Optum | CardinalCare
Virginia's Medicaid Program

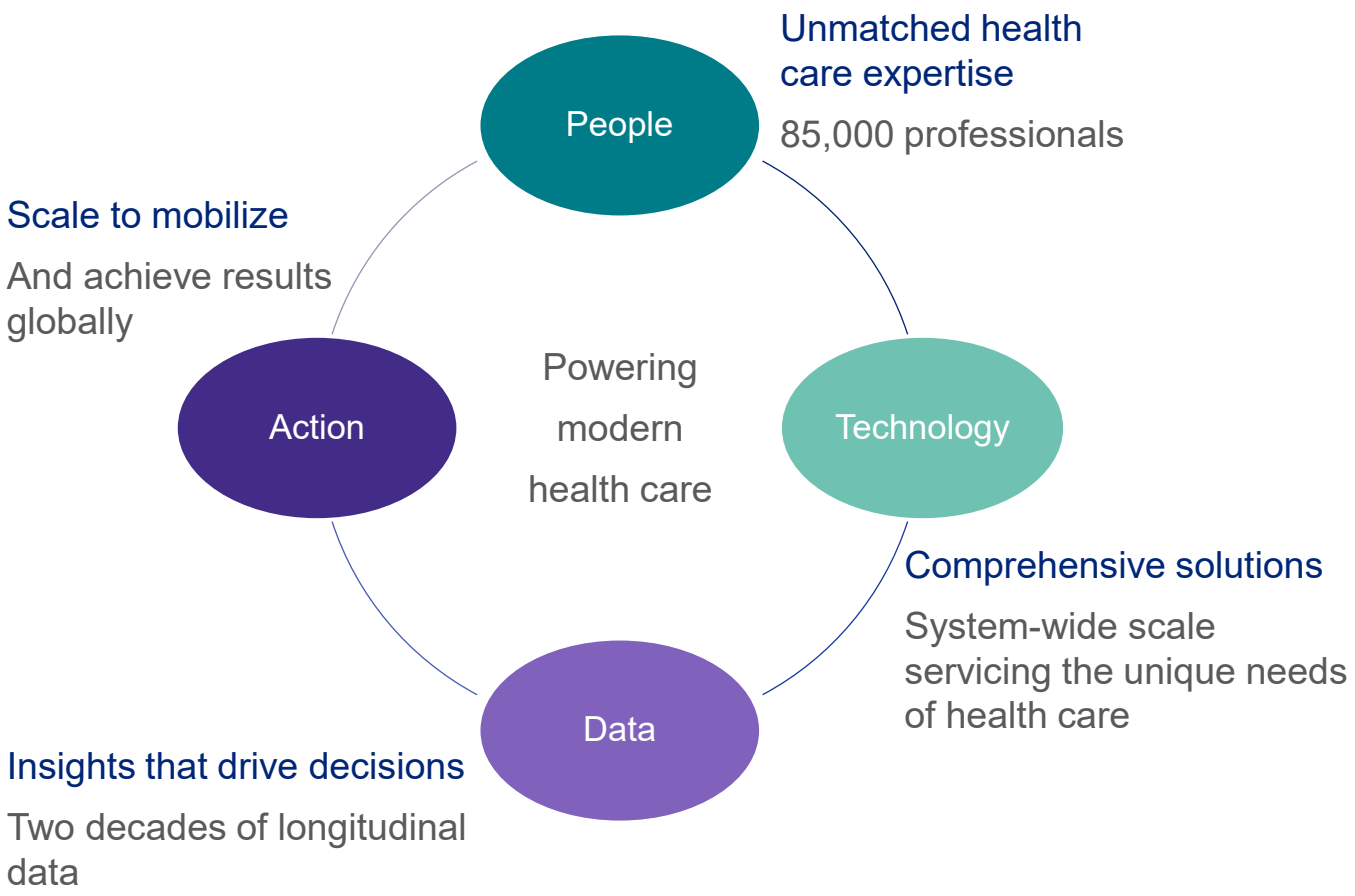
VA Medicaid Bravo Phase II

ABA Provider Orientation

Optum with UnitedHealthcare Community Plan Virginia

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

UNITEDHEALTH GROUP®

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

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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

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Optum VA Medicaid Bravo Phase II ABA Program Member Information

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Member ID card

- Will be 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

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 VA Medicaid MHS ABA services, a client must meet both of the following criteria:

- Be under the age of 21
- Be covered under VA Medicaid MHS ABA Program

AND meet the following criteria:

- Have a current DSM dx that is relevant to the need for behavioral therapy or has a provisional psychiatric diagnosis

VA Medicaid Bravo Phase II ABA Program Services

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VA Medicaid Bravo Phase II 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
- 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

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VA Medicaid Bravo Phase II ABA provider credentialing criteria (2 of 2)

ASD Groups

- Sign up for the portal at [Home - Department of Medical Assistance Services (virginia.gov)]
- 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)

Steps in Providing Treatment

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Clinical Team: VA Medicaid Bravo Phase II ABA program

Dedicated Autism Clinical Team

There is a dedicated ABA clinical team that will be supporting the VA Medicaid Bravo Phase II 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

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

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
- When calling the Autism Care Advocate, you must have:
  - ❑ Member's name
  - ❑ ID #
  - ❑ Date of birth
  - ❑ Address

Assessment/Treatment Request requirements

- Prior authorization not required for initial assessment
- Prior Authorization obtained by utilizing the portal on providerexpress.com
- 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.

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

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)

ABA Initial Authorization Request and Continued Stay forms

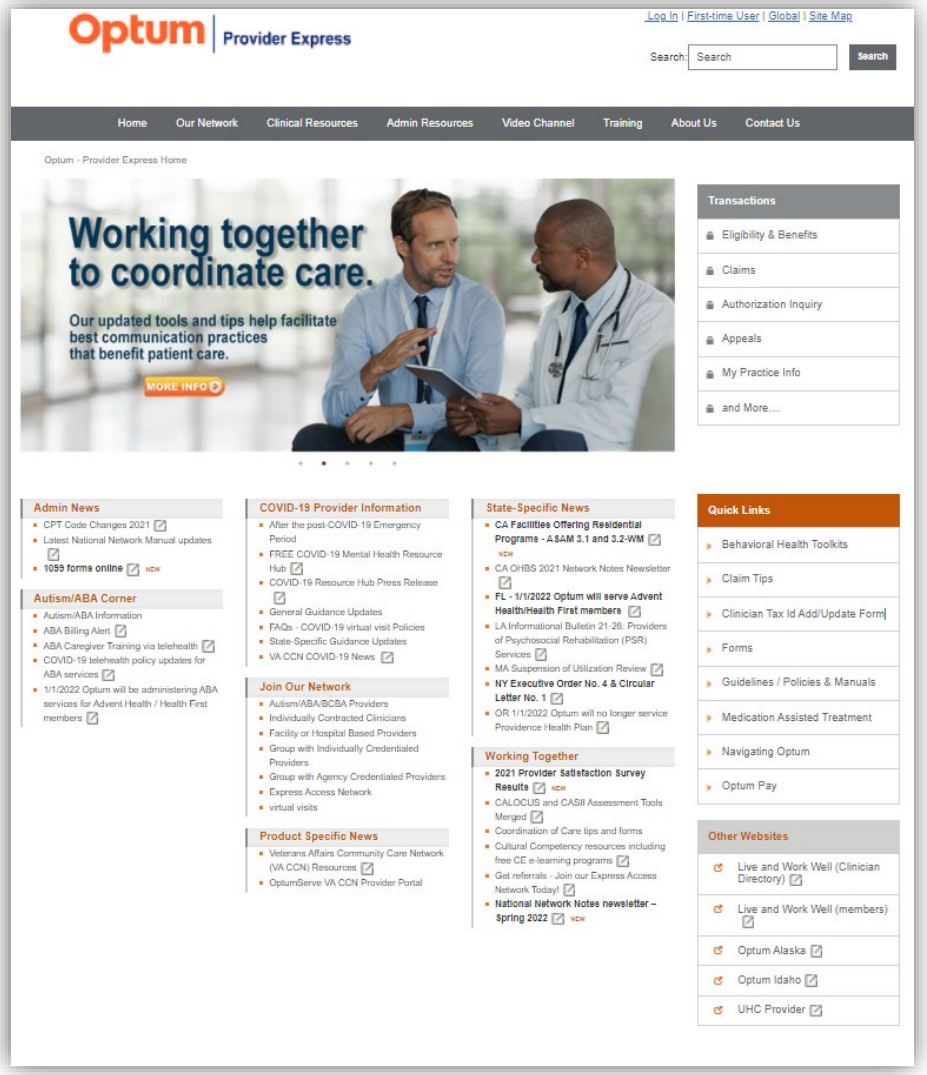
Forms are available on the Autism ABA Corner on providerexpress.com

- Initial assessments do not require an authorization, but ongoing assessments do
- Submit forms via portal within 14 business days
- electronicforms.force.com/ABATreatment

Prior Assessment Authorization – online portal submission

providerexpress.com >
Autism/ABA Information

Prior Authorization forms



VA MEDICAID ABA program

Coding, Billing and Reimbursement

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VA Medicaid Bravo Phase II ABA Program provider fee schedule

UNITED BEHAVIORAL HEALTH			
Billing Code	Modifier	Service Description	Units
97151	HO	Individual Assessment	15 min
97151	TF	Individual Assessment	15 min
97151	HN	Individual Assessment	15 min
97152	HN	Individual Assessment	15 min
97152		Individual Assessment	15 min
97153	HO	Individual Treatment	15 min
97153	TF	Individual Treatment	15 min
97153	HN	Individual Treatment	15 min
97153		Individual Treatment	15 min
97154	HO	Group Treatment	15 min
97154	TF	Group Treatment	15 min
97154	HN	Group Treatment	15 min
97154		Group Treatment	15 min
97155	HO	Individual Treatment	15 min
97155	TF	Individual Treatment	15 min
97155	HN	Individual Treatment	15 min
97156	HO	Family Training	15 min
97156	TF	Family Training	15 min
97156	HN	Family Training	15 min
97157	HO	Group Family Training	15 min
97157	TF	Group Family Training	15 min
97157	HN	Group Family Training	15 min
97158	HO	Group Treatment	15 min
97158	TF	Group Treatment	15 min
97158	HN	Group Treatment	15 min
0362T	HO	Team Functional Analysis	15 min
0362T	TF	Team Functional Analysis	15 min
0362T	HN	Team Functional Analysis	15 min
0373T	HO	Team Modified Treatment	15 min
0373T	TF	Team Modified Treatment	15 min
0373T	HN	Team Modified Treatment	15 min

1	QMHP: Qualified Mental Health Professional (QMHP), QMHP-Child, QMHP-Eligibile (the same as Board of Counseling QMHP-trainee)
2	CSAC/S: Certified Substance Abuse Counselor or Certified Substance Abuse Counselor Supervisee LMHP Type: Licesnsed Mental Health Professions (LMHP), LMHP-Resident, LMHP-Resident in Psychology, or LMHP-Supervisee
3	Technician level includes LMHP-Rs, LMHP-RPs. LMHP-Ss, Registered Behavior Technician (RBT's) and other unlicensed lvel staff.
4	Modifier Descriptions HO Licensed Behavior Analysts TF Licesnsed Mental Health Professional HN Licensed Assistant Behavior Analyst

Claims submission

Required Claim Forms:

- Form 1500 claim form

Electronic Claims Payer ID: 87726

Please send paper claims to:

- Optum
  P.O. Box 5270
  Kingston, NY 12402-5270

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

- Optum – 1-877-843-4366, Fax: 1-855-368-1542

Claims submission (cont.)

- 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
- 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 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 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.)

Additional information regarding EDI is available on:

- EDI Contacts | UHCprovider.com

and

- UHCprovider.com

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 Optum Pay 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 Optum Pay with UnitedHealthcare Commercial or UnitedHealthcare Medicare Solutions, you will automatically receive direct deposit and electronic statements through Optum Pay 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 remember:

- An NPI number and taxonomy code is always required on all claims
- A complete diagnosis is also required on all claims
- The rendering provider's 10-digit NPI is required in box 24J and must be enrolled in VA ABA Medicaid Network. (The rendering provider is the BCBA/Licensed Clinician)

Claims Filing Deadline

- Providers have 365 days from the date of service to file Medicaid claims

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

Examples of coding Issues related to claims 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/incorrect
- Required authorization missing
- Units exceed authorization (e.g., 10 inpatient days were authorized, facility billed for 11 days)

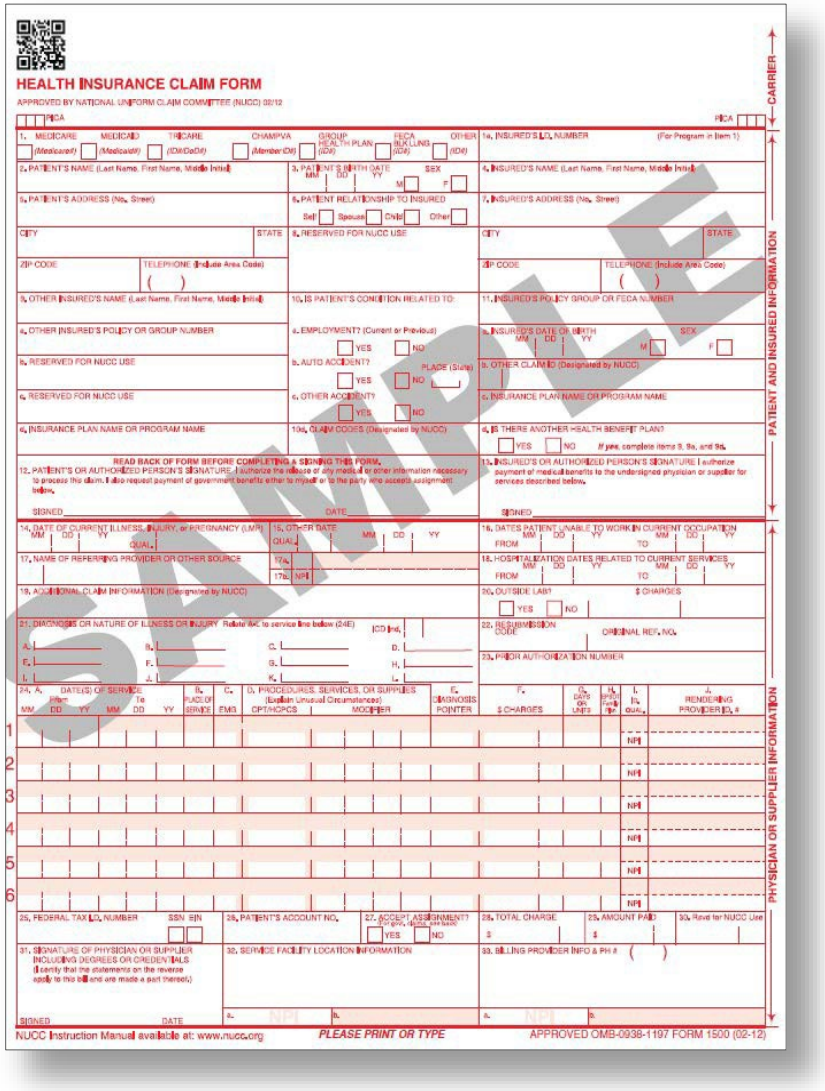
Claims Submission Option 3 – hardcopy

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 follow billing instructions provided by your Network Manager based on your contract and system set-up.



Diagnostic coding

Guides for Coding:

- DSM-5 defined conditions
- Current DSM dx that is relevant to the need for behavioral therapy or has a provisional psychiatric diagnosis
- A complete diagnosis with all 4 digits is required on all claims utilizing the ICD-10 coding.

Appeals and Grievances

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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 Par 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, UHCCP 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 Non-Coverage 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 appeal relating 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 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 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 the United 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

Resources

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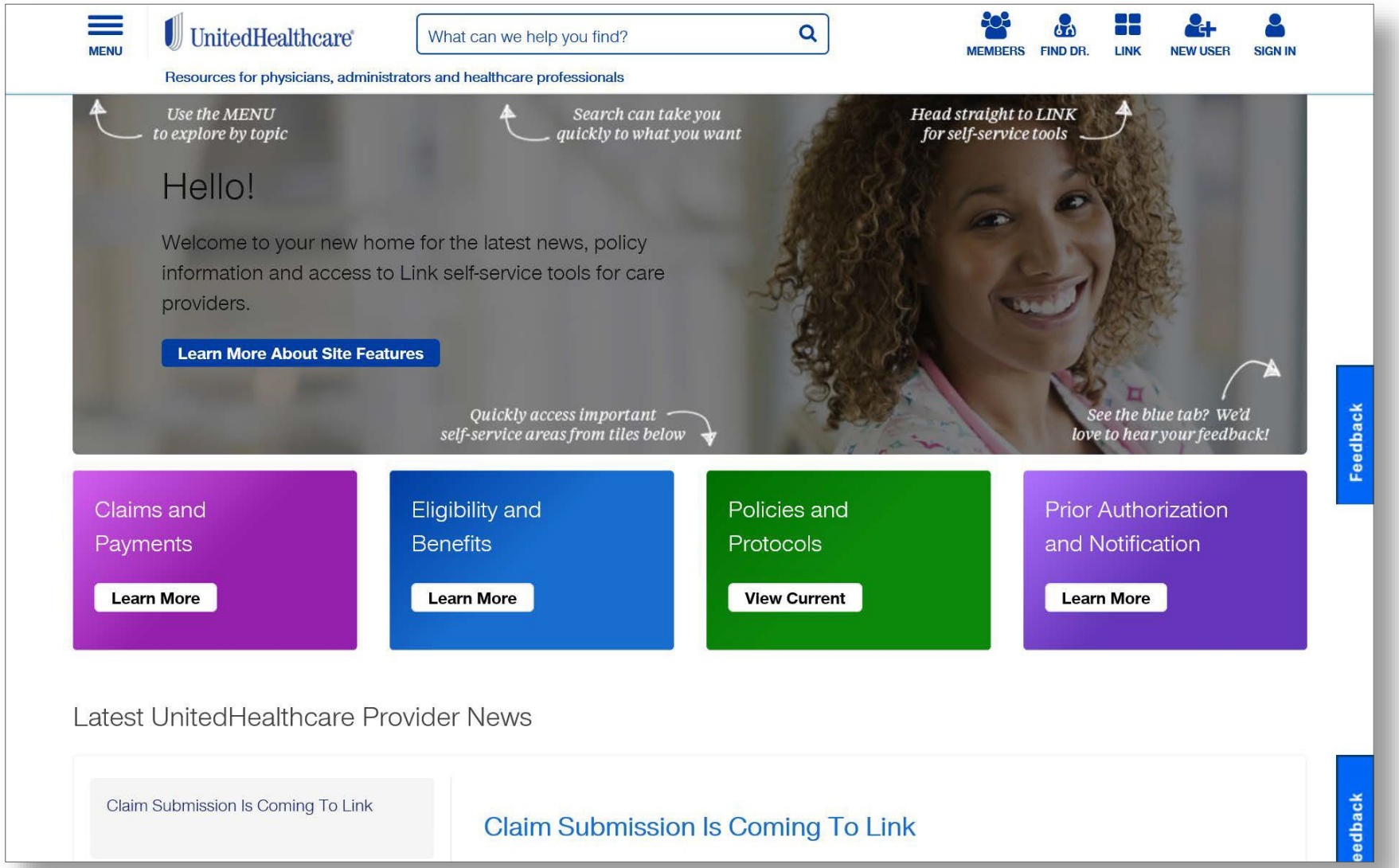
UHCprovider.com provider website



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 a One Healthcare 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 a One Healthcare ID that has been connected to the Tax ID of your practice, facility or organization.

Video: Accessing Link via UHCprovider.com

Need a One Healthcare ID?

Please register to create your One Healthcare ID.

Have a One Healthcare ID, but need to connect a Tax ID?

To start the process, sign in with your One Healthcare 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 UnitedHealthcare Provider Portal?

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

Quick Reference Guide

Optum

VA Medicaid EPSDT ABA Program

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 • Being familiar with the Network Manual located on our web site: providerexpress.com >Guidelines / Policies & Manuals> Network Manual
Prior Authorization	All autism services require prior authorization, except for initial assessment, 97151 & 97152: • 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 1-855-268-1542
Claims Paper Submission	Mail paper claims to: • United Healthcare, P.O. Box 5270, Kingston, NY 12402 • 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: • providerexpress.com • Payer ID for submitting claims is 87726
Claim Status	Claims status can be obtained by calling Customer Service Center: • 1-877-843-4366 • Or through the Web portal at uhcprovider.com
Claim Appeals	Claim appeals should be sent to: • Optum, Appeals and Grievances, P.O. Box 31364, Salt Lake City, UT 84131-0364 • Or via fax at 1-855-368-1542
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	Melanie Bishop, Specialty Network Manager Email: Melanie.r.bishop@uhc.com

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