Optum

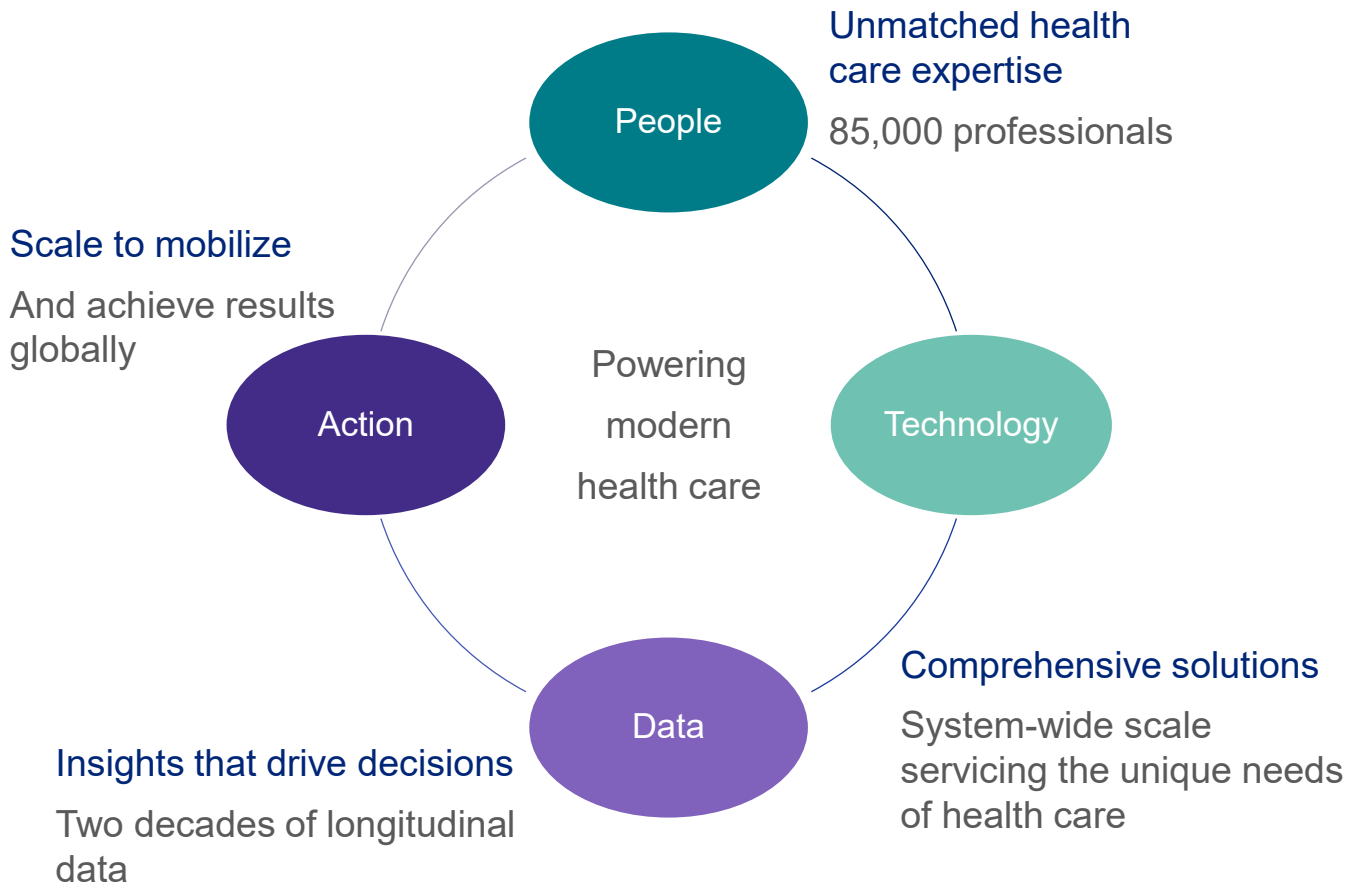
Hawaii QUEST Integration (Medicaid)

ABA Provider Orientation

Optum with UnitedHealthcare
Community Plan of Hawaii

Who is Optum?

- Optum is a collection of people, capabilities, competencies, technologies, perspectives and partners sharing the same simple goal: to make the health care system work better for everyone
- Optum works collaboratively across the health system to improve care delivery, quality and cost-effectiveness
- We focus on three key drivers of transformative change:
  1. Engaging the consumer
  2. Aligning care delivery
  3. Modernizing the health system infrastructure



UnitedHealth Group Structure

Optum

Helping make the health system work better for everyone

Information and technology- enabled health services:

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

UnitedHealthcare®

Helping people live healthier lives

Health care coverage and benefits:

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

Our United Culture

Our mission is to help people live healthier lives

Our role is to make health care work for everyone

Integrity.

Compassion.

Relationships.

Innovation.

Performance.

Honor commitments
Never compromise

Walk in the shoes of the people we serve
And those with whom we work

Build trust through collaboration

Invent the future, learn from the past

Demonstrate excellence
in everything we do

Who is Optum

Optum and You

Our relationship with you is foundational to the recovery and well-being of the individuals and families we serve. We are driven by a compassion that we know you share. Together, we can set the standard for industry innovation and performance.

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)

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

Simultaneous NCQA and URAC accreditation

Staff expertise:

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

URAC
ACCREDITED
HEALTH UTILIZATION
MANAGEMENT

MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION
NCQA
ACCREDITATION
FULL

Hawaii QUEST Integration Member Information

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Member ID card

- ID card is sent directly to the member
- The member's ID number is their Medicaid number
- All relevant contact information is on the back of the card for both medical and behavioral customer service

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

These can also be found on the website: providerexpress.com

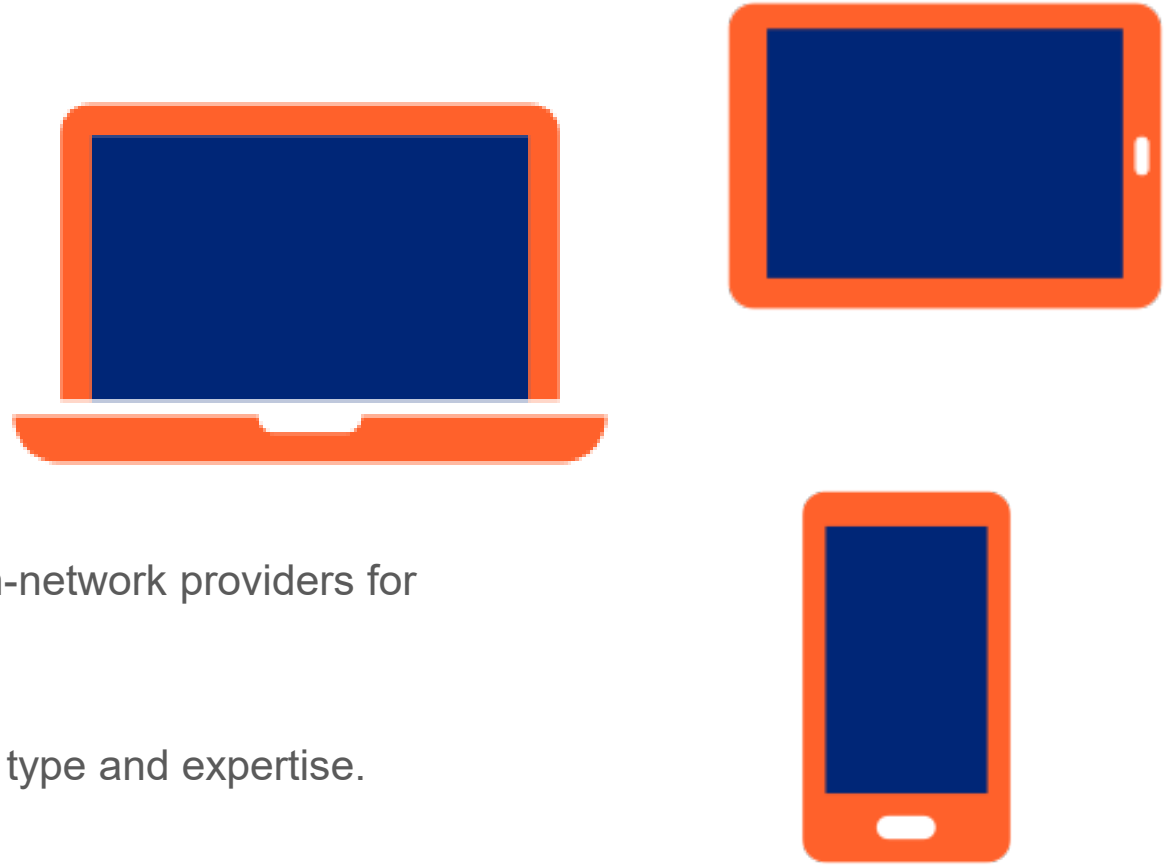
These rights and responsibilities are in keeping with industry standards. All members benefit from reviewing these standards in the treatment setting

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

Live and Work Well makes it 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 engine allows members and providers to locate in-network providers for behavioral health and substance use disorder services.

Providers can be located geographically, by specialty, license type and expertise.

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

Who is eligible?

To be eligible for ABA services, a client must meet <u>both</u> of the following criteria:

- Be under the age of 21
- Be covered under Hawaii QUEST Integration Program

And:

- Have a documented Autism Spectrum Diagnosis, as defined by the most current version of the Diagnostic and Statistical Manual (DSM-5)

Hawaii QUEST Integration Program Services

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ABA Credentialing Criteria (1 of 2)

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
- Minimum of 6 months supervised experience or training in the treatment of applied behavior analysis/intensive behavior therapies
- Minimum professional liability coverage of $1 million per occurrence/ $1 million aggregate

ABA Credentialing Criteria (2 of 2)

ABA / IBT Groups

- BCBAs must meet standards on the previous slide
- BCBA on staff providing program oversight
- BCBA performs skills assessments and provides direct supervision of Behavioral Technicians in joint sessions with client and family
- Behavioral Technicians meet state requirements (RBT) and receive appropriate training and supervision by BCBAs or licensed clinician
- $1 million per occurrence/$3 million aggregate of professional liability and $1m/$1m of general liability if services are provided in a clinic setting
- $1 million per occurrence/$3 million aggregate of professional liability and $1m/$1m of supplemental insurance if the agency provides ambulatory services only (in the patient's home)
- Successful completion of medical record and site audit, as applicable

Required: NPI, Medicaid Enrollment and EIN/TIN

National Provider Identifier (NPI):

- Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans
- The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information
- We require that all claims submitted have an NPI number and taxonomy codes for reimbursement
- To obtain an NPI number, follow the instructions on the NPI web site:
  - nppes.cms.hhs.gov

Tax Identification Number (TIN), Employee Identification Number (EIN), or Social Security Number (SSN) information:

- irs.gov
- Employer ID Number (EIN)

Professional Liability Insurance:

- BACB - Behavior Analyst Certification Board has coverage information; enter “liability in the site’s “Search” feature located in the right side of the menu

ABA Virtual Visits

Optum allows BCBAs/Licensed BH Clinicians (remove, BCBAs only are allowed for HI Quest) within contracted ABA practices to conduct ABA supervision and/or caregiver training via telehealth.

In order to provide supervision and/or caregiver training services via telehealth, you must be an approved Optum virtual visits provider who has attested to meeting the requirements specific to providing these services:

- You can complete and submit a virtual visits attestation on our virtual visits page of Provider Express and will be notified of approval or denial
- Once approved as a virtual visits provider, please be sure to alert the Optum Care Advocate that the ABA supervision and caregiver training services will be provided virtually when completing the authorization process.

To bill for the virtual ABA Supervision of Behavior Technicians and Family Training and Guidance after receiving authorizations:

- Simply include the same procedure code you would use for an in-person service, 97155 or 97156, on your claim with the “02” place of service code to let us know the service was provided via telehealth

Additional information and resources can be found on our ABA page at Provider Express.

Steps in Providing Treatment

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Clinical Team: Hawaii QUEST Integration ABA

Enhanced Autism/ABA Clinical Team

There is a dedicated, enhanced autism/ABA clinical team that will be supporting the HI QUEST Integration ABA program

- Each team member is a licensed behavioral health clinician or BCBA with experience and training in Autism
- Supervised by a manager who is a licensed psychologist and BCBA-D

Intake

At Intake

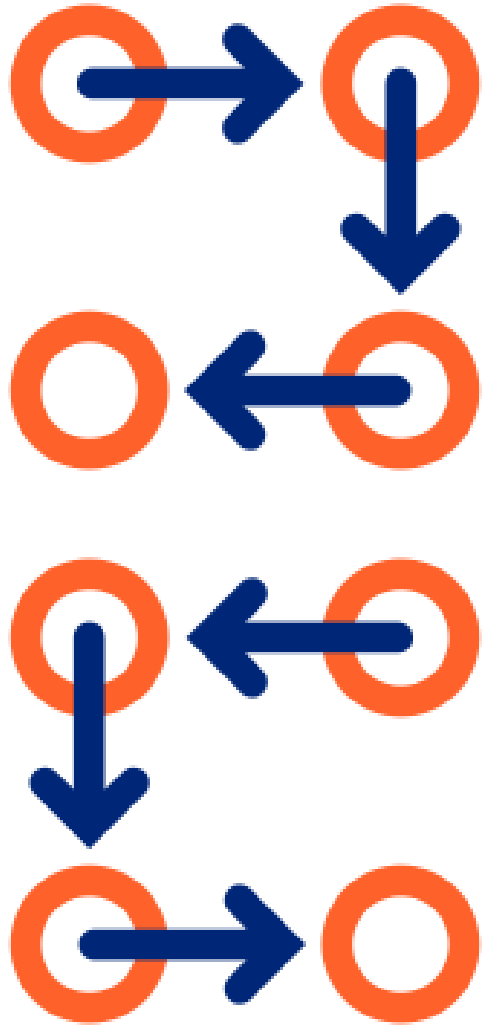
- Copy front and back of the member's insurance card
- Record subscriber's name and date of birth

Additional information to obtain from the member

- Consent for services
- Informed Consent: services, to leave voicemail, email, etc.
- Release of Information to communicate with other providers
- Consent for billing using protected health information, including signature on file

Information to provide to the member or subscriber

- Your HIPAA policies
- Your billing policies and procedures



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

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 (not all ABA services require prior approval for HI QUEST Integration ABA program)
- When calling the Autism Care Advocate, you must have:
  - ❑ Member's name
  - ❑ ID #
  - ❑ Date of birth
  - ❑ Address

Re-evaluation & prior authorization requirements

Prior authorization not required for assessments (but referral may be required from the PCP)

To avoid breaks in treatment, rendering provider shall submit a request for PA at least 2 weeks prior to the end of the approved treatment period

If the diagnosing provider suspects ASD and requires further evaluation before making a definitive diagnosis, the patient may qualify for up to a 26-week trial of ABA. This trial period may be approved for an extension, or additional trial periods may be approved.

Diagnoses that qualify for a trial of ABA include, but are not limited to:

1. Global Developmental Delay 315.8 (F88)
2. Social (Pragmatic) Communication Disorder 315.39 (F80.89)
3. Language Disorder 315.32 (F80.9)
4. Unspecified Communication Disorder 307.9 (F80.9)
5. Expressive Language Disorder (F80.1)
6. Receptive Language Disorder (F80.2)

Assessment/ Treatment Request Requirements

- Prior authorization not required for assessments
- Treatment Authorization Request Form can be submitted either –
  - online at electronicforms.force.com/ABATreatment/s/
  - or via fax at 1-888-541-6691
- Meet Medical Necessity – this applies to initial and concurrent reviews
- Provider must submit the results of the ABA assessment and the treatment request for any treatment requests.

Prior Assessment Authorization – Online Portal Submission

providerexpress.com>
Autism/ABA Information

Prior Authorization - Online Portal Submission

Optum | Provider Express

Log In | First-time User | Global | Site Map

Search: Search Search

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

Optum - Provider Express Home > Clinical Resources > Autism/Applied Behavior Analysis > abaHIMedicaid

Hawaii QUEST ABA Program

United Behavioral Health (UBH), operating under the brand Optum, assumed management of the Medicaid autism program benefits for Hawaii QUEST Integration members with coverage through UnitedHealthcare Community Plan effective January 1, 2016.

To assist you in your participation in this program, learn more about the process for applying to the network, and the clinical protocols required in this unique network, please review the resource materials below.

- Hawaii QUEST ABA Provider Orientation
- Hawaii QUEST ABA Provider Quick Reference Guide
- Hawaii QUEST ABA Treatment Request Form and Guidelines
- ABA Treatment Request Form Electronic Submission

Contact Us/Request to Join the Network

Elianet Montejo Morell
elianet.montejo.morell@optum.com

Treatment Request Requirements

Meet Medical Necessity

Goals are:

- Related to the core deficits
- Objective
- Measurable
- Individualized

Includes:

- Baseline and mastery criteria
- Transition Plan to lower level of care
- Discharge Criteria
- Behavior Reduction Plan/Crisis Plan
- Parent Goals
- Supervision and treatment planning hours
- Relevant psychological information
- Coordination of care with other providers

Not educational in nature

For more information, please see the Treatment Request Guidelines on the Autism/Applied Behavior Analysis page of Provider Express.

Clinical Information Requirements for each Review

- Confirmation member has an appropriate DSM-5 diagnosis that can benefit from ABA
- Any medical or other mental health diagnoses
- Any other mental health or medical services member is in
- Any medications member is taking
- How many hours per week is member in school?
- Parent participation
- Why IBT now?

- How long has member been in services?
- Goals must not be educational or academic in nature; they must focus only on the core deficits such as imitation, social skills deficits and behavioral difficulties
- Discharge criteria
- Must meet medical necessity (see Provider Express for the Level of Care Guidelines and Coverage Determination Guidelines)

For more information, please see the Treatment Request Guidelines on the Autism/Applied Behavior Analysis page of Provider Express.

Concurrent Reviews

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 in
- Any medications member is taking
- How many hours per week is member in school?
- Parent participation

- Progress or lack thereof
- Goals must not be educational or academic in nature – focusing only on the core deficits such as imitation, social skills deficits and behavioral difficulties
- Discharge criteria
- Must meet medical necessity (see Provider Express for the Optum Autism/ABA Clinical Policy)

Coding, Billing and Reimbursement

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HI Medicaid Fee Schedule

UNITED BEHAVIORAL HEALTH			
Billing Code	Modifier	Service Description	Units
97151	HP	Behavior identification assessment, administered by qualified healthcare professional, each 15 minutes of qualified healthcare professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the	15 min
	HO		15 min
97152	HP	Behavior identification supporting assessment, administered by qualified healthcare professional, face-to-face with the patient, each 15 minute.	15 min
97152	HO		15 min
97152	HN		15 min
0362T	HP	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components:	15 min
0362T	HO	• qualified healthcare professional who is on site4; • with the assistance of two or more technicians;	15 min
0362T	HN	• for a patient who exhibits destructive behavior; • completed in an environment that is customized to the patient's behavior.	15 min
97153	HP	Adaptive behavior treatment by protocol, administered by qualified healthcare professional, face-to-face with one patient, each 15 minutes	15 min
97153	HO		15 min
97153	HN	Adaptive behavior treatment by protocol, administered or supervised by qualified healthcare professional, face-to-face with one patient, each 15 minutes.	15 min
97153	HM		15 min
0373T	HP	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components:	15 min
0373T	HO	• administered by qualified healthcare professional who is on site4; • with the assistance of two or more technicians;	15 min
0373T	HN	• for a patient who exhibits destructive behavior;	15 min
0373T	HM	• completed in an environment that is customized,to the patient's behavior.	15 min
97154	HM	Group adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with two or more patients, each 15 minutes. Limit 2 patients per RBT	15 min
97155	HP	Adaptive behavior treatment with protocol modification, administered by qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient,	15 min
97155	HO	each 15 minutes.	15 min
97155	HN	Adaptive behavior treatment with protocol modification, administered by qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient,	15 min
97156	HP	Family adaptive behavior treatment guidance, administered by qualified healthcare professional (with	15 min
97156	HO	or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes.Family	15 min
97156	HN	Training by provider	15 min
97157	UN	Multiple-family group adaptive behavior treatment guidance, administered by qualified healthcare	15 min
97157	UP	professional (without the patient present), face-to-face with multiple sets of	15 min
97157	UQ	guardians/caregivers,each 15 minutes.	15 min
97157	UR	Refer to chart for billing for more than 2 families. Limit group size to 6 families.	15 min
97157	US	Modifier for group size: UN (2 or less), UP (3), UQ (4), UR (5), US (6)(group size = # families)Billing based on # of families present when services rendered. Only one 97157 billable per day.	15 min
97158	HP	Group adaptive behavior treatment with protocol modification, administered by qualified healthcare	15 min
97158	HO	professional, face-to-face with multiple patients, each 15 minutes.Limit 2 patients per QHP	15 min
97158	HN		15 min

1	Use of Modifiers: Modifiers should be used in billing to reflect the credentials of staff delivering services and allow for proper claims payment.
2	HP - Doctoral level - BCBA-D HO - Masters degree - BCBA HN - Bachelors degree - BCaBA HM - Less than a Bachelors degree - RBT

Claims Submission

- If not submitting claims online, providers must submit claims using the current Form 1500 claim form with appropriate coding
- UnitedHealthcare Community Plan requires that you initially submit your claim within 365 days of the date of service
- When a provider is contracted as a group, the payment is made to the group, not to an individual
- Submit electronically using an EDI clearinghouse and payer ID # 87726
- All claim submissions must include:
  - ❑ Member name
  - ❑ Medicaid identification number
  - ❑ 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

Claims Submission (cont.)

Please send paper claims to:

- Optum Behavioral Health
  P.O. Box 30757
  Salt Lake City, Utah 84130-0760

Claims status can be obtained by calling the Claims Customer Service Center:

- Optum – 1-888-980-8728
- Logging into providerexpress.com or UHCprovider.com

Claims Submission Option 1- Online

Log on to providerexpress.com or 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 Form 1500 claim 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/Electronically

Electronic Data Interchange (EDI) is an exchange of information

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 Option 2 - EDI/Electronically (cont.)

You may use any clearinghouse vendor to submit claims

- Payer ID for submitting claims is 87726

Additional information regarding EDI is available on:

- EDI Contacts | UHCprovider.com

and

- UHCprovider.com

Online Claims Submission

- Electronic Data Interchange (EDI) Support Services
  - Provides support for all electronic transactions involving claims and electronic remittances
- EDI Issue Reporting Form
  - This form should be used to report EDI related issues
  - Providers can also call us at 1-800-210-8315 or e-mail us at ac_edi_ops@uhc.com
- UHCprovider.com Help Desk – 1-866-842-3278
  - If a provider experiences technical problems, needs assistance in using UHCprovider.com or has login or User ID/Password issues, they can call the UHCprovider.com Help Desk for support

Optum Pay™

With Optum Pay, you receive electronic funds transfer (EFT) for claim payments, plus your EOBs are delivered online:

- Lessens administrative costs and simplifies bookkeeping
- Reduces reimbursement turnaround time
- Funds are available as soon as they are posted to your account

To receive direct deposit and electronic statements through EPS you need to enroll at myservices.optumhealthpaymentservices.com/registrationSignIn.do

Here's what you'll need:

- Bank account information for direct deposit
- Either a voided check or a bank letter to verify bank account information
- A copy of your practice's W-9 form

If you're already signed up for EPS with UnitedHealthcare Commercial or UnitedHealthcare Medicare Solutions, you will automatically receive direct deposit and electronic statements through EPS for UnitedHealthcare Community Plan when the program is deployed.

*Note: For more information, please call **1-866-842-3278**, option 5 or go to UHCprovider.com > Claims, Billing and Payments > Optum Pay.*

Claims Tips

To Ensure Clean Claims :

- An NPI number and taxonomy code is always required on all claims
- A complete diagnosis is also required on all claims

Claims Filing Deadline

- Providers have 365 days from the date of service to file Medicaid claims
- Any correction requests must be submitted within (1) year of the date of original denial on a paper claim via mail with “CORRECTED CLAIM” noted

Claims Processing

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

Balance Billing

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

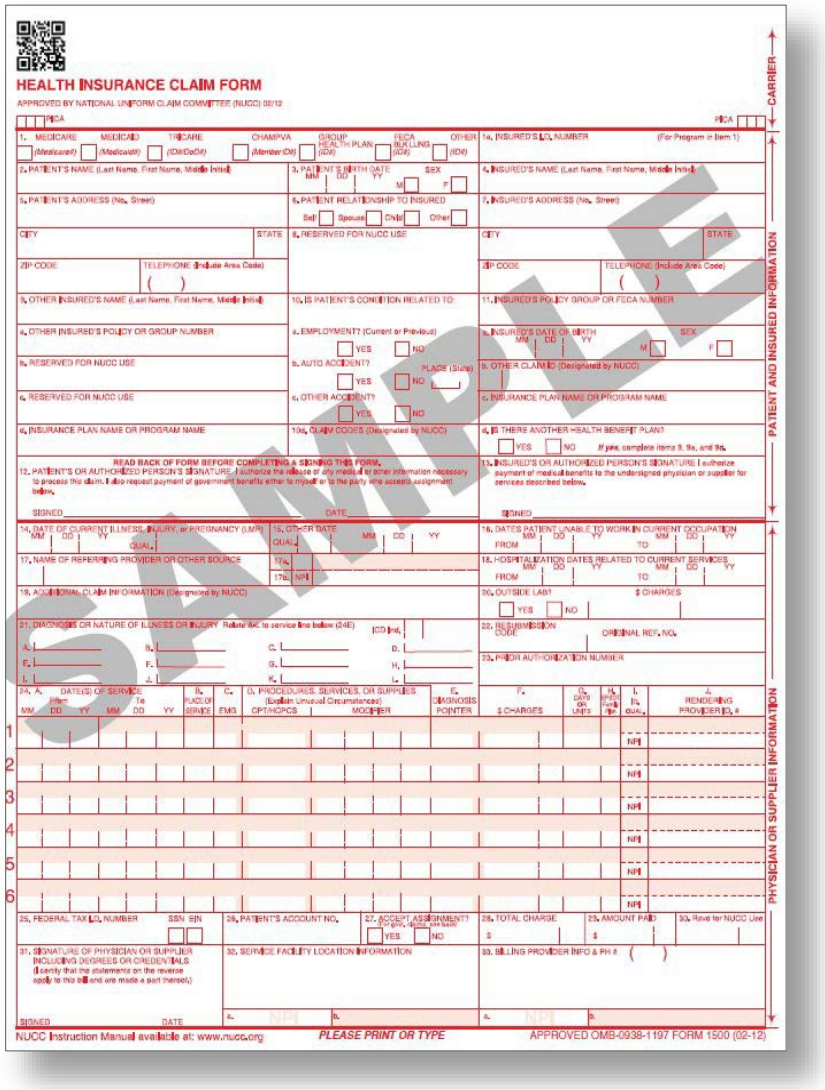
Form 1500 - Claim Form

All billable services must be coded.

- Coding can be dependent on several factors:
  - ❑ Type of service (assessment, treatment, etc.)
  - ❑ Rate per unit (BCBA vs. Paraprofessional)
  - ❑ Place of service (home or clinic)
  - ❑ Duration of therapy (1 hr. vs. 15 min)
  - ❑ One DOS per line

You must select the code that most closely describes the service(s) provided.

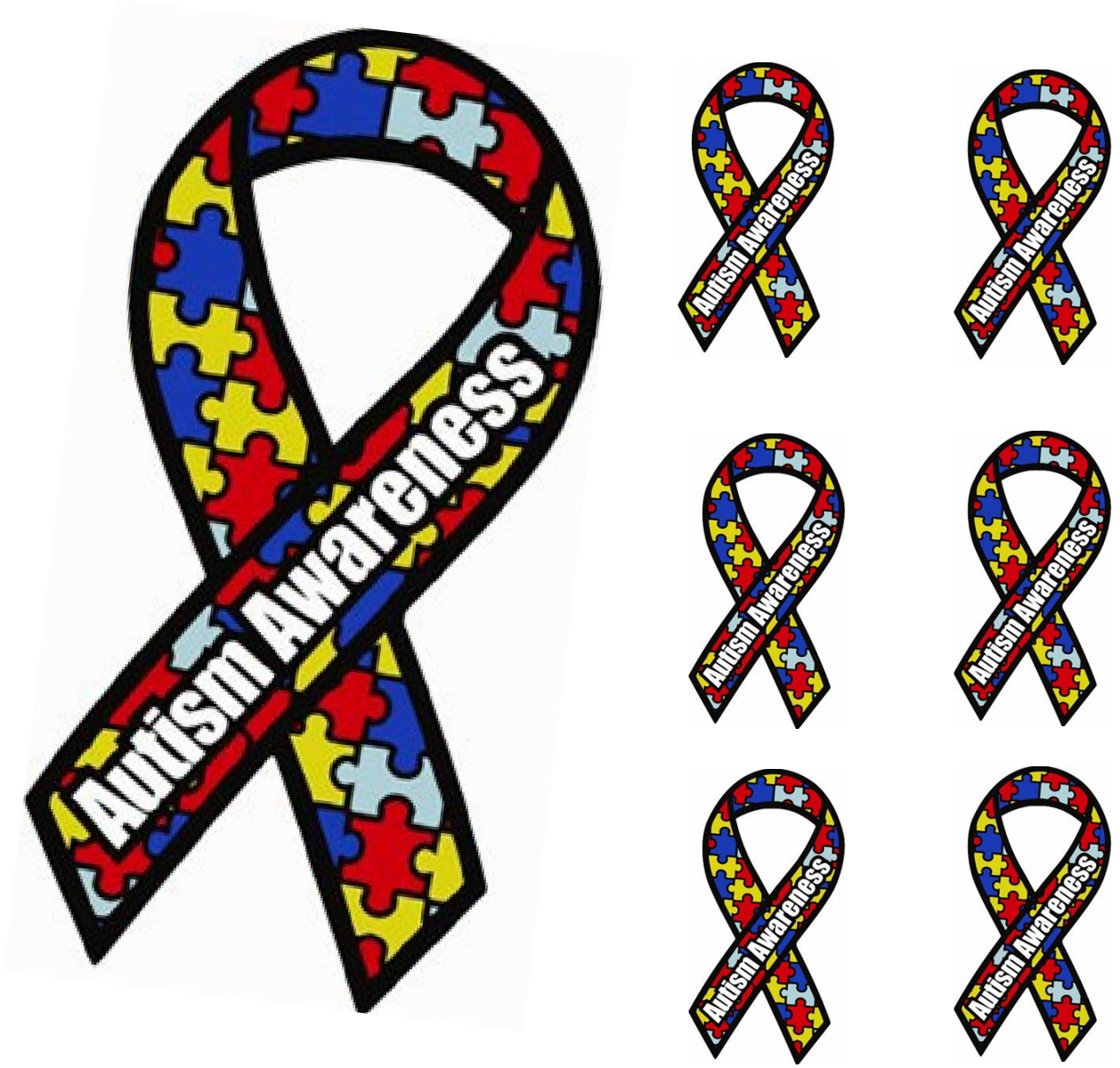
Please note: Field 31 must have a rendering provider name. Rendering supervisor (BCBA/BCBA-D) will bill for all services under the supervisory protocol.



Diagnostic Coding

Guides for Coding:

- DSM-5 defined conditions:
- Current autism diagnosis, F84.0
- A complete diagnosis with all 4 digits is required on all claims utilizing the ICD-10 coding.



Appeals & Grievances

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Appeals

QUEST Integration Providers have 60 days to file an appeal from the date of the Health Plan's notice of action or decision.	
▪ A Reconsideration Form must be submitted to appeal a decision through the Provider Dispute Unit (PDU). If the decision is not in the provider's favor through the reconsideration process, then an appeal needs to be submitted to:	UnitedHealthcare Community Plan Attention: Grievance & Appeals Department 1132 Bishop St., Ste. 400 Honolulu, HI 96813
▪ If the provider is not satisfied with the result of the reconsideration process, the provider may file a provider Claims appeal to the following address:	UnitedHealthcare Community Plan QUEST Integration Grievance & Appeals Department 1132 Bishop St., Ste 400 Honolulu, HI 96813
▪ Providers may also call or email with Claims appeal to:	888-980-8728 HI_AG@UCH.com

Expedited Appeals

- Providers must provide the Health Plan specific details for the expedited appeal

- It is highly recommended that providers call to request an expedited review:
  - 1-888-980-8278 or
  - TTY: 711 for hearing impaired Monday through Friday
  - 7:45 a.m. and 4:30 p.m. HST.

Grievances

Provider grievance can be filed verbally or in writing. To file a grievance, call Provider Services toll free at 1-888-980-8728 or TTY: 711 for hearing impaired, between 7:45 a.m. and 4:30 p.m. HST, Monday through Friday. Written grievances should be sent to:

UnitedHealthcare Community Plan Attention: Grievance & Appeals Department 1132 Bishop St., Ste. 400
Honolulu, HI 96813

Or fax: 1-**844-700-7938**

There is no time limit on filing a grievance

Resources

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providerexpress.com

You can find:

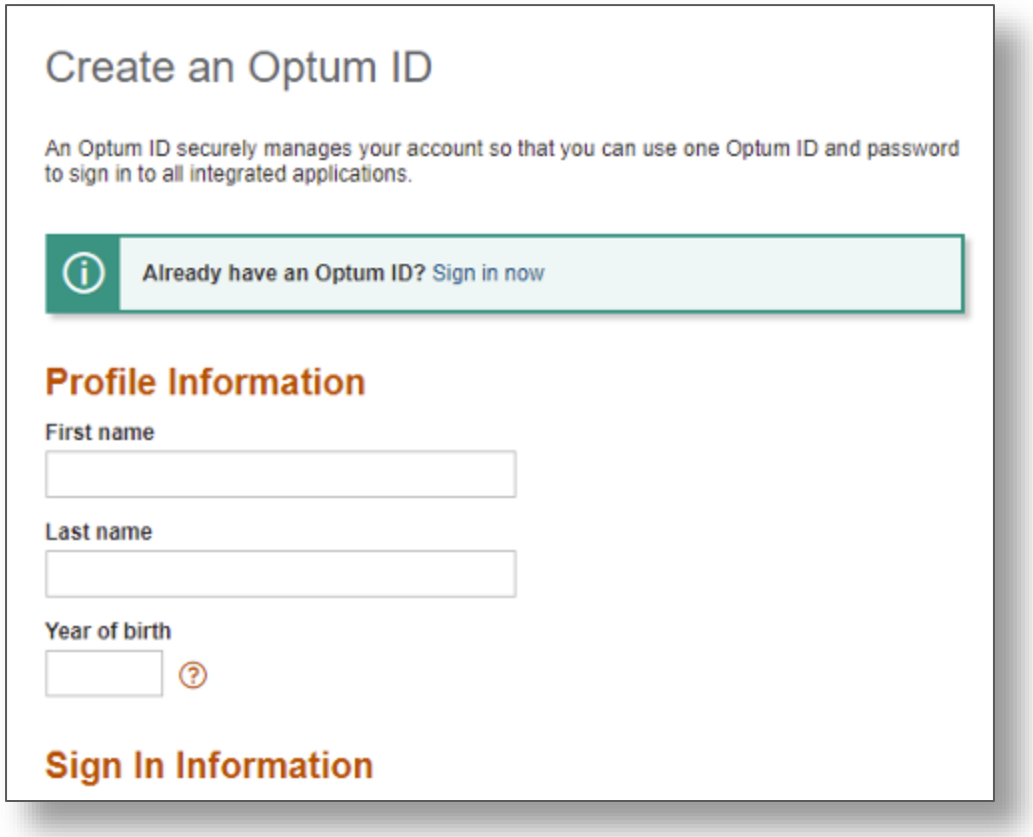
- Level of Care Guidelines
- ABA Clinical Policy
- Best Practices
- Optum Network Manual
- Contact Information
- Common Forms
- Verify Benefits and Eligibility
- Claims Status
- Claim Submission
- Authorization Status

Please contact your assigned Provider Advocate for any practice updates (demographics, etc.)

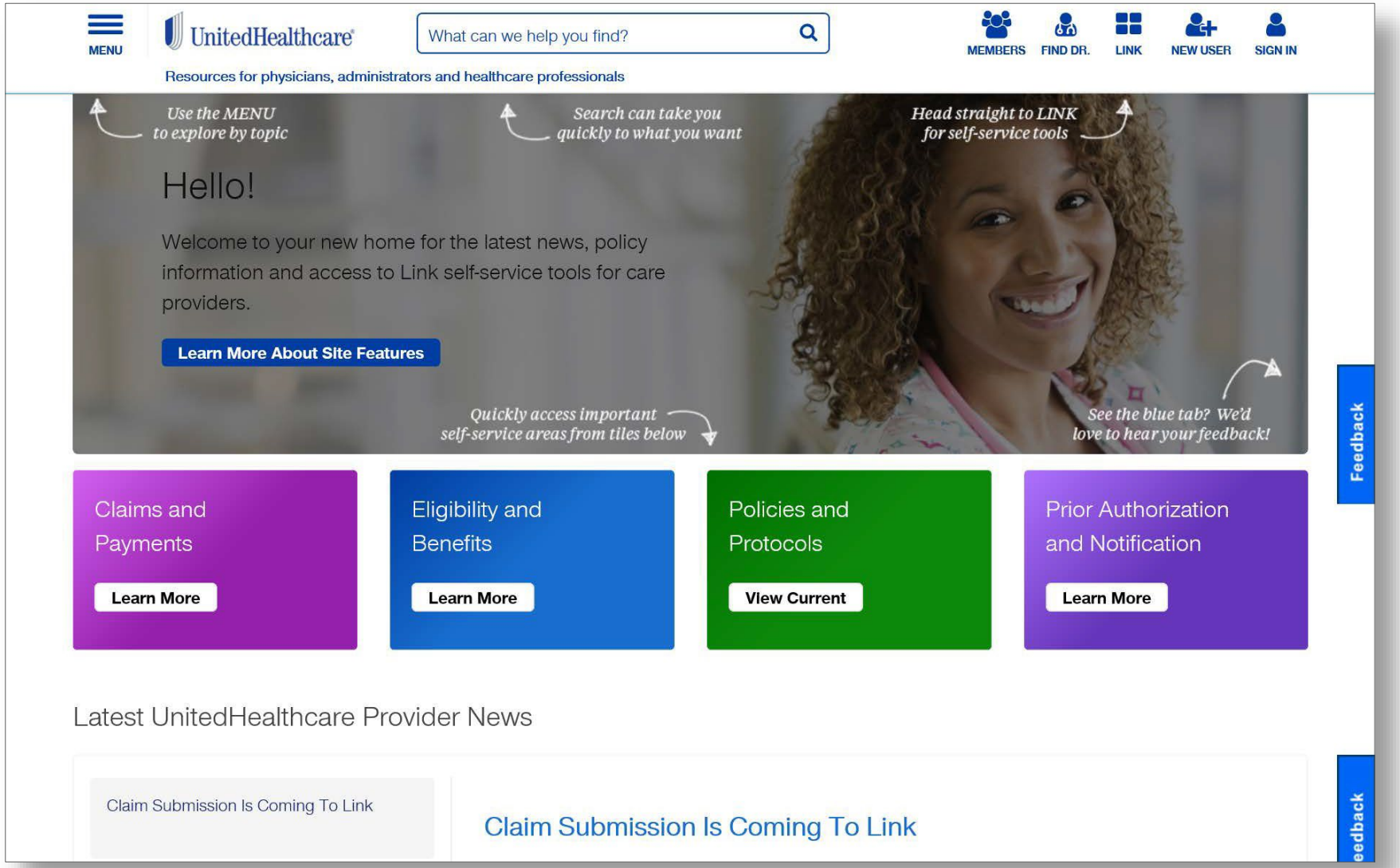
providerexpress.com

providerexpress.com - First Time Users

- Register online for immediate access to secure transactions
- No fees apply
- Provider Express Support Center available from 7:00 a.m. to 9:00 p.m. Central time – toll free at 1-866-209-9320
- Live chat feature also available



UHCprovider.com Provider Website



New User Registration

UHCprovider.com

Provides clinicians with access to the latest news, policy information and to Link self- service tools for care providers

Create an Optum ID

In order to access secure content on UHCprovider.com or to access Link self- service tools to submit claims, verify eligibility or to check for prior authorization requirements, you first need to have an Optum ID that has been connected to the Tax ID of your practice, facility or organization.

Video: Accessing Link via UHCprovider.com

Need an Optum ID?

Please register to create your Optum ID.

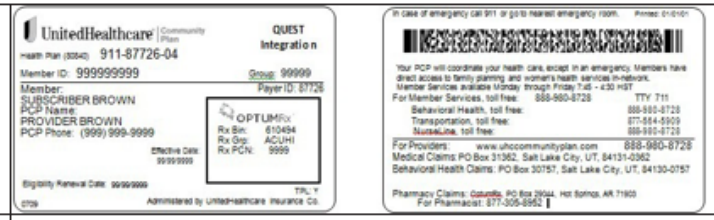
Have an Optum ID, but need to connect a Tax ID?

To start the process, sign in with your Optum ID on UHCprovider.com and click "No" when asked if you received a registration letter that included a security code. From that point, complete the required fields for the form as prompted. For help see the Accessing Link - Quick Reference Guide.

Need help accessing certain applications on Link?

If you are unable to access specific Link Self- Service application using your Tax ID connected Optum ID login, please contact your organization's practice administrator – they are the only ones able to manage and make changes to account access.

Hawaii Quest ABA Provider Quick Reference Guide

ID Card	
Clinician is Responsible for:	Verifying benefits/eligibility online at providerexpress.com or call the Behavioral Health number located on the back of the member's ID card • Obtaining authorization as necessary • Be familiar with the Network Manual, located on our website, providerexpress.com > Guidelines / Policies & Manuals
Prior Authorization	All autism services require prior authorization: • Verify benefits/eligibility online at providerexpress.com or call the Behavioral Health number located on the back of the member's ID card • Prior Authorization can be obtained via Treatment Authorization Request Form and submitted either o Online at https://optumpeeraccess.secure.force.com/ABAtreatment/ o Or via fax at 1-888-541-6691
Claims Paper Submission	Mail paper claims to: • UnitedHealthcare, P.O. Box 30757, Salt Lake City, UT 84130-0760 • All autism provider services must be billed on a Form 1500 • Submission should occur within 365 days of date of service
Electronic Submission	Submit claims online through: • www.unitedhealthcareonline.com • Submit electronically using the EDI clearing house Payer ID 87726
Claim Status	Claims status can be obtained by calling Customer Service Center: • 1-866-980-8728 • Or through the Web portal at providerexpress.com or UHCprovider.com
Claim Appeals	Claim appeals process must be submitted within 60 days of receipt of notice or decision: • Mailed to UnitedHealthcare Community Plan Attention: Appeals & Grievance Department, 1132 Bishop Street, Suite 400 Honolulu, HI 96813 • Fax to 1-844-700-7938 • Emailed to Hi_aq@uhc.com
Update Practice Info	You can update your practice information by contacting your designated Autism Network Manager.
Disclaimer	Information contained herein is subject to change. Please contact your Network Manager with any questions.
Network Management	Elianet Montejo Morell, Specialty Network Manager Email: Elianet.montejo.morell@optum.com

Helpful Websites

To get an NPI number:

- NPPES (hhs.gov)

To learn more about HIPAA:

- HIPAA Home | HHS.gov

To learn more about Tax IDs or Employee IDs:

- irs.gov

Optum provider website:

- providerexpress.com
- Claim Tips: Provider Express > Quick Links > Claim Tips
- Claim Forms: Provider Express > Quick Links > Forms > Optum Forms - Claims

Autism Votes website:

- Advocate | Autism Speaks

Helpful Websites cont.

Hawaii Med-QUEST Division (MQD) revised memorandum

- medquest.hawaii.gov/en.html

Hawaii Quest Integration 2018 Provider Manual

- uhcprovider.com/en/health-plans-by-state/hawaii-health-plans/hi-comm-plan-home.html

To learn more about HIPAA

- hhs.gov/hipaa/index.html

Provider and Member Resources

An extensive condition-based library covering key behavioral and medical topics can be found on liveandworkwell.com under the Health and Well-Being Center within BeWell.

- Abuse & Neglect: Child
- Abuse: Domestic Violence
- Abuse & Neglect: Elder
- ADHD (Adult)
- ADHD (Youth)
- Alzheimer's & Dementia
- Anxiety
- Arthritis
- Asthma
- Autism
- Bipolar (Adult)
- Bipolar (Youth)
- Cancer
- Childhood Illness
- Chronic Pain
- Depression (Adult)
- Depression (Youth)
- Diabetes
- Eating Disorders (Adult)
- Eating Disorders (Youth)
- Heart Disease/Circulatory
- HIV
- Infertility
- Obesity
- Personality Disorders
- Obsessions & Compulsions
- Phobias
- Postpartum Depression
- Post-Traumatic Stress Disorder
- Schizophrenia (Adult)
- Schizophrenia (Youth)
- Sexual Problems
- Stress
- Traumatic Brain Injury 51

Key Terms: General

- NPI
- CPT
- HCPCS
- HIPAA
- Form 1500
- HCFA 1500
- CMS 1500
- Modifiers
- Units
- Prior authorization
- Signature on file

- DSM-5 diagnosis
- ICD-10 diagnosis code
- Subscriber ID or Member ID
- Dependent
- Policy or Group Number
- TIN or EIN
- Place of Service
- Diagnosis Pointer
- Fee schedule
- Par/Non-Par
- SPD/COC

Key Terms: Completing Claim Forms

- Type of plan box
- Patient name
- Dependent
- Subscriber ID or Member ID
  Signature on File
- Patient address
- Policy or Group Number
- Prior authorization
- DSM-5 diagnosis
- ICD-10 diagnosis code
- ICD indicator
- Dates of Service
- Place of Service
- Procedure Code
- Modifiers
- Diagnosis Pointer
- Charges (total)
- Units
- NPI and Provider ID
- TIN or EIN
- Accept assignment
- Total charge
- Amount paid by patient
- Balance due