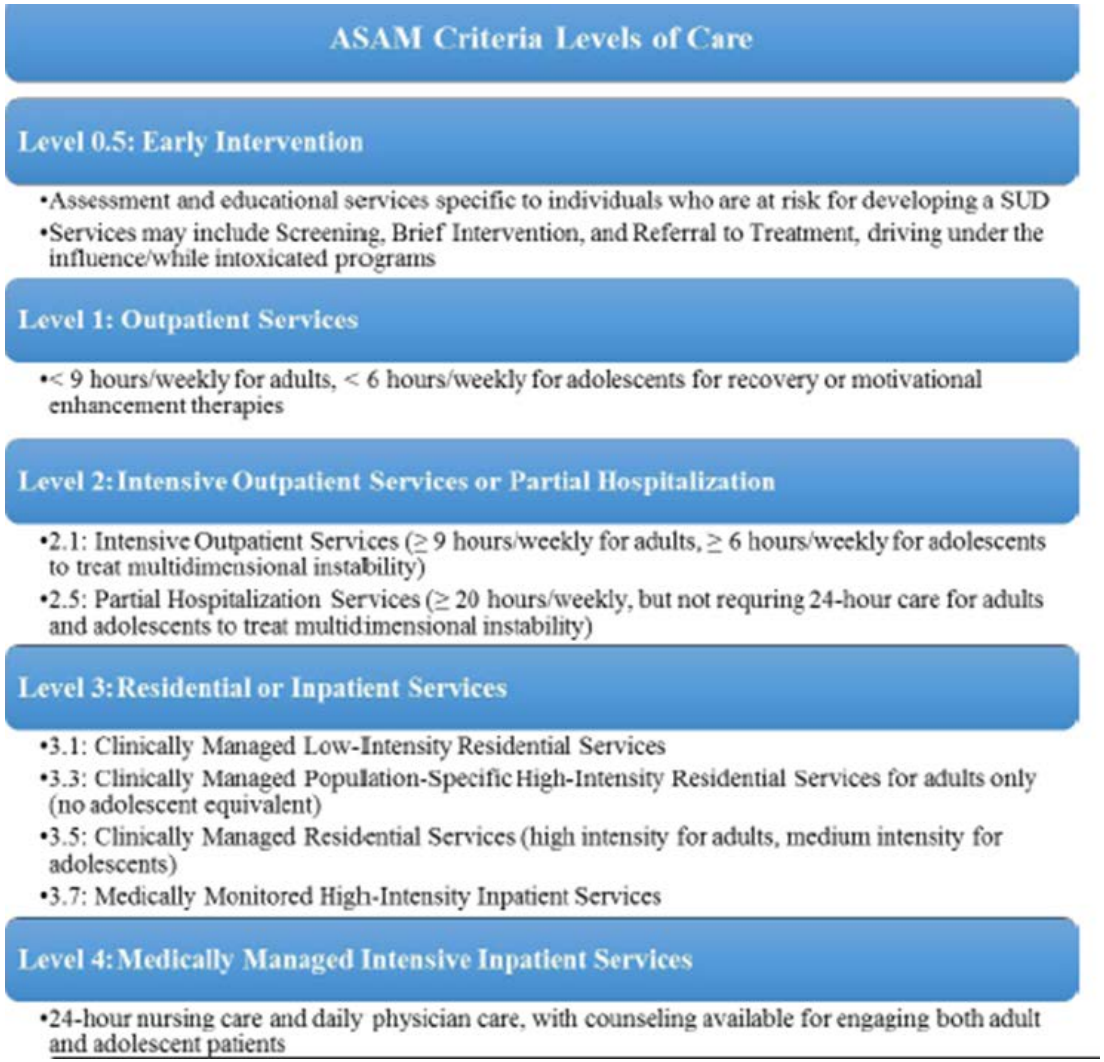
- PACT is for people with severe mental health disorders, who frequently need care in a psychiatric hospital or other crisis service. These clients often have challenges with traditional services, and may have a high risk or history of arrest and incarceration.
- PACT serves up to 800 people statewide with effective and intensive outreach services. These services are evidence-based, recovery-oriented, and provided through a team approach. With small caseloads, PACT teams can address each person's needs and strengths to provide the right care at the right time.
- Peer specialists help people transition back into their communities. Up to 85% of services are available within communities.

Program reviews are conducted at least once a year to measure progress with the following goals:

- Reduce the need for care within state hospitals
- Increase satisfaction and quality of life
- Decrease the use of community inpatient and crisis services
- Increase employment; and
- Reduce involvement with criminal justice

ASAM Criteria

American Society of Addiction Medicine (ASAM) - State Resource



ASAM Criteria Levels of Care

Level 0.5: Early Intervention

- Assessment and educational services specific to individuals who are at risk for developing a SUD
- Services may include Screening, Brief Intervention, and Referral to Treatment, driving under the influence/while intoxicated programs

Level 1: Outpatient Services

- < 9 hours/weekly for adults, < 6 hours/weekly for adolescents for recovery or motivational enhancement therapies

Level 2: Intensive Outpatient Services or Partial Hospitalization

- 2.1: Intensive Outpatient Services (≥ 9 hours/weekly for adults, ≥ 6 hours/weekly for adolescents to treat multidimensional instability)
- 2.5: Partial Hospitalization Services (≥ 20 hours/weekly, but not requring 24-hour care for adults and adolescents to treat multidimensional instability)

Level 3: Residential or Inpatient Services

- 3.1: Clinically Managed Low-Intensity Residential Services
- 3.3: Clinically Managed Population-Specific High-Intensity Residential Services for adults only (no adolescent equivalent)
- 3.5: Clinically Managed Residential Services (high intensity for adults, medium intensity for adolescents)
- 3.7: Medically Monitored High-Intensity Inpatient Services

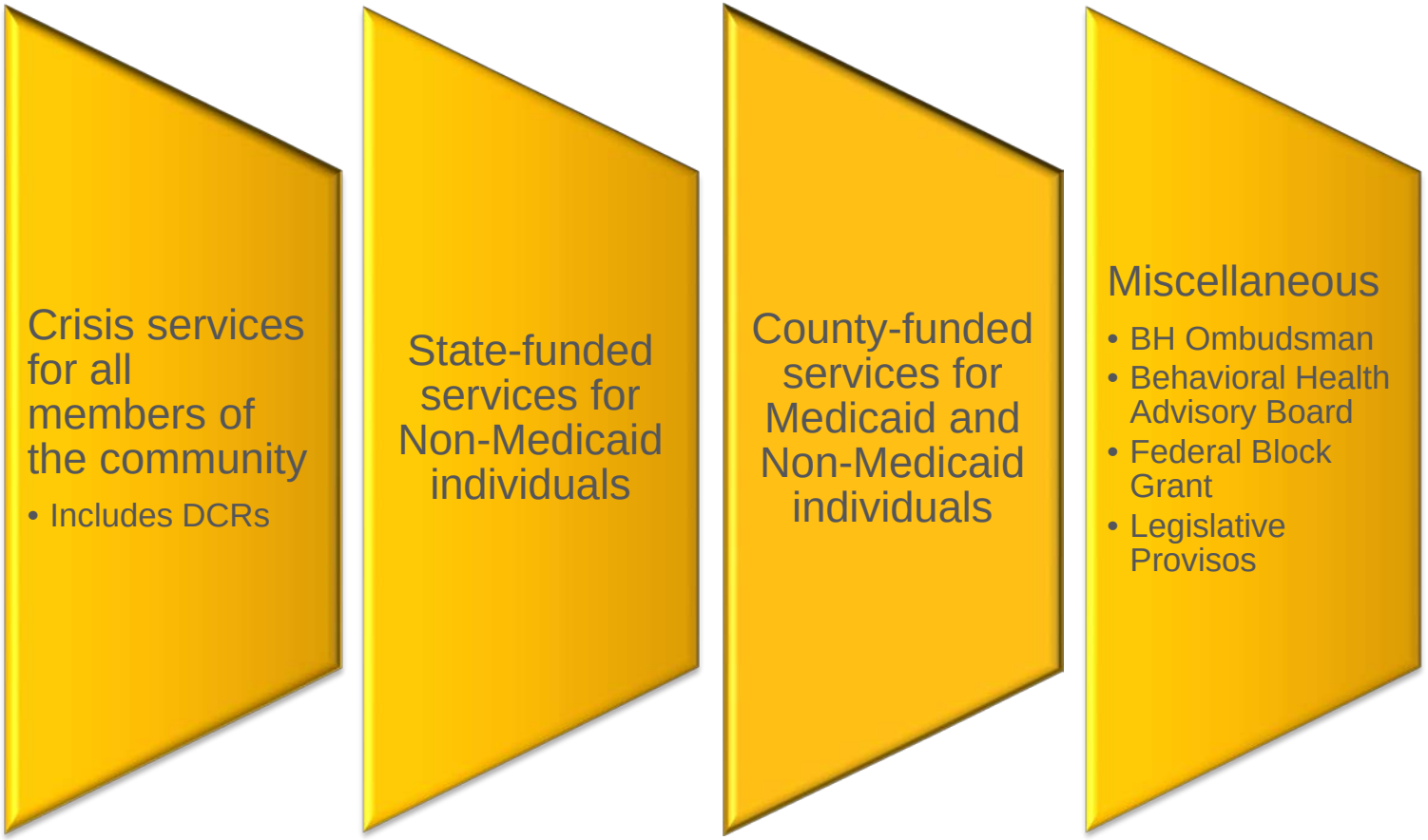
Level 4: Medically Managed Intensive Inpatient Services

- 24-hour nursing care and daily physician care, with counseling available for engaging both adult and adolescent patients

Institute for Mental Disease (IMD) Services

- Institutions for Mental Disease (IMD) are a newly covered benefit allowed by CMS. An IMD is a hospital, nursing facility, freestanding psychiatric hospital, or other institution of more than sixteen beds which primarily provides diagnosis, inpatient psychiatric treatment or care of persons with psychiatric or substance disorders, including medical attention, nursing care and related services.
- IMD services are considered "in lieu of" which allows states and MCO's to cover some Medicaid BH/SUD services at alternate facilities such as free standing psychiatric hospitals, state hospitals, and psychiatric nursing homes.
- Length of stay is determined by the medical necessity guidelines, however IMD limitations of 15 days per calendar month are applicable for individual age 21-65. People under age 21 and over age 65 may have unlimited days in an IMD.

Services Not Covered by MCO Contracts



UnitedHealthcare Community Plan

BHO-ASO Responsibilities

What services will the BHO-ASO provide to anyone in the regions, regardless of insurance status?

Certain services must be available to anyone, regardless of their insurance status or income level. The following services may be provided by the BHO-ASO to anyone in the region who is experiencing a mental health or substance use disorder crisis:

- A 24/7/365 regional crisis hotline for mental health and substance use disorder crises
- Mental health crisis services, including the dispatch of mobile crisis outreach teams, staffed by mental health professionals and certified peer counselors
- Short-term substance use disorder crisis services for people intoxicated or incapacitated in public
- Application of mental health and substance use disorder involuntary commitment statutes, available 24/7/365 to conduct Involuntary Treatment Act assessments and file detention petition

Crisis Services

24-hour crisis line

Statewide

Crisis services are available to support you, based on where you live.

See your local crisis line contact list

Nationwide

Phone: 1-800-273-8255
Online: National Suicide Prevention Lifeline

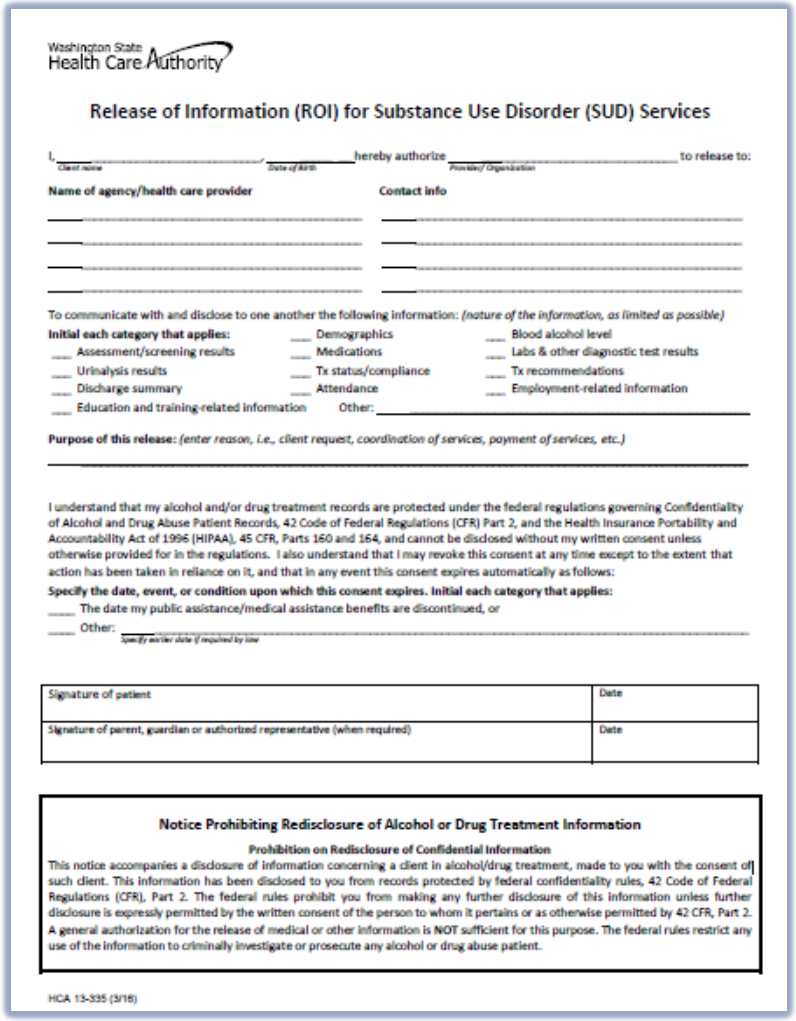
In North Sound Region

Phone: 1- 800-584-3578
Online: northsoundbho.org/Services/

Release of Information

- We release information only to the individual, or to other parties designated in writing by the individual, unless otherwise required or allowed by law
- Members must sign and date a Release of Information for each party that the individual grants permission to access their PHI, specifying what information may be disclosed, to whom, and during what period of time
- The Member may decline to sign a Release of Information which must be noted in the Treatment Record; the decline of the release of information should be honored to the extent allowable by law
- PHI may be exchanged with a network clinician, facility or other entity designated by HIPAA for the purposes of Treatment, Payment, or Health Care Operations

SUD Confidentiality



Washington State Health Care Authority

Release of Information (ROI) for Substance Use Disorder (SUD) Services

I, _____ (Client name) _____ (Date of birth) hereby authorize _____ (Provider/ Organization) to release to:

Name of agency/health care provider	Contact info

To communicate with and disclose to one another the following information: *(nature of the information, as limited as possible)*

Initial each category that applies:

- ___ Assessment/screening results
- ___ Urinalysis results
- ___ Discharge summary
- ___ Education and training-related information
- ___ Demographics
- ___ Medications
- ___ Tx status/compliance
- ___ Attendance
- ___ Blood alcohol level
- ___ Labs & other diagnostic test results
- ___ Tx recommendations
- ___ Employment-related information

Other: _____

Purpose of this release: *(enter reason, i.e., client request, coordination of services, payment of services, etc.)*

_____

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 Code of Federal Regulations (CFR) Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Specify the date, event, or condition upon which this consent expires. Initial each category that applies:

- ___ The date my public assistance/medical assistance benefits are discontinued, or
- ___ Other: _____ (Specify earlier date if required by law)

Signature of patient	Date
Signature of parent, guardian or authorized representative (when required)	Date

Notice Prohibiting Redisclosure of Alcohol or Drug Treatment Information

Prohibition on Redisclosure of Confidential Information

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules, 42 Code of Federal Regulations (CFR), Part 2. The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR, Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HCA 13-335 (3/16)

[Sharing substance use disorder information HCA guide]

UnitedHealthcare Community Plan

Coding, Billing and Reimbursement

UnitedHealthcare Community Plan

Claims Submission

Electronic Claims Payer ID: 87726

ERA Payer ID: 04567

Claims/Customer Service # :

- Phone: 1-866-556-8166
- Fax: 1-855-312-1470

Required Claim Forms (if not submitting electronically)

- Form 1500 (CMS-1500 form) or UB-04

Paper Claims:

When submitting behavioral Claims by paper, please mail claims to:

UnitedHealthcare
PO Box 31365
Salt Lake City UT 84131-0365

Claims Submission (continued)

We encourage providers to submit claims electronically in one of two ways:

- Online through uhcprovider.com, or
- Using Electronic Data Interchange (EDI) through a clearinghouse vendor

Performing claim submission electronically offers distinct benefits:

- **Fast** - eliminates mail and paper processing delays
- **Convenient** - easy set-up and intuitive process, even for those new to computers
- **Secure** - data security is higher than with paper-based claims
- **Efficient** - electronic processing helps catch and reduce pre- submission errors, so more claims auto-adjudicate
- **Notification** - you get feedback that your claim was received by the payer; provides claim error reports for claims that fail submission
- **Cost-efficient** - you eliminate mailing costs, the solutions are free or low-cost

Claims Submission (continued)

- If not submitting claims online, providers must submit claims using the current 1500 Claim Form or UB-04 with appropriate coding
- UnitedHealthcare Community Plan requires that you initially submit your claim within 365 days of the date of service
- When a clinician is contracted through a group, the payment is made to the group, not to the individual clinician
- All claim submissions must include:
  - Member name, Medicaid identification number and date of birth
  - Provider's Federal Tax I.D. number
  - National Provider Identifier (NPI)
  - Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at cms.gov

Electronic Claims Submission Option 1- Online

Log on to 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 **1-866-842-3278**

Claims Submission Option 2 - EDI

- You may use any clearinghouse vendor to submit claims
- Payer ID for submitting claims is 87726

Additional information regarding EDI is available on:

UHCprovider.com > Menu > Resource Library > Electronic Data Interchange

UnitedHealthcare Community Plan

Electronic Payment & Statements (EPS)

- With EPS, you receive electronic funds transfer (EFT) for claim payments and your Explanations of Benefits (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.
- 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

Note: 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.

Claims Tips

To ensure "clean claims" remember:

- An NPI number is required on all claims
- A complete diagnosis is also required on all claims

Claims filing deadline

- Providers should refer to their contract with United to identify the timely filing deadline that applies

Claims processing

- Clean claims, including adjustments, will be adjudicated within 14 days of receipt

Balance billing

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

Claims Tips (continued)

Member Eligibility

- Provider is responsible to verify Member eligibility through Provider one website

Coding Issues

Coding issues including incomplete or missing diagnosis Invalid or missing HCPC/CPT examples:

- Submitting claims with codes that are not covered services
- Required data elements missing, (e.g., number of units)

Provider information missing/incorrect

- Example: provider information has not been completely entered on the claim form or place of service

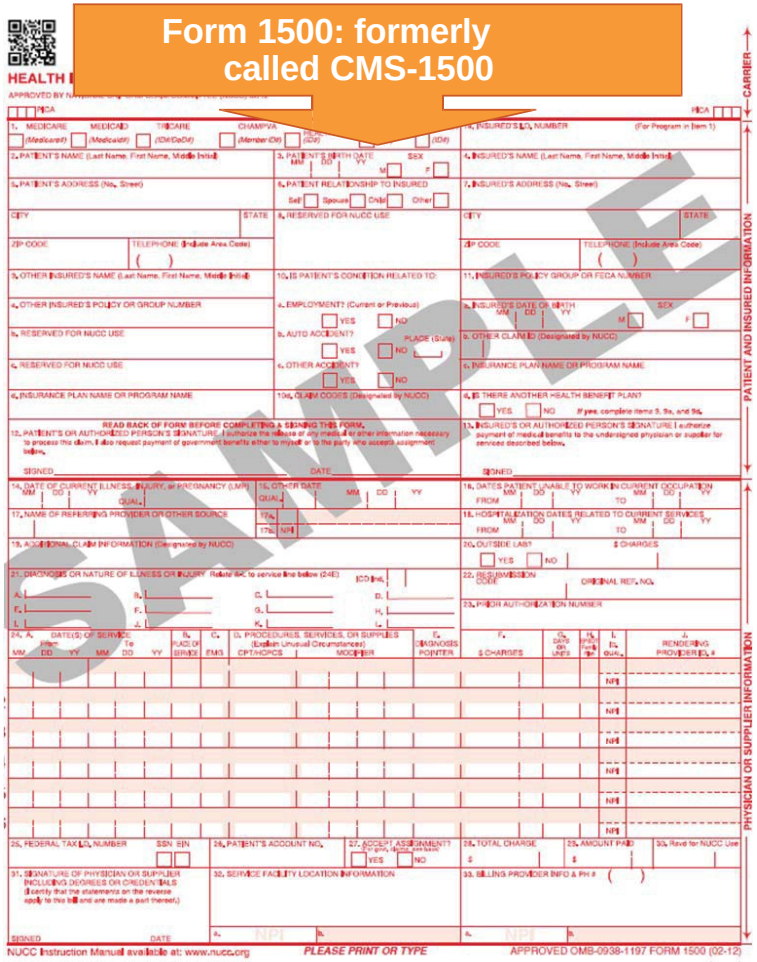
Prior Authorization Required

- Prior Authorization is required for all services or when additional units are being requested

1500 Claim Form

All billable services must be coded. Coding is dependent on several factors:

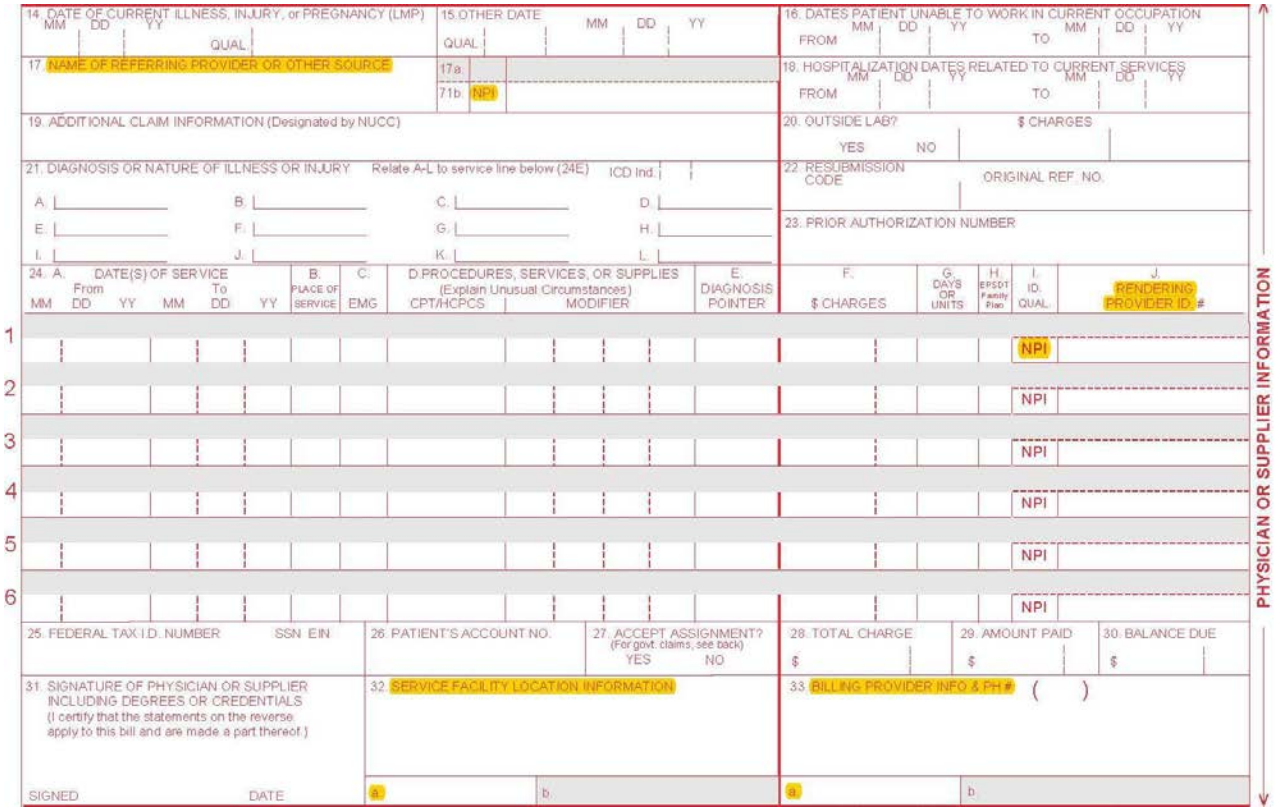
- Type of service (assessment, treatment, etc.)
- Use appropriate modifier for specific provider type
- Rate per unit
- Place of service (home or clinic)
- Duration of therapy (1 hr vs. 15 min)
- One DOS per line



1500 Claim Form (continued)

The HCFA 1500 Form has 4 sections where provider information is stored, they have been highlighted for easy reference. The CRE Edit will review each section when a provider name and NPI number is populated.

- 17b – Referring, Prescribing physician and NPI number
- 24J – Rendering physician and NPI number
- 32A – Service location and NPI number
- 33A – Billing provider and NPI number

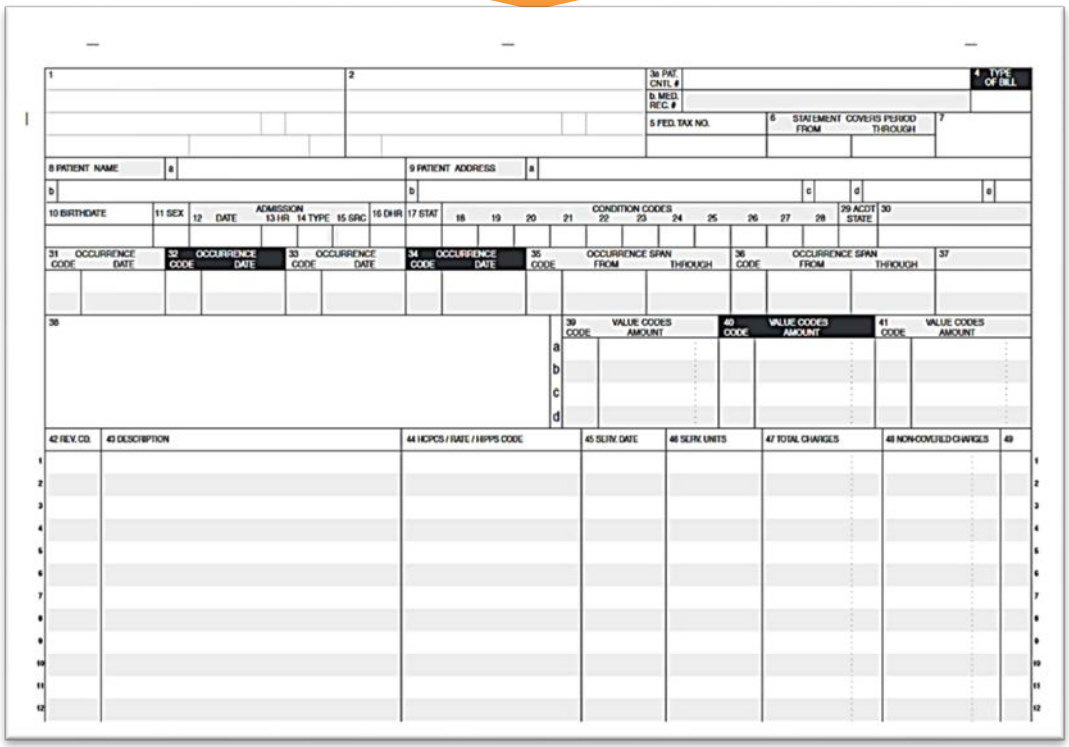


UB-04 - Claim Form

All billable services must be coded.
Coding is dependent on several factors:

- Type of service (assessment, treatment, etc.)
- Use appropriate modifier for specific provider type
- Rate per unit
- Place of service (home or clinic)
- Duration of therapy (1 hr vs. 15 min)
- One DOS per line

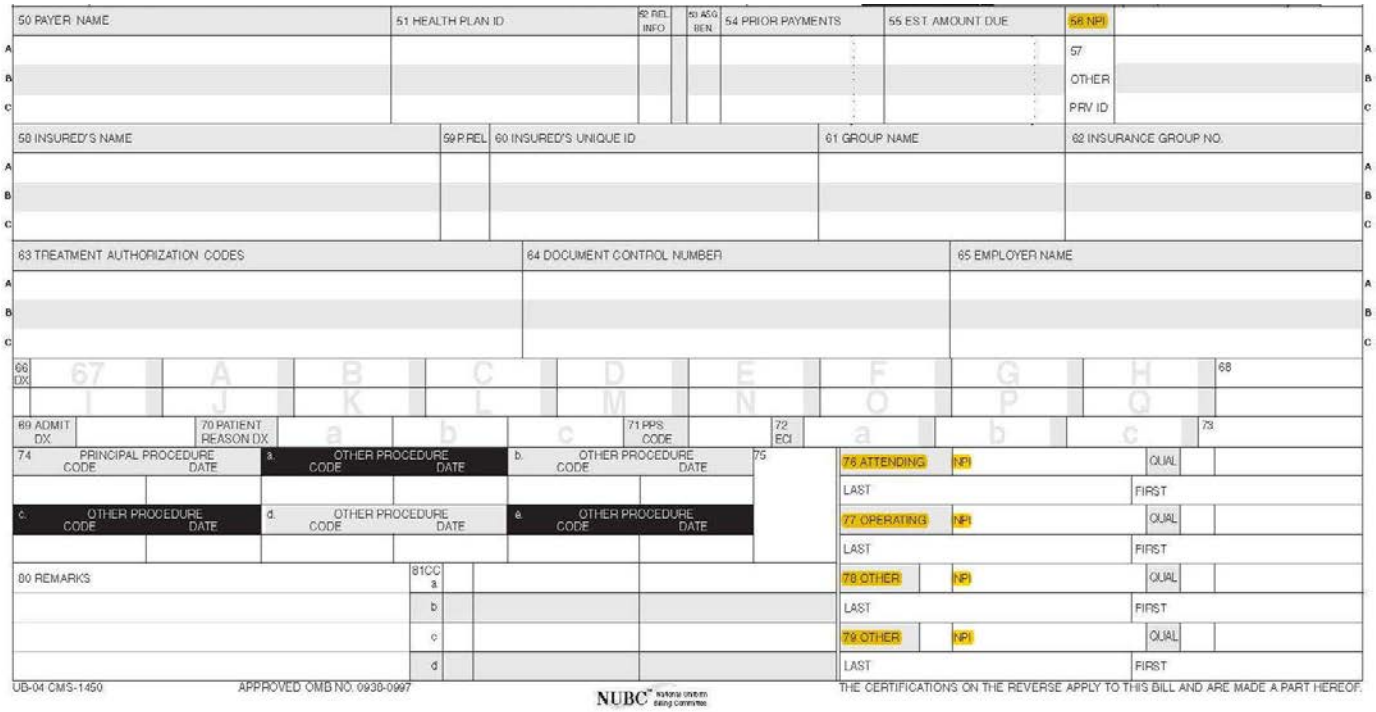
CMS-UB04



UB-04 - Claim Form (continued)

The UB04 has 5 sections where provider data is stored, these have been highlighted for easy reference. The CRE edit will validate the provider information when these boxes are filled.

- Field 56 – Bill to/Pay to provider and NPI
- Field 76 – Attending provider and NPI
- Field 77 – Operating provider and NPI
- Field 78 – Reserved for other provider and NPI
- Field 79 – Reserved for other provider and NPI



Smart Edits

- UnitedHealthcare's Smart Edits solution identifies and returns claims with potential errors before they enter the claims processing system. This way, you can review problematic claims in a matter of hours instead of getting denials days later. Smart Edits are expected to increase the rate of clean and complete claims you submit, help improve the claims processing time, and reduce claims denials and resubmissions.

- Smart Edit messages explain why the claim was returned and provide direction on how to correct the claim for re-submission. The explanation won't affect the process you use to correct a returned claim. Re-submit the claim electronically with the modifications suggested by Smart Edit notifications to minimize potential denials or rework.

Appeals and Grievances

UnitedHealthcare Community Plan

Appeals

Definitions:

- Pre-Service: Appeal of a service that has not yet been received by a Member. Determination is made within 14 calendar days of request. Notification sent to provider and Member.
- Post-Service: Appeal of a service after it has been received by a Member. Determination is made within 14 calendar days of request. Notification sent to provider and Member.

Appeals

- Must be requested as soon as possible after the Adverse Determination
- Must be requested within 180 days from receipt of the notice of action letter
- Optum makes a reasonable effort to contact you prior to making a determination on the appeal. If we're unsuccessful in reaching you, an urgent appeal determination is made based on the information available to Optum at that time.
- Notification occurs as expeditiously as the Member's health condition requires, within three (3) business days, unless the appeal is pertaining to an appeal relating to an ongoing emergency or denial of continued hospitalization, which we will complete investigation and resolution of not later than one (1) business day after receiving the request.

Appeal requests can be made orally or in writing;
however, an oral request to appeal shall be followed up by a written, signed appeal.

Services While In Appeal

- You may continue to provide service following an adverse determination, but the Member should also be informed of the adverse determination.
- The Member or the Member representative should be informed that the care will become the financial responsibility of the Member from the date of the adverse determination forward.
- The Member must agree in writing to these continued terms of care and acceptance of financial responsibility. You may charge no more than the Optum 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 the terms of your Agreement.

Grievances

We strive for the best customer service, but if your patient has a grievance please contact us:

- Call 1-866-556-8166 and a Customer Service representative will assist with the grievance process

- Or send a written grievance to:

United Behavioral Health
Appeals & Grievances
P.O. Box 30512
Salt Lake City, Utah 84130-0512

Fax: 1-855-312-1470

CRITICAL INCIDENTS

- Incidents that need to be reported to UHC are as follows:
- Homicide or attempted homicide by a member;
- A major injury or trauma that has the potential to cause prolonged disability or death of the member that occurs in a facility licensed by the State of WA to provide publicly funded services;
- An unexpected death of a member that occurs in a facility licensed by the State of WA to provide publicly funded services;
- Abuse, neglect or exploitation of a member (excluding child abuse which should be reported to other authorities);
- Violent acts allegedly committed by a member, such as arson, assault resulting in serious bodily harm, homicide or attempted homicide by abuse, drive by shooting, extortion, kidnapping, rape, sexual assault or indecent liberties, robbery, vehicular homicide;
- Unauthorized leave of a mentally ill offender or a sexual or violent offender from a facility that accepts involuntary admissions;
- Any event involving a member that has attracted or is likely to attract media attention.
- Critical Incident form should be:
  - Emailed to: wa_criticalinc@uhc.com, **or**
  - Faxed to: 1-844-680-9871

Resources

UnitedHealthcare Community Plan

Interpreter Services (Service covered through HCA)

All Amerigroup, CHPW, Coordinated Care, Molina, and United Healthcare Community Plan Members or potential Members with a primary language other than English, or who are deaf or hearing impaired, are entitled to receive interpreter services free of charge. Interpreter services shall be provided as needed for all interactions with Members including, but not limited to:

- Customer Service
- When receiving covered services from any provider
- Emergency Services
- Steps necessary to file grievances and appeals

Providers of covered outpatient medical services must arrange for interpreter services through HCA's interpreter service vendor Universal Language Service (Universal).

How do you request an interpreter?

- Register with Universal's online scheduling platform
- Once registered, Universal will train you on how to access an interpreter using their online service portal

The HCA Interpreter Services program is available to healthcare providers serving limited English proficient (LEP), Deaf and Hard of Hearing, and Blind Medicaid clients and individuals applying for or receiving DSHS or DCYF services. For more information, visit HCA's Interpreter Services webpage.

Partnership Access Line (PAL)

The Partnership Access Line (PAL) is a telephone-based child mental health consultation system funded by the state legislature, being implemented in Washington State. PAL employs child psychiatrists, child psychologists, and social workers, affiliated with Seattle Children's Hospital, to deliver its consultation services. The PAL team is available to any primary care provider throughout Washington State.

PCPs may call 1-866-599-7257 between the hours of 8:00 a.m. and 5:00 p.m. for any type of child mental health issue that arises with any child, not just UnitedHealthcare members. Additional information regarding PAL may be found at:

seattlechildrens.org > Healthcare Professionals > Tools and Resources > Partnership Access Line/

Transportation Broker (Service covered through HCA)

Medicaid clients may be eligible for non-emergency medical transportation, which can be arranged and paid for Medicaid clients with no other means to access medical care through HCA contracted brokers listed below. 7-14 days advance notice is recommended.

The HCA Non-Emergency Medical Transportation (NEMT) program now allows non-emergency transportation for all clients going to and/or from SUD or MH facilities for any length of stay.

North Sound Region		
County	Broker	Phone
Island San Juan Skagit	Northwest Regional Council/Area Agency on Aging	1-800-860-6812
Snohomish	Hopelink	1-855-766-7433 TDD/TTY: 1-800-246-1646 To cancel a ride or check on Status: 1-888-913-2172
Whatcom	Northwest Regional Council/Area Agency on Aging	360-738-4554 1-800-860-6812

Provider Contracting

We are pleased that you have chosen to contract with us for Washington Integrated Managed Care.

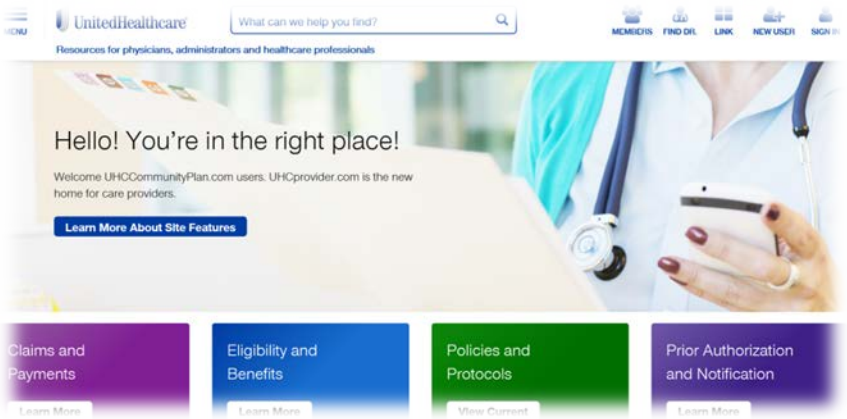
Danielle Politte
Network Manager (North Sound IMC WA)
Optum / United Behavioral Health
Danielle.Politte@optum.com
Phone: 1-425-201-7103
Fax: 1-866-225-9845

UnitedHealthcare Provider Website

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 uhcprovider.com, select New User from the home page
- You may also obtain additional information through the help desk at **1-866-842-3278**



For Member eligibility, claim status, and reference materials, go to > *Tools and Resources* > *UnitedHealthcare Community Plan Resources Customer Service for website support:* **1-800-600-9007**

Website Technical Support

If you have questions about using the *Provider Express* site, need help with requesting a user ID and password, or need technical assistance, call:

Provider Express Support Center: 1-866-209-9320 (toll-free)
8 a.m. to 8 p.m. Eastern time

Provider and Member Resources

Important Telephone Numbers

Member Services and Care Coordination

Phone numbers are:

- Members – 1-877-542-8997
- Providers – 1-877-542-9231

National Provider Manual:

Provider Express > Guidelines / Policies & Manuals > Manuals > Network Manual > **National Network Manual**

WA IMC Medicaid BH Provider Manual & Other Resources:

Provider Express > Our Network > State-Specific Provider Information > Washington > **WA Integrated Managed Care Resources**

Questions and Answers

Thank you.