



Provider Orientation: New York Medicaid and Wellness4Me

September & October 2015

United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum

Today's speakers

- Joyce B. Wale, LCSW, Executive Director, Behavioral Health
- Lisa Camardo, Director of NY Behavioral Health Operations
- Lana Kats, MBA, Director of Network Management for NY Public Sector
- Adrene Cohen, RN, MA, MPA, FACHE, Northeast Regional Director, Accountable Care Programs and Health Homes
- Seth Mandel, MD, MBA, Behavioral Health Medical Director, Wellness4Me
- Peg Elmer, LCSW, Clinical Director, Wellness4Me
- Margaret Sullivan, RN, MSN, Clinical Director, Mainstream Medicaid
- Barbara Tedesco, MS, CRC, Recovery and Resiliency Manager
- Gayle Parker-Wright, LCSW-R, Network Trainer
- Eunice Hudson, Provider Education Specialist
- Allandro Pierre, MHA, Network Manager
- Missy Lerma, LCSW, Director of Network Management

Agenda

- Welcome and Introduction
 - Overview of Optum and UnitedHealthcare Community Plan
 - Health Homes
 - Benefits
 - Clinical Vision
 - Clinical and Utilization Management Requirements
 - Cultural Competency
 - Quality Improvement
 - Credentialing and Recredentialing
 - Recovery and Resiliency
 - Billing
 - Provider Express and UnitedHealthcare Online
 - Network Services
-

UnitedHealthcare Community Plan

UnitedHealthcare Community Plan (Community Plan)

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

Introduction to Optum

United Behavioral Health (UBH) was officially formed on February 2, 1997, via the merger of U.S. Behavioral Health, Inc. (USBH) and United Behavioral Systems, Inc. (UBS)

United Behavioral Health, operating under the brand Optum, is a wholly owned subsidiary of UnitedHealth Group

- Optum is a health services business
- You will see UBH, UBH I.P.A. and Optum in our communications to you

We are dedicated to making the health system better for everyone. For the individuals we serve, you play a critical role in our commitment to helping people live their lives to the fullest.

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 ethics

Walk in the shoes of 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

Managed care transition

- The NYS Office of Mental Health (OMH) is collaborating with the Department of Health (DOH) and Office of Alcoholism and Substance Abuse Services (OASAS) to implement the managed care transition in response to the recommendations and guiding principles set forth by the Medicaid Redesign Team (MRT) Behavioral Health (BH) Subcommittee
- The vision is to create a system that provides New Yorkers with fully integrated behavioral and physical health services offered within a comprehensive, accessible and recovery oriented system
 - For adults 21 and older, the integration of all Medicaid behavioral health (BH) and physical health (PH) benefits under managed care will go into effect **October 2015 in NYC** and on **July 2016 in the rest of New York State** and will be delivered through **two BH managed care models**

Managed care transition, continued

Managed care models:

- **Qualified Mainstream Managed Care Organizations (MCOs):** For all adults served in mainstream MCOs throughout the State, the qualified MCO will integrate all Medicaid State Plan covered services for mental illness, substance use disorders (SUDs), and physical health conditions
- **Health and Recovery Plans (HARPs):** HARPs will manage care for adults with significant behavioral health needs
 - They will facilitate the integration of physical health, mental health, and substance use services for individuals requiring specialized expertise, tools, and protocols which are not consistently found within most medical plans
 - In addition to the State Plan Medicaid services offered by mainstream MCOs, qualified HARPs will offer access to an enhanced benefit package comprised of **Home and Community Based services (HCBS)** designed to provide the individual with a specialized scope of support services not currently covered under the State Plan

Managed care transition, continued

The Managed Care System is being developed based on the Medicaid Redesign Team (MRT) guiding principles

- Person-Centered Care management
- Integration of physical and behavioral health services
- Recovery oriented services
- Patient/Consumer Choice
- Ensure adequate and comprehensive networks
- Tie payment to outcomes
- Track physical and behavioral health spending separately
- Reinvest savings to improve services for BH populations
- Address the unique needs of children, families & older adults

Wellness4Me (Health and Recovery Plan, HARP): phase 1

- **Starting October 1, 2015** both the Mainstream Medicaid and **Wellness4Me Plan** (HARP) benefits will be rolled out
- These products are for members who are 21 years and older residing in the 5 boroughs of New York City
 - It will be phased in over a 3 month period
- Home and Community Based Services (HCBS) for Wellness4Me members will begin **January 1, 2016**
- Membership by Borough / County
 - Bronx = Bronx County
 - Brooklyn = Kings County
 - Queens = Queens County
 - Manhattan = New York County
 - Staten Island = Richmond County

Wellness4Me Plan (HARP): phases 2 & 3

Phase 2

- **July 1, 2016:** includes all adults 21+ years old, in the rest of state
 - All New York State, eligible adults 21 and older, who meet the criteria can be enrolled in the Wellness4Me Plan

Phase 3

- **January 1, 2017:** all adults under 21 years old, adolescents and children in New York City (5 Boroughs), Nassau and Suffolk
- **July 1, 2017:** all adults under 21 years old, adolescents and children in the rest of state

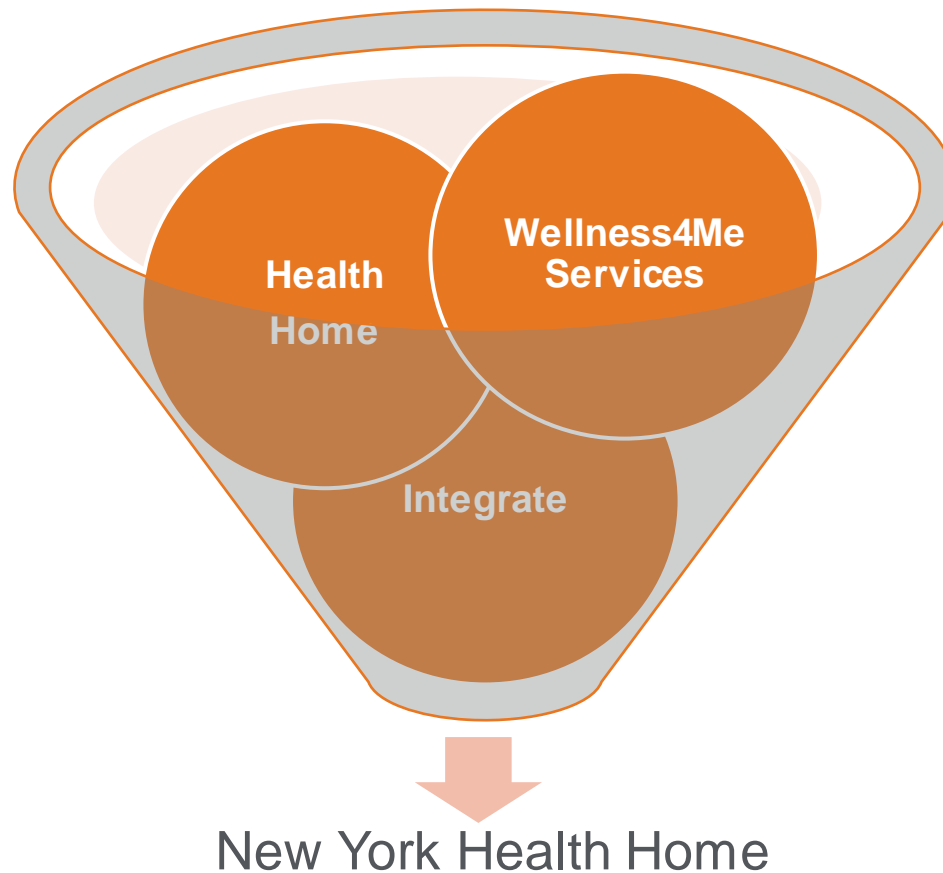
Understanding Wellness4Me

- Wellness4Me is a new UnitedHealthcare Community Plan product for HARP-eligible members
- A member cannot be enrolled in the UnitedHealthcare Wellness4Me Plan and a Managed Medicaid Plan – **The member must choose one plan**
- The member must clinically qualify for Wellness4Me Plan based on the results of the New York State (NYS) Community Mental Health Assessment (needs assessment)
- NYS will “passively” enroll Community Plan members into the Wellness4Me Plan based on diagnosis and claims history
- Members can “**opt out**” of joining the Wellness4Me Plan and enroll in the Managed Medicaid plan within the first 90 days of enrollment
- Members can dis-enroll from either benefit within the first 90 days of enrollment
 - **After 90 days**, members must have a good reason to dis-enroll (e.g., moved out of the service area)

Wellness4Me Health Homes and Care Coordination

Adrene Cohen, RN, MA, MPA, FACHE, Northeast Regional Director,
Accountable Care Programs and Health Homes

Wellness4Me Care Coordination and Health Homes



Populations Health Homes serve

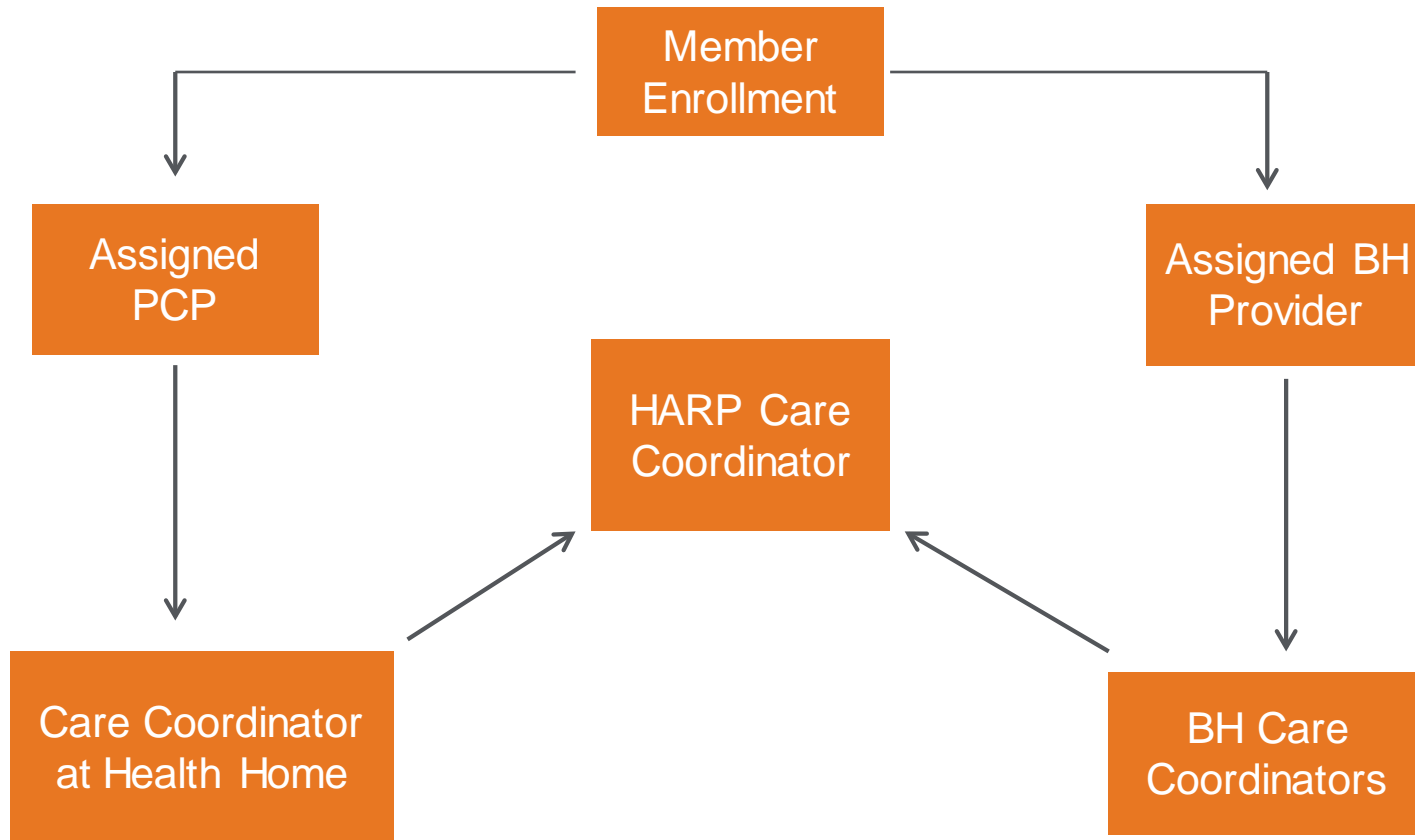
- Individuals who are experiencing a severe disability or mental illness
- High risk homeless
- Medication Assisted Therapy (MAT)
- Members seeking permanent housing and a sense of community
- Transition from jail/prison
- Court-ordered community dwellers
- Members with complex medical conditions such as obesity, diabetes, asthma, HIV, congestive heart failure, etc.

What is a Health Home?

The six (6) core Health Home functions mandated by the Patient Protection Act are:

Operational Priorities	Medical	Behavioral	Social
Transition of care	X	X	X
Care coordination	X	X	X
Referral management	X	X	X
Individual care	X	X	X
Health promotion	X	X	X
Care support for family/caregiver	X	X	X

Overview of the process



Care Coordination

- Care Coordination will include:
 - Documentation of a Plan of Care by the behavioral and medical care team in one document
 - The Care Plan will indicate the activities and strategies to achieve stated care goals for the member
 - The interdisciplinary team that is created from the collaboration among providers facilitates the integration of care

Documentation

Documentation will reside in a platform that is shared and provides reports

- The reports will facilitate tracking of
 - Referrals
 - Met/unmet goals
 - Appointments scheduled 90 days post hospitalization or emergency department visit
 - Hospitalizations or emergency department visits and 7 day follow-up
 - High-risk comorbid members for hospital avoidance
 - Alerts and other activities

Goals of Health Homes

- To use data to monitor member's status
- To avoid service duplication
- To identify members who require care coordination or HARP services upon discharge
- To identify members who have not seen their PCP/Health Homes
- To create metrics that facilitate monitoring and evaluation
- To reduce cost

UnitedHealthcare Accountable Care Team

Program Managers are Registered Nurses

- Work on care transitions
- Work with Community Health Workers (CHWs) to engage members with a Health Home
- Train Health Homes/Coordination Management Agencies (CMAs) in care needs and provider contact




Wellness4Me, Mainstream Medicaid and Benefits
Lana Kats, MBA, Director of Network Management for NY Public Sector

Wellness4Me Plan (HARP) and Mainstream Medicaid

Covered Benefits for Wellness4Me and Mainstream Medicaid		
Services	Wellness4Me	Mainstream Medicaid
Medically Supervised Outpatient Withdrawal (OASAS Services)	Covered	Covered
Outpatient Clinic and Opioid Treatment Program (OTP) Services (OASAS Services)	Covered	Covered
Outpatient Clinic Services (OMH Services)	Covered	Covered
Comprehensive Psychiatric Emergency Program	Covered	Covered
Continuing Day Treatment	Covered	Covered
Partial Hospitalization	Covered	Covered
Personalized Recovery-Oriented Services (PROS)	Covered	Covered
Assertive Community Treatment (ACT)	Covered	Covered
Intensive Case Management/Supportive Case Management	Covered	Covered
Inpatient Hospital Detoxification (OASAS Service)	Covered	Covered
Inpatient Medically Supervised Inpatient Detoxification (OASAS Service)	Covered	Covered
Inpatient Treatment (OASAS Service)	Covered	Covered
Rehabilitation Services for Residential SUD Treatment Supports (OASAS Service)	Covered	Covered
Inpatient Psychiatric Services (OMH Service)	Covered	Covered
Crisis Intervention	Covered	Covered

Membership cards: New York Medicaid, front of card

 **UnitedHealthcare**[®] | Community Plan

Health Plan (80840) 911-87726-04

Member ID: 000000236 Group Number: NYCDFHP


Member:

CIN#:

PCP Name:

PCP Phone:

Payer ID: 87726

 **OPTUMRx**[™]

Rx Bin: 610494
Rx Grp: ACUNY
Rx PCN: 9999

0501

UnitedHealthcare Community Plan for Adults
Administered by UnitedHealthcare of New York, Inc.

Membership cards: New York Medicaid, back of card

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

Printed: 06/10/15

This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website myuhc.com/communityplan or call.

For Members:	800-493-4647	TTY 711
NurseLine:	877-597-7801	TTY 711

For Providers :	uhccommunityplan.com	866-362-3368
Medical Claims:	PO Box 5240, Kingston, NY, 12402-5240	

Pharmacy Claims: OptumRXPO Box29044,HotSprings,AR 71903
For Pharmacists: 877-305-8952


Wellness4Me Plan (HARP) vs. Behavioral Health Benefit

The Home and Community Based Services are ONLY available to members enrolled in Wellness4Me Plan (HARP).

HCBS will not start until 1/1/2016 to allow time for all HARP members to receive their full assessment and for Plans of Care to be documented.

HCBS Services for Adults Meeting Targeting and Functional Needs		
Services	Wellness4Me	Mainstream Medicaid
Rehabilitation • Psychosocial Rehabilitation • Community Psychiatric Support and Treatment (CPST)	Covered	Not Covered
Empowerment Services - Peer Supports	Covered	Not Covered
Habilitation • Habilitation • Residential Supports in Community Settings	Covered	Not Covered
Family Support and Training	Covered	Not Covered
Employment Supports • Pre-vocational • Transitional Employment • Intensive Supported Employment • On-going Supported Employment	Covered	Not Covered
Education Support Services	Covered	Not Covered
Respite • Short-term Crisis Respite • Intensive Crisis Respite	Covered	Not Covered
Non-Medical Transportation	Covered	Not Covered

Membership cards: New York Wellness4Me, front of card

 **UnitedHealthcare**® | Community Plan

Health Plan (80840) 911-87726-04

Member ID: 000000238 Group Number: NYWEL4ME


Member:

CIN#:

PCP Name:

PCP Phone:

Payer ID: 87726

 **OPTUMRx**™

Rx Bin: 610494
Rx Grp: ACUNY
Rx PCN: 9999

0501

UnitedHealthcare Community Plan - Wellness4Me
Administered by UnitedHealthcare of New York, Inc.

Membership cards: New York Wellness4Me, back of card

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

Printed: 06/10/15

This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website myuhc.com/communityplan or call.

For Members: 866-433-3413 TTY 711

NurseLine: 877-597-7801 TTY 711

For Providers : uhcommunityplan.com 866-362-3368
Medical Claims: PO Box 5240, Kingston, NY, 12402-5240

Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 877-305-8952

Clinical Vision

Seth Mandel, MD, MBA, Behavioral Health Medical Director, Wellness4Me

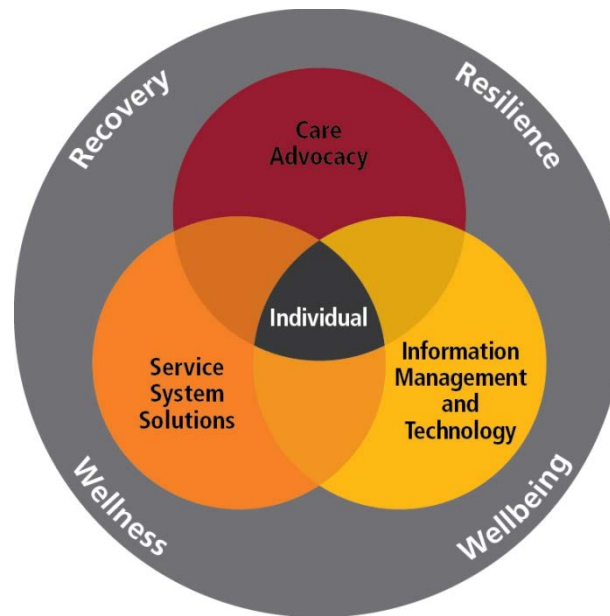
Our Clinical Vision

Care Advocacy

The purpose of Care Advocacy is intervention on behalf of individuals living with a health issue. We improve the experience of individuals we serve, using a range of tools and resources. We are dedicated to recovery, resiliency, wellness and wellbeing provided at the highest quality and most cost-effective manner.

Service System Solutions

The purpose of Service System Management is to improve the structure of, access to and practice within systems of care. We build relationships within local communities to learn about and improve healthcare systems.



Information Management and Technology

The purpose of Information Management and Technology is to create a more engaging, effective and affordable healthcare experience and to empower individuals in their pursuit of well-being.

Our goals

Recovery Focus

- Apply recovery principles from first call through natural community supports
- Support use recovery language and principles in every aspect of our work

Improve Access to Care

- Right care at the right time
- Collaborate with providers to ensure timely access to services
- Increase community-based services

Integrate Physical and Behavioral Health

- No wrong door access to care
- Eliminate silos through integrated person-centered care plans
- Broaden provider focus for integrating care

Reduce Cost

- Reduce readmissions to inpatient
- Engage community based crisis stabilization and use of PCP services
- Increase use of natural community supports

Tools for system transformation

Utilization Management

- Review requests for service against LOCG's /LOCADTR:
 - Prior Notification
 - Pre-Certification
 - Prior Authorization
 - Concurrent Review
 - Transition Planning for successful discharge

Care Coordination

- Follow-up support after discharge
- Risk assessment and safety planning
- Coordination with community resources
- Support member's recovery goals
- Engagement of member, family, and other support systems in development of care plan

Person-Centered Care

- Align closely with Health Home and Accountable Care Teams
- Care plans include:
 - Strength-based assessment, including culture
 - Measurable/attainable/realistic/timely objectives
 - Keeps the person in context of their environment and natural supports

Quality Driven Outcomes

- Team-Facing Measures:
 - Call quality
 - Inter-rater reliability measures
- Performance Improvement Projects
- Provider/Member - Facing Measures include HEDIS/NCQA
- HCBS
- Special Populations



Clinical and Utilization Management Requirements
Peg Elmer, LCSW, Clinical Director, Wellness4Me
Margaret Sullivan, RN, MSN, Clinical Director, Mainstream Medicaid

Frequently used acronyms

- ACT: Assertive Community Treatment
- CDT: Continuing Day Treatment
- SPOA: Single Point of Access
- PROS: Personalized Recovery Oriented Services
 - ISR: Initial Service Recommendation
 - IRP: Individualized Recovery Plan
 - IR: Intensive Rehabilitation
 - ORS: Ongoing Rehabilitation and Supports
 - CRS: Community Rehabilitation and Support
- OTP: Opioid Treatment Program
- LOCADTR: Level of Care for Alcohol & Drug Treatment Referral

Ambulatory behavioral health services

- Assertive Community Treatment (ACT)
- OMH Clinic services
- Continuing Day Treatment (CDT)
- Comprehensive Psychiatric Emergency Program (CPEP)
- Intensive Psychiatric Rehabilitation Treatment (IPRT)
- Partial Hospitalization
- Personalized Recovery Oriented Services (PROS)
- Transportation
- Crisis Intervention

Authorization requirements: mental health

Service	Prior Authorization	Concurrent Review Authorization	State: Additional Guidance
Outpatient mental health office and clinic services including: initial assessment; psychiatric assessment; psychosocial assessment; medication treatment; and individual, family/collateral, and group psychotherapy	No	Yes	MMCOs/HARPs must pay for at least 30 visits per treatment episode without requiring authorization. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.
Psychological or neuropsychological testing	Yes	N/A	
Mental Health Continuing Day Treatment (CDT)	Yes	Yes	
Mental Health intensive outpatient (note: NOT State Plan)	Yes	Yes	
Mental Health partial hospitalization	Yes	Yes	
Assertive Community Treatment (ACT)	Yes	Yes	New ACT referrals must be made through local Single Point Of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determinations of eligibility and appropriateness for ACT following forthcoming NYS guidelines.

Authorization requirements: PROS

Service	Prior Auth	Concurrent Review Authorization	State: Additional Guidance
Personalized Recovery Oriented Services (PROS) Pre-Admission Status	No	No	Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to Plan. Providers bill the monthly Pre-Admission rate but add-ons are not allowed. Pre-Admission is open-ended with no time limit.
PROS Admission: Individualized Recovery Planning	Yes	No	Admission begins when ISR is approved by Plan. Initial Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date. Upon admission, providers may offer additional services and bill add-on rates accordingly for: <ul style="list-style-type: none"> • Clinical Treatment; • Intensive Rehabilitation (IR); or • Ongoing Rehabilitation and Supports (ORS). Prior authorization will ensure that individuals are not receiving duplicate services from other clinical or HCBS providers.
PROS Active Rehabilitation	Yes	Yes	Begins when IRP is approved by Plan. Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Base/ Community Rehabilitation and Support (CRS) and Clinic Treatment services.

Authorization requirements: substance use disorders

Service	Prior Authorization	Concurrent Review Authorization	State: Additional Guidance
Outpatient office and clinic services provided by OASAS-certified agencies including: initial assessment; psychiatric assessment; psychosocial assessment; medication treatment; and individual, family/collateral, and group psychotherapy	No	Yes	See OASAS guidance regarding use of LOCADTR tool to inform level of care determinations.
Medically supervised outpatient substance withdrawal	No	Yes	Plans may require notification through a completed LOCADTR report for admissions to this service within a reasonable time frame.
Opioid Treatment Program (OTP) services	No	Yes	
Substance Use Disorder intensive outpatient	No	Yes	Plans may require notification through a completed LOCADTR report for admissions to this service within a reasonable time frame.
Substance Use Disorder day rehabilitation	No	Yes	Plans may require notification through a completed LOCADTR report for admissions to this service within a reasonable time frame.
Stabilization and Rehabilitation services for residential SUD treatment	Yes	Yes	

Utilization management

Prior Authorization

- Inpatient Mental Health
- Inpatient SUD: Medically Managed Detox
- Inpatient Rehab
- Outpatient Mental Health: PHP, IOP, ECT, PROS, CDT, ACT, Psychological Testing
- SUD: Residential Rehab

Concurrent Review

- Inpatient: review is due on the last covered day
- Outpatient: updated clinical is due before the last covered day

Discharge Review

- Discharge date, medications and disposition
- Follow-up appointment within 7 days (inpatient level of care)
- Identification of biopsychosocial needs and follow-up (housing, medical, etc)

Retrospective Review

- Conducted for all covered levels of care for members who are eligible for benefits during the identified dates of service
- Must be requested within 120 days

Level of care guidelines

- Where can providers find level of care guidelines?

Mental Health

Provider Express:

- providerexpress.com
- Provider Manual
- Final LOCG's pending NYS approval

Substance Use Disorders

Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)

NY LOCADTR 3

- <https://extapps.oasas.ny.gov>

Level of Care Guidelines (LOCG): provider resource

- Common Criteria for Guidelines- commitment of NYS and MCO's to decrease provider burden
- Your homework assignment: review all relevant LOCGs
- LOCGs will be posted to Provider Express- visit this site frequently for updates and valuable information
- LOCGs are reviewed and updated annually
- Use it to train staff
- Many of these guidelines are pending review and approval by NYS
- Understanding how to use these guidelines as a clinical tool can greatly improve your managed care experience

Level of Care Determinations SUD: LOCADTR

- Designed for substance abuse treatment providers, the LOCADTR assists providers in making decisions about the appropriate level of care for a member
- The LOCADTR is meant to ensure that all members in need of treatment for a substance use disorder have access to care and are placed in the least restrictive, but most appropriate level of care available
- In addition to helping providers and members, the data collected by the tool will also be studied and analyzed to provide further insights into its effectiveness and allow for adjustments and updates to be made
- Level of care is determined by a variety of factors, including:
 - Diagnostic information (for example, the number of DSM-5 criteria the member meets)
 - Assessment of the member's need for crisis or detoxification services (for instance, determining possible medical complications from withdrawal)
 - Risk factors (such as the presence of severe medical and psychiatric conditions)
 - Resources available to the member (for example, a social or family network who are supportive of recovery goals)

Inpatient Substance Use Disorder (SUD) reviews

- Provider's are required to submit clinical information via UnitedHealthcare Online Provider Portal
- Include a PDF file of the LOCADTR report with the clinical documentation
- Our Facility Based Care Advocates (FBC-A) will review clinical information and enter it in LOCADTR
- When the Level of Care is consistent with the provider report, services are authorized
- If the LOCADTR Level of Care is not consistent with the request, our FBC-A will call the provider to request additional clinical information
- Any overrides in LOCADTR require clinical justification: if you select an override you can anticipate a call from our FBC-A to substantiate the request

Override options

NEED TO OVERRIDE LOCADTR RECOMMENDATION

There is a need to override LOCADTR recommendation for the following reason:

- Not applicable
- The recommended level of care is not available.
- There are additional clinical factors documented below.
- There is an external mandate that is documented below.

- It is extremely important that providers document relevant information to substantiate an override
- Indicating that this level of care is not available within your service delivery system does not substantiate an override

Medical necessity

Care Advocates use the Level of Care Guidelines when making medical necessity determinations and as guidance when providing referral assistance.

Generally accepted standards of practice

- Based on credible scientific evidence
- Generally recognized by the relevant medical community
- Use evidenced-based outcomes to validate the practice

Clinically appropriate

- Type, frequency, extent, and duration of services
- Considered effective for the treatment of mental illness, substance use disorder, or associated symptoms

Determinations of medical necessity

- Informed by
 - Unique aspects of the case
 - Member's benefit plan
- Available services
 - Ability of provider to meet the member's immediate needs
 - Alternatives that exist in the service area

What happens if medical necessity is not met?

- If a clinical review results in a disagreement about level of care there are a few options:
 - Peer Review
 - Full denial
 - Partial denial
 - Appeals
- When a determination is made that a level of care is not the right care at the right time we will:
 - Work closely with providers to identify a transition plan
 - Assist provider and members in finding services that meet the member's needs

Evidence-Based Practices

Examples of Evidence-Based Practices (not an all inclusive list)

- Motivational Interviewing
- Person-Centered Care
- Trauma Informed Care
- Risk Assessment and Crisis Intervention
- Integrated Whole Health Model
- Critical Time Intervention
- Recovery and Resiliency
- Individualized Recovery Planning
- Cognitive Behavioral Therapy
- Dialectical Behavioral Therapy

Special populations

- Transition Age Youth (TAY)
 - Most vulnerable as they transition from child to adult system
 - Need to collaborate to identify and educate youth as they approach age 21
 - Identify youth that may qualify for Wellness4Me (HARP) and Health Homes
- Co-occurring Physical and Behavioral Health and/or SUD
 - Integrated models of care
- First episode psychosis
 - OnTrackNY - required tracking of first episode
 - Supportive Transition and Recovery Team (START)
 - NYS Qualified FEP Providers
- Opioid Dependence
 - Epidemic
 - Identifying, referring and linking members to appropriate SUD services

Wellness4Me: HCBS covered services

- Psychosocial Rehabilitation
- Community Psychiatric Support and Treatment (CPST)
- Habilitation/Residential Support Services
- Family Support and Training (FST)
- Short-Term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Empowerment Services – Peer Supports (OMH)
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Transportation

HCBS utilization parameters

HCBS will be subject to utilization caps at the Member level that apply on a rolling basis (any 12 month period).

- Tier 1 HCBS: limited to \$8,000
- Tier 1 and Tier 2 combined have an overall cap of \$16,000

Utilization caps exclude crisis respite: short-term crisis respite and intensive crisis respite are each limited within their own individual caps to 7 days per episode and 21 days per year

Tier 1: Employment, education and peer support
Tier 2: Full array of HCBS

Individualized Service Planning

- Plans of Care

- Master integrated document
- Includes all services: providers, frequency and duration, contact information
- Ideally POC will be completed by Health Home Care Coordinators
- POC must be submitted to the Plan for approval
 - Confirming providers in network
 - Verifying members eligibility for the services listed
 - Evaluating POC for recovery goals that are person-centered and echo the members goals in their words
- Our Care managers complete the POC when:
 - Member is not enrolled or is refusing Health Home care coordination or
 - Member is not Health Home eligible
 - We are committed to assist members with field based care advocates, peers, community health workers and housing specialists

Service specific plans

- The member's diagnosis or presenting issues warranting services
- The member's problems *and* strengths
- The member's service goals are consistent with the purpose and intent of the program
- Plan for the provision of additional services to support the recipient outside of the program
- Criteria for discharge planning
- Person-centered care planning is clear and includes
 - Consistent goals and objectives
 - Concrete and easy to understand information (who, what and when)
 - Evaluation of goal attainment
 - Proactive planning to prevent or de-escalate crisis

HCBS eligibility

NEW YORK STATE Office of Mental Health Office of Alcoholism and Substance Abuse Services		Eligibility Assessment	
SECTION A: IDENTIFICATION INFORMATION			
Name (First, Middle Initial, Last)		Health Home where person is enrolled	
Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small>		Is person on HARP-eligible list? <input type="radio"/> On HARP list <input type="radio"/> Not on HARP list	
What was individual's sex at birth? <small>(on original birth certificate)</small> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Other		Medicaid ID (CIN) <input type="text"/>	
Gender Identity <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Other <input type="radio"/> Could not (would not) answer		Health Home Local Case <input type="text"/>	
Sexual Orientation <input type="radio"/> Heterosexual or straight <input type="radio"/> Homosexual, gay, or lesbian <input type="radio"/> Bisexual <input type="radio"/> Other <input type="radio"/> Not sure <input type="radio"/> Could not (would not) respond		What is person's religion? <input type="radio"/> Roman Catholic <input type="radio"/> Mainline Protestant <input type="radio"/> Evangelical Protestant <input type="radio"/> Non-denominational Protestant <input type="radio"/> Historically Black Protestant <input type="radio"/> Eastern Orthodox <input type="radio"/> Latter-Day Saints (Mormon) <input type="radio"/> Unknown <input type="radio"/> Unspecified Christian <input type="radio"/> Jewish <input type="radio"/> Muslim <input type="radio"/> Buddhist <input type="radio"/> Hindu <input type="radio"/> Other <input type="radio"/> No religion	
Date of Assessment <input type="text"/> / <input type="text"/> / <input type="text"/>			
Residential/Living status at time of assessment <input type="radio"/> Private home/apartment/rented room <input type="radio"/> DOH adult home <input type="radio"/> Homeless - shelter <input type="radio"/> Homeless - street <input type="radio"/> Mental Health supported/supportive housing (all types) <input type="radio"/> OASAS/SUD community residence <input type="radio"/> OCFS/ACS/DSS community residence program (Family foster care group home, Therapeutic foster care)		Living Arrangement <input type="radio"/> OPWDD community residence <input type="radio"/> Long-term care facility (nursing home) <input type="radio"/> Rehabilitation hospital/unit <input type="radio"/> Hospice facility/palliative care unit <input type="radio"/> Acute care hospital/unit <input type="radio"/> Correctional facility <input type="radio"/> Other <input type="radio"/> Alone <input type="radio"/> With spouse/partner only <input type="radio"/> With spouse/partner and other(s) <input type="radio"/> With child (not spouse/partner) <input type="radio"/> With parent(s) or guardian(s) <input type="radio"/> With sibling(s) <input type="radio"/> With other relatives <input type="radio"/> With non-relative(s)	
Individual receives housing supports <input type="radio"/> No <input type="radio"/> Yes		Residential Instability Residential stability over LAST 2 YEARS (e.g., 3 or more moves, no permanent address, homeless, living in shelter) <input type="radio"/> No <input type="radio"/> Yes	
Form Version 1.6		Content © InterRAI Corporation, Washington DC, 1994, 1996, 1997, 1999, 2002, 2005, 2006 (P) State Items © State of New York, 2014 Form © Center for Information Management, Inc., Ann Arbor, MI 2015	
		Page 1 of 7	

HCBS eligibility, continued

NEW YORK STATE Office of Mental Health Office of Alcoholism and Substance Abuse Services		Community Mental Health Assessment	
SECTION A: IDENTIFICATION INFORMATION			
Name (First, Middle Initial, Last)		Health Home where person is enrolled	
Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/> <small>Month Day Year</small>		Is person on HARP-eligible list? <input type="radio"/> On HARP list <input type="radio"/> Not on HARP list	
What was individual's sex at birth? (on original birth certificate) <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Other		Medicaid ID (CIN) <input type="text"/>	
Gender Identity <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> Other <input type="radio"/> Could not (would not) answer		Health Home Local Case <input type="text"/>	
Sexual Orientation <input type="radio"/> Heterosexual or straight <input type="radio"/> Homosexual, gay, or lesbian <input type="radio"/> Bisexual <input type="radio"/> Other <input type="radio"/> Not sure <input type="radio"/> Could not (would not) respond		Social Security Number <input type="text"/>	
Marital Status <input type="radio"/> Never married <input type="radio"/> Married <input type="radio"/> Partner/Significant Other <input type="radio"/> Widowed		<input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Unknown	
Date of Assessment <input type="text"/> / <input type="text"/> / <input type="text"/>			
Reason for Assessment <input type="radio"/> First assessment <input type="radio"/> Routine reassessment <input type="radio"/> Return assessment <input type="radio"/> Significant change in status reassessment <input type="radio"/> Exit assessment <input type="radio"/> Other (e.g., research)		Person's expressed goals of care Identify primary goal	
Capacity Capable to consent to treatment <input type="radio"/> No <input type="radio"/> Yes Capable to disclose to information relating to clinical record <input type="radio"/> No <input type="radio"/> Yes Capable to manage property <input type="radio"/> No <input type="radio"/> Yes Has a substitute decision-maker for personal care or financial decisions <input type="radio"/> No <input type="radio"/> Yes			

Form Version 1.6

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Cultural Competency

Gayle Parker-Wright, LCSW-R, Network Trainer

Cultural competency

- Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals, that enables effective work in cross-cultural situations
- Competence means having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by members and their communities

Cultural competency, continued

- Culture refers to integrated patterns of human behavior within various racial, ethnic, religious or social groups, including:
 - Language
 - Thoughts
 - Communications
 - Actions
 - Customs
 - Beliefs
 - Values
 - Institutions



Importance and value of cultural competence

- Given the diverse ethnic population in New York, providers must be prepared to provide culturally appropriate services
- Service settings and approaches should be culturally sensitive to engage individuals from diverse backgrounds to access services
- Promoting open discussions about mental health or substance abuse issues is an important step to reduce the stigma many individuals have
- Emphasizing individualized goals and self-sufficiency encourages members to live their lives to the fullest



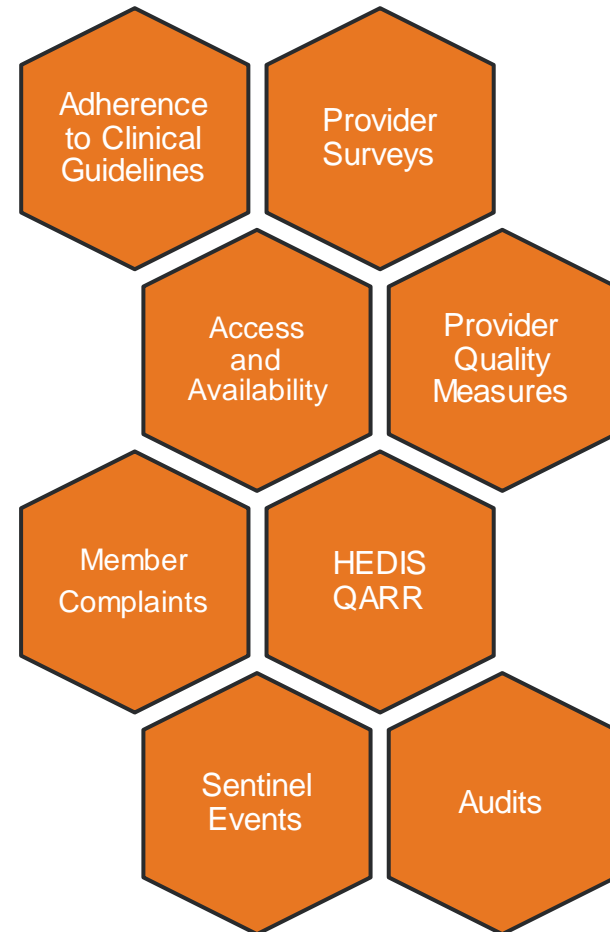
Quality Improvement
Missy Lerma, LCSW, Director of Network Management

Quality improvement

Quality of care is measured and monitored throughout the organization.

Examples of how we measure quality:

- HEDIS® measures
- Complaints
- Sentinel Events
- Provider Satisfaction Surveys
- Member Satisfaction Surveys
- Coordination of Care
- Best Practice Guidelines



NCQA & HEDIS

- **What is NCQA?**

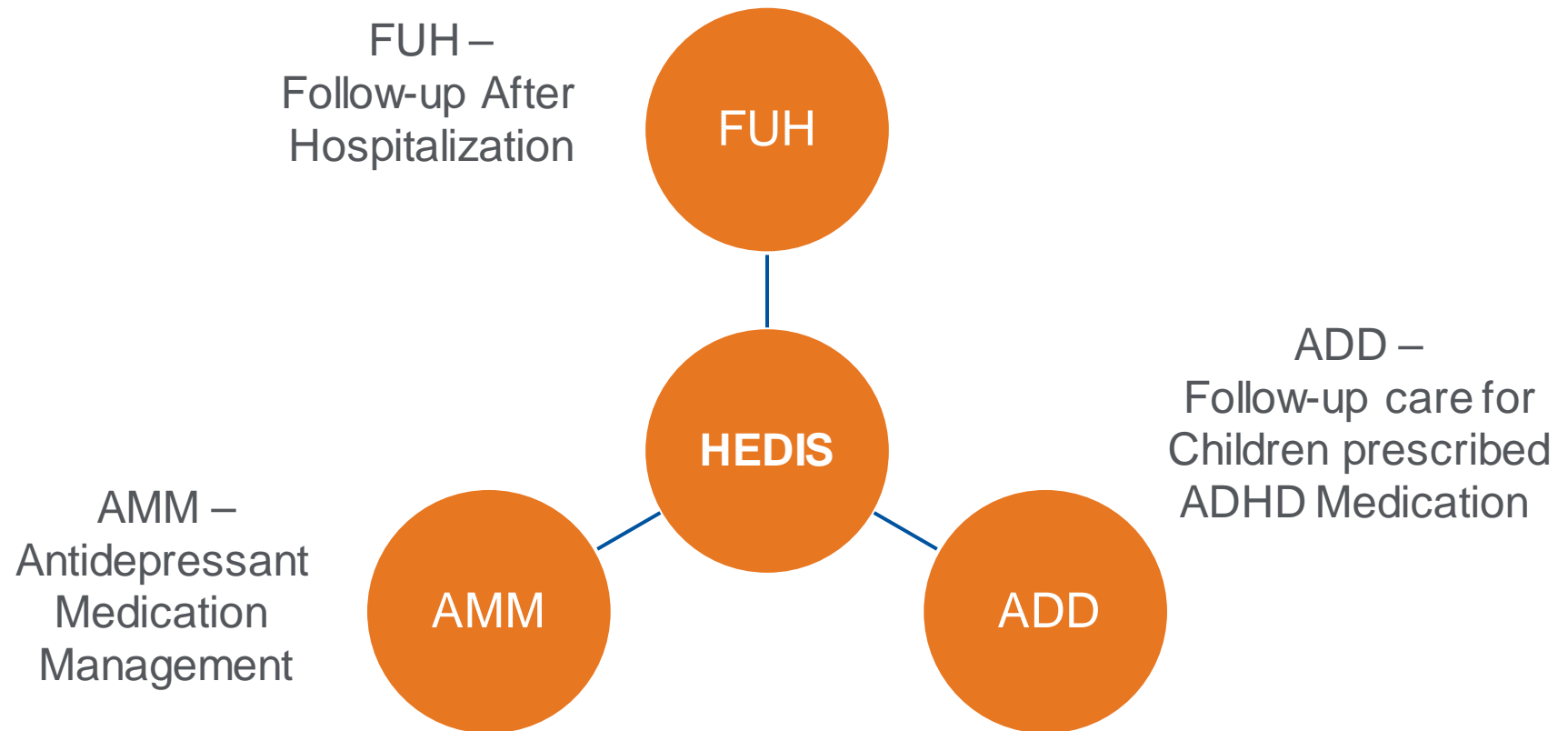
National Committee for Quality Assurance

- **What is HEDIS?**

Healthcare Effectiveness Data and Information Set

A tool used by more than 90% of America's Health Plans to measure performance on important dimensions of care and service.

Examples of behavioral health HEDIS measures



Member complaints

As an organization we investigate all member complaints (also known as grievances)

Complaints may be reported in different ways:

- Information is provided by the member and/or family member to the Health Plan or other internal department that reports cases
- Member direct report through calling the Health Plan Customer Service Department

Providers are part of the investigative process

- Submit medical records for review
- Provide a response to an allegation
- Cooperate as necessary to resolve the investigation

Sentinel Events

What is a Sentinel Event?

Sentinel events are defined as a serious, unexpected occurrence involving a Member that is believed to represent a possible quality of care issue on the part of the practitioner/facility providing services, which has, or may have, deleterious effects on the Member, including death or serious disability, that occurs during the course of a Member receiving behavioral health treatment.

Reporting Sentinel Events to Quality:

- If you are aware of a sentinel event involving a Member, you **must** notify UnitedHealthcare Community Plan within **one business day** of the occurrence
- Standardized reporting forms (located [here](#) on Provider Express) should be sent directly to the Quality Department through secure fax or email:
 - Fax: 844-342-7704 – Attn: Quality Department
 - Email: NYBH_QIDept@uhc.com
- Additional information about Sentinel Events can be found in the Behavioral Health Provider Manual

Appeals

An Appeal is any of the procedures that deal with the review of adverse determinations on the health care services a Member is entitled to receive or any amounts that the Member must pay for a covered service.

All Appeals should be submitted to:

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

For questions about Appeals, you may call **866-362-3368**

Provider quality audits

- Provider audits are completed for a variety of reasons:
 - On-going monitoring of providers, including Home and Community Based Services providers
 - At the time of Credentialing and Recredentialing for providers without OMH/OASAS certification and without a national accreditation (for example, The Joint Commission or CARF)
 - Quality of Care (QOC) investigation
 - Investigation of member complaints regarding the physical environment of an office or agency

Provider quality audits, continued

Elements reviewed during audits

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

Scoring of Audits

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

Audit tools

- There are 8 audit tools for New York Medicaid:
 - Organizational Provider Site Audit Tool
 - Treatment Record Review Tool
 - HCBS Record Tool
 - Case Management Record Tool
 - Psychosocial Rehab Record Tool
 - Peer Support Record Tool
 - Clinician Site Audit Tool
 - Home Office Site Audit Tool
- The audit tools will be posted to providerexpress.com once they are finalized: from the home page, choose Our Network > Welcome to the Network > New York > Quality Improvement > Audit Tool Names

Documentation standards

- Information regarding documentation standards for behavioral health providers can be located in 3 places:
 - The Optum Network Manual (located on providerexpress.com): from the home page, choose Clinical Resources > Guidelines/Policies & Manuals > Optum Network Manual > Treatment Record Documentation Requirements
 - The New York Mainstream Medicaid and Wellness4Me Behavioral Health Provider Manual (Coming Soon, will be located on Provider Express: from the home page choose Our Network > Welcome to the Network > New York > NY Medicaid Behavioral Health Provider Manual)
 - The audit tools

Documentation standards, continued

Highlights of documentation standards

- Record must be legible
- All entries must be signed by the rendering provider
- Entries must include the start and stop time or length of time spent in the session (for timed sessions)
- A Psychiatric and medical history, including the presenting problem, is documented
- Risk assessments (initial and on-going), including safety planning when applicable are present
- A Substance abuse screening is completed
- For children and adolescents, a complete developmental history is documented

Documentation standards, continued

- Treatment planning documentation includes
 - Short- and long-term goals that are objective and measurable
 - Time frames for goal attainment
 - Updates to the plan when goals are achieved or new issues are identified
 - Modifications to goals if goals are not achieved
- For members that are prescribed medications documentation includes
 - The date of the prescription, along with dosage and frequency
 - Rationale for medication adjustments
 - Informed consent for medications
 - Education regarding the risks/benefits/side-effects/alternatives

Documentation standards, continued

- Coordination of care is completed (and documented) with Primary Care Physicians
- Coordination of care is completed (and documented) with other treating providers
- If the member refuses to allow coordination to occur, that is clearly documented in the treatment record
- Discharge planning should be on-going and a discharge summary is documented when services are completed
- Medical necessity for services that are rendered is clearly documented

Provider quality audits, continued

Feedback to providers

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

Credentialing and Recredentialing

Allandro Pierre, MHA, Network Manager

Network participation requirements

– **The participation process begins with submission of the provider application**

- Clinicians contracting on an individual basis complete the CAQH universal application online at www.caqh.org
- Agencies pursuing group contracts complete the Agency Application

– **Additional required application materials include**

- Signed Agreement
- Signed Disclosure of Ownership and Control Interest Statement
 - One per clinician pursuing individual contracting
 - One per agency if pursuing a group contract

– **Pre-contractual site audits**

- Required for unaccredited agencies pursuing group contracts
- May be waived if licensed by OMH/OASAS

– **Approval by Optum Credentialing Committee**

Credentialing of groups and agencies

Group Contracts

- For provider group agencies that employ both licensed professional and unlicensed paraprofessional staff to render services under the umbrella of the agency, Optum will execute group contracts with the agency as the contracting entity
- Group agencies must submit the Agency Application, including the services being provided and the licensed clinical professionals on the staff roster (when requested)
- The individual licensed clinicians on staff do not need to submit CAQH applications or be individually credentialed when they work for the agency under a group contract Agreement

The Credentialing Committee

- A standing committee comprised of:
 - Network clinicians (the majority of the Committee)
 - Not employees of Optum
 - Represent behavioral health disciplines including:
 - Psychiatrists
 - Nurses
 - Psychologists
 - Master’s Level clinicians
 - Licensed Optum staff (the minority of the Committee)

The Credentialing Committee, continued

- Chaired by Optum Medical Director (licensed Psychiatrist)
- Decisions and actions of the Committee are:
 - Non-discriminatory
 - Guided by consideration of each applicant’s potential contribution to providing effective, efficient health care services for the individuals we serve
 - Based on Optum’s need for providers in the service area

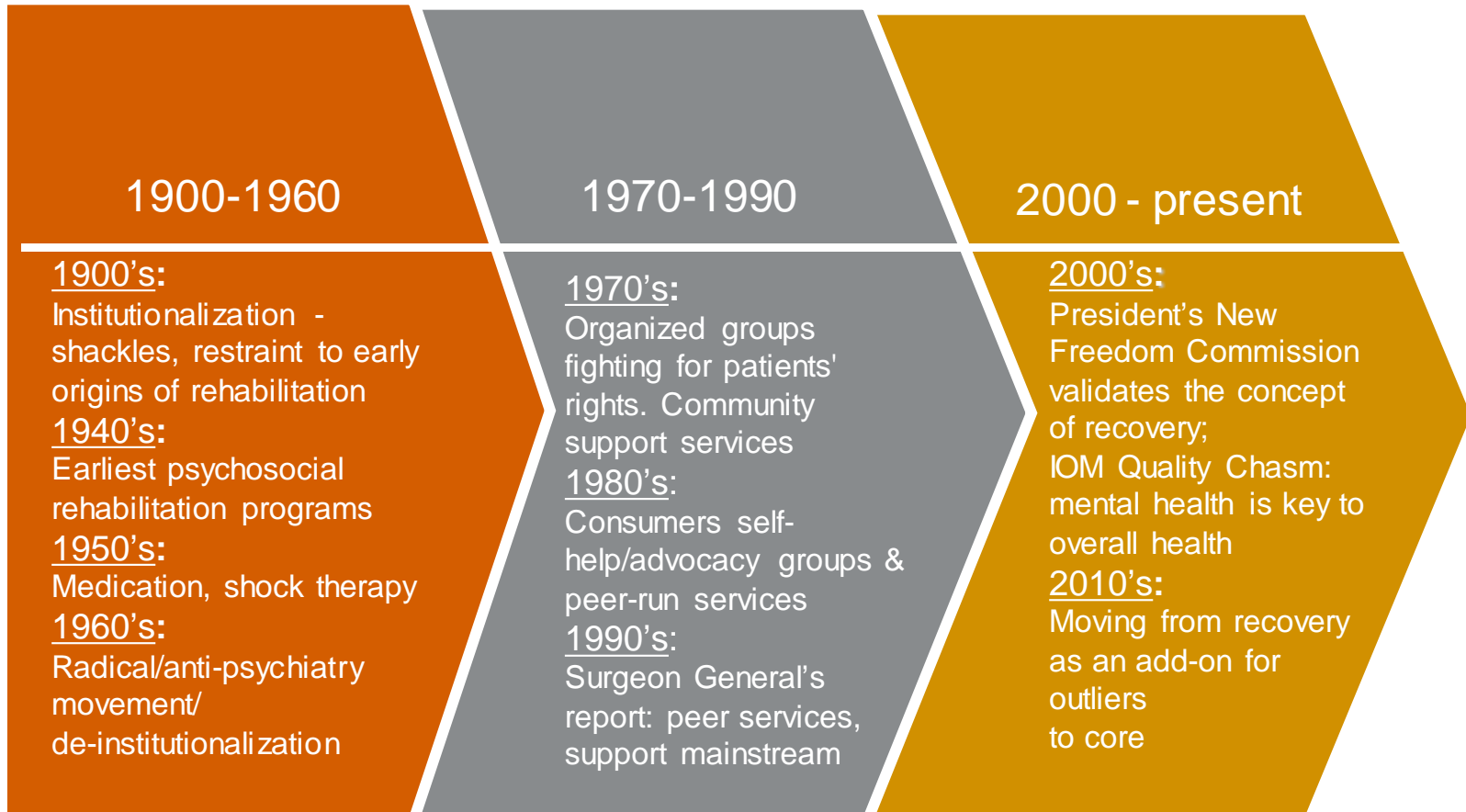
Recredentialing

- Recredentialing is completed every 36 months (3 years)
 - This time line is established by NCQA
- Several months prior to the recredentialing date, a recredentialing packet will be sent to the provider
- Completion of the entire recredentialing packet is required for the recredentialing process to be completed
- Site audits will be completed for organizational providers as indicated by Optum policy
- Failure to complete the recredentialing paperwork or participate in the recredentialing site audit (when applicable) will impact the provider's status in the network
- Completion of the recredentialing process takes time, it is important to submit required documentation as soon as possible

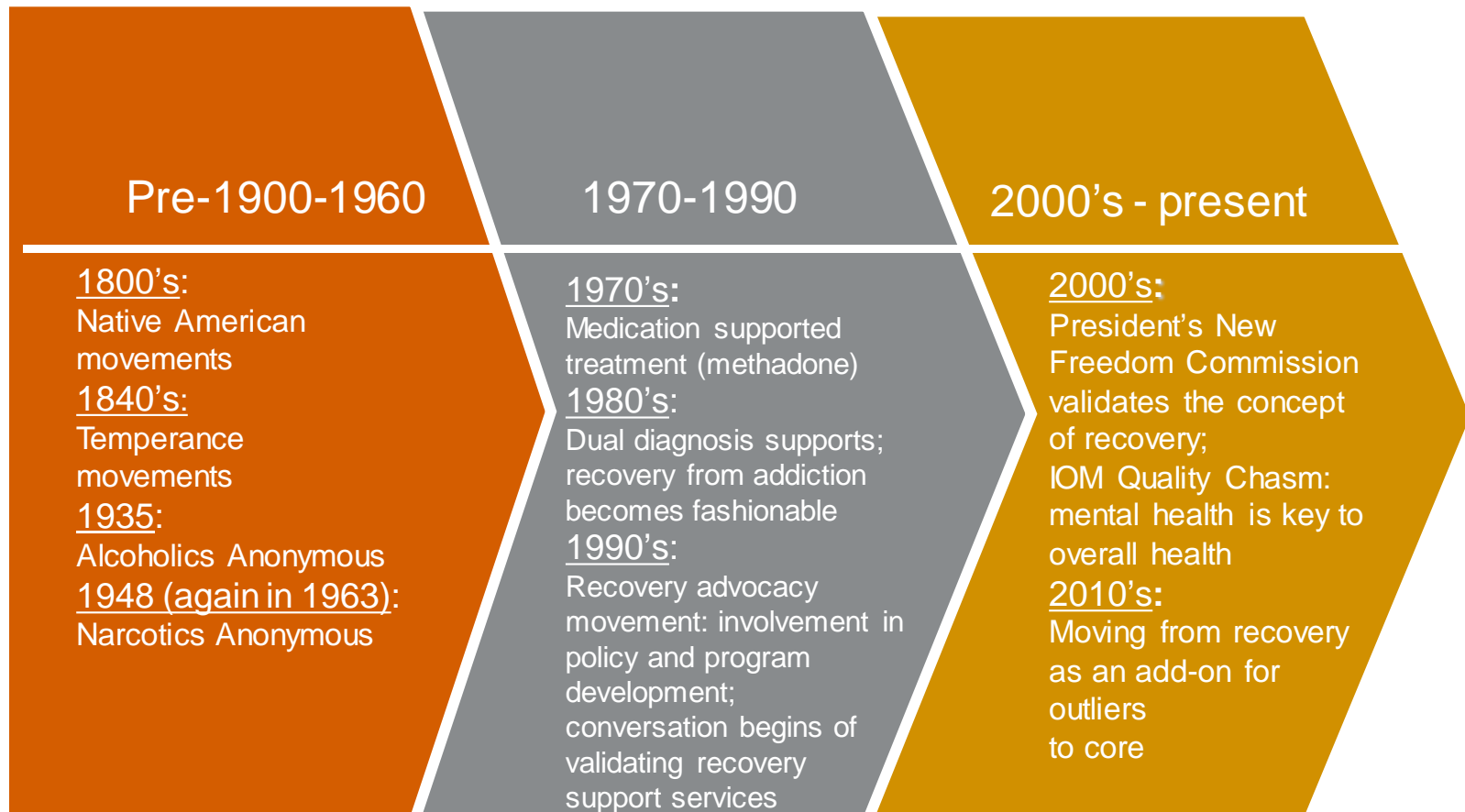


Recovery and Resiliency and Peer Support Services
Barbara Tedesco, MS, CRC, Recovery and Resiliency Manager

Origins of recovery: it's mainstream now



Origins of addiction recovery



New SAMHSA definition

Working Definition of Recovery

A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

Principles of Recovery

- Person-driven
- Occurs via many pathways
- Holistic
- Supported by peers
- Supported through relationships
- Culturally-based and influenced
- Supported by addressing trauma
- Involves individual, family, and community strengths and responsibility
- Based on respect
- Emerges from hope

Four major domains that support recovery:

- **Health:** Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way
- **Home:** A stable and safe place to live
- **Purpose:** Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- **Community:** Relationships and social networks that provide support, friendship, love, and hope

Shifting the paradigm

Illness/Deficit Focused	Recovery/Person-Centered
Mastery of the professional treating deficits – compliance of individual	Partnership emphasizing collaboration, strengths, and empowerment leading to resilience
Services begin with illness assessment and work toward illness reduction goals	Services begin with engagement and work toward quality of life goals
Recovery from the illness sometimes results after illness and behaviors are managed	Personal recovery is central from beginning to end
Motivation for change is externally driven	Motivation for change based on personal hope and individuals' own goals
Medication compliance is key	Medication is one tool based on informed choice
Use techniques that promote illness control and reduction of risk	Use techniques that promote personal growth and self-responsibility
Services are forever and embedded in MH system	Emphasis on personal life management and the use of natural community resources

Resilience

Definition of Resilience

“The capacity of a system, enterprise, or a person to maintain its core purpose and integrity in the face of dramatically changed circumstance.”

Good News

- “New research suggests that there are concrete things we can do to bolster resilience”
- “Resilience appears to be a common phenomenon of basic human adaptation systems”
- “Patterns of resilience depend upon habits of the mind that we can cultivate”

Adapted from: “Resilience: Why Things Bounce Back,” Andrew Zolli & Ann Marie Healy (2012)

Facilitators of Resilience

- Trauma informed practices: What happened to you vs. what is wrong with you
- Build optimism, accentuate strengths
- Strong support system, including self-help
- Cultural identity and pride
- Hope
- Creativity and powers of persuasion
- Mindfulness
- Inspire and be inspired

Proactive approach to crisis planning

Planning for a crisis is best done before the crisis

- Psychiatric Advance Directives
- Wellness and Recovery Plans (WRAP)
- Mental Health First Aid: <http://www.mentalhealthfirstaid.org/cs/>

Additional Resources

- <http://www.power2u.org/consumerrun-statewide.html>
- <http://www.cdirectory.org/>
- http://www.iccd.org/search_form.php

Warm Lines:

- Parachute NYC includes a **peer operated Support Line 646–741–HOPE**
 - All services are confidential and there is no need for a referral
 - Live answer available from 4:00 p.m. - 12:00 a.m. Eastern time

Peer support specialists

Certified Peer Specialist	<ul style="list-style-type: none">• Person who acknowledges “lived experience” and maintains strong recovery strategies• Uses recovery strategies and formal training for the benefit of others• May offer emotional support, share knowledge, teach skills toward meaningful life goals
Effectiveness	<ul style="list-style-type: none">• Engaging and retaining people in MH and SU services• Supporting people in taking active role in treatment• Lowering re-hospitalization rates/reducing ER services
Effectiveness	<ul style="list-style-type: none">• Increasing overall satisfaction with services• Reducing symptoms and/or substance use• Improvements in practical outcomes (employment, housing, etc.)
Why	<ul style="list-style-type: none">• Supported by New Freedom Commission, SAMHSA, Crossing the Quality Chasm, etc• Evidence-based practice• It works



Billing and Claims
Eunice Hudson, Provider Education Specialist

Links to resource documents

- HARP Mainstream Billing and Coding Manual

<https://www.omh.ny.gov/omhweb/bho/harp-mainstream-billing-manual.pdf>

- HCBS Manual

<https://www.omh.ny.gov/omhweb/News/2014/hcbs-manual.pdf>

- Fee Schedule and Rate Codes

<https://www.omh.ny.gov/omhweb/bho/phase2.html>

Billing requirements

Requirements

- 837i claim form (institutional) electronic form
- UB-04 (institutional) paper form
- Medicaid fee-for-service rate code
- Value code “24”
- Valid procedure code(s)
- Procedure code modifiers (as needed)
- Units of service

Location of state billing and coding manual:

<https://www.omh.ny.gov/omhweb/bho/harp-mainstream-billing-manual.pdf>

Managed Care Technical Assistance Center

The Managed Care Technical Assistance Center (MCTAC) is a training, consultation, and educational resource for all mental health and substance use disorder providers in New York State.

Recent trainings:

- Integrated Managed Care Billing Guidance (guidance on how to submit clean claims)
- HCBS Service Cluster Webinar Series

Also available:

- Interactive glossary of terms
- Managed Care Language Guide
- Frequently Asked Questions
- MCO Plan Comparison Matrix

Website: <http://mctac.org>



Mainstream Medicaid

New Carved-In Services

Assertive Community Treatment (ACT) services

- Billed once per month
- Use one rate code for the month's services
- Use the last day of the month in which the services were rendered as the date of service
- Use of rate code, procedure code and modifier combinations are required

OMH Clinic services

- Use of rate code, procedure code and modifier combinations
 - OMH Clinics, both hospital-based and free-standing, have been billing Fee-For-Service (FFS) under the Ambulatory Patient Group (APG) rate setting methodology, using rate code, procedure code, and modifier code combinations, since October 1, 2010
 - For non-SSI recipients enrolled in managed care, OMH Clinics have been billing Medicaid plans for those same rate code, procedure code, and modifier code combinations, and receiving the government rate (APG rate) for those services, since September 1, 2012
 - As of the effective date of the behavioral health managed care carve-in and the creation of the HARPs, we will cover OMH clinic services for all enrollees and mirror the APG rates as we do now for the non-SSI population

Continuing Day Treatment (CDT)

Recipient only:

- Billed on a daily basis
- Three tiers
 - 1-40 hours
 - 41-64 hours
 - 65+ hours
- Two types of visits
 - Full and Half day
- Combination of rate code, procedure code and modifier code(s)

Collateral, group collateral, preadmission and crisis visits:

- Billed separately from the regular CDT visits

Additional services

Comprehensive Psychiatric Emergency Program (CPEP)

- Billed on a daily basis
- Combination of rate code, procedure code and modifier code(s)
 - Brief Emergency Visit
 - Full Emergency Visit
 - Crisis Outreach Services
 - Interim Crisis Service
 - Extended Observation Bed

Intensive Psychiatric Rehabilitation Treatment (IPRT)

- Billed on a daily basis
- Combination of rate code, procedure code and modifier code(s)
- Reimbursement is provided for service duration of at least one hour and not more than five hours per recipient, per day

Additional services, continued

Partial Hospitalization

- Billed on a daily basis
- Combination of rate code, procedure code and modifier code(s) is dependent on the number of hours of service a day
- Reimbursement is provided for service duration of at least four hours and not more than seven hours per recipient, per day

Personalized Recovery Oriented Services (PROS)

- Reimbursed on a monthly case payment basis
- Use the last day of the month as the date of service
- Use of rate code, procedure code and modifier combinations
- All the line level dates of service must also be the last day of the month

PROS cross-walk example

Prog	Rate Code	Rate Code / Service Title	Px Code	Modifiers	Units of Service	Modifier Definitions
PROS	4521	PROS COMM REHAB SRVCS 13-27 UNITS	H2019	U2	13-27	Level 2 (state- defined)
	4525	PROS CLIN TRMT ADD-ON	T1015	HE	1	Mental health program

Claim 1 – Rate code 4521 in the header (field 39 on UB-04) plus H2019U2 and 13-27 units at the line level (fields 44 and 46)

PROS example, UB-04

		39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
		a 24	4521				
		b					
		c					
		d					
44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49		
H2019U2	13-27						

Claim 1 – Value Code 24 and Rate code 4521 in the header (field 39 on UB-04) plus H2019U2 and 13-27 units at the line level (fields 44 and 46)

Transportation

Medically Necessary Transportation for Behavioral Health Services:

- Medically necessary transportation for behavioral health will be a carved-out service
- Bill directly to the state by the transportation provider

Non-Medical Transportation (only for Wellness4Me Members and individuals in HIV Special Needs Programs (SNPs) meeting the eligibility criteria based on the plan of care)

- Bill directly to the state by the transportation provider

Crisis intervention

- Provided off-site
- Fee includes transportation, do not bill separately
- Two separate types of sessions
 - Per hour
 - Billed daily in one hour units with a limit 4 units (4 hours) per day
 - Requires the participation of at least 2 staff (one can be non-licensed)
 - Per diem
 - Billed daily with a max unit of 1 (5+ hours)
 - Requires the participation of at least 2 staff

Office of Alcoholism and Substance Abuse Services (OASAS)

Substance Use Disorder Services & Billing

Billing requirements

OASAS claims are reimbursed based on APG methodology

- UB-04 claim form; 837i
- Value code
- Rate code
- Revenue codes
- CPT/HCPCS codes
- Procedure modifiers
- Date of service
- Service units
- OASAS Credentialed Alcoholism and Substance Abuse Counselor (CASAC) ID Number

OASAS: Important modifier reminders

- The HF modifier is requested for all OASAS claim types
 - The modifier does not impact pricing but will support data collection
- OTP programs will continue to use the KP modifier for the first medication administration visit of the service week

OASAS: outpatient rate codes, freestanding facilities

Rate codes are assigned based upon certification/program type and Setting (hospital vs. freestanding)

Title 14 NYCRR Part 822 Community/Freestanding (Article 32 only)

- Chemical Dependence Outpatient Clinic program – rate code 1540
- Chemical Dependence Outpatient Rehabilitation Program – rate code 1573
- Opiate treatment program – rate code 1564

Medical Services

Title 14 NYCRR Part 822 Community/Freestanding (Article 32 only)

- Chemical Dependence Outpatient Program – rate code 1468
- Chemical Dependence Outpatient Rehabilitation Program – rate code 1570
- Opiate Treatment Program – rate code 1471

OASAS: outpatient rate codes, hospital-based

Title 14 NYCRR Part 822 Hospital Based OASAS Certified Outpatient (Article 28 and Article 32)

- Chemical Dependence Outpatient Clinic program – rate code 1528
- Chemical Dependence Outpatient Rehabilitation Program – rate code 1561
- Opiate treatment program – rate code 1567

Medical Services

Title 14 NYCRR Part 822 Hospital Based OASAS Certified Outpatient (Article 28 /Article 32)

- Chemical Dependence Outpatient Program – rate code 1552
- Chemical Dependence Outpatient Rehabilitation Program – rate code 1558
- Opiate Treatment Program – rate code 1555

Service combinations

NYS Allowable Billing Combinations of OMH/OASAS State Plan Services and HCBS								
HCBS/State Plan Services	OMH Clinic/OLP	OASAS Clinic	OASAS Opioid Treatment Program	OMH ACT	OMH PROS	OMH IPRT/CDT	OMH Partial Hospital	OASAS Outpatient Rehab
PSR	Yes	Yes	Yes				Yes	
CPST							Yes	
Habilitation	Yes	Yes	Yes				Yes	
Family Support and Training	Yes	Yes	Yes			Yes	Yes	Yes
Education Support Services	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Peer Support Services	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Employment Services	Yes	Yes	Yes			Yes	Yes	Yes

Quick reminders

- Use value code 24
- One rate code per claim
- Include units as applicable
- There cannot be a hyphen in your Tax Identification Number (TIN)
- NPI numbers are required
- A complete diagnosis is required
- Verify member eligibility
- Obtain prior authorization for those services that require it
- Home and Community Based Services require authorization except
 - Short term crisis respite up to 72 hours
 - Staff transportation

Submission of Claims

Clean claim

A claim with no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim is considered a clean claim.

- All required fields are
 - Complete
 - Legible

All claim submissions must include:

- Member's name, Medicaid identification number and date of birth
- Provider's Federal Tax I.D. number (TIN)
- National Provider Identifier (NPI)
- A complete diagnosis (ICD-10-CM)

Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at [cms.gov](https://www.cms.gov)

Claims submission deadline

- Providers must initially submit claims within one hundred and twenty (120) days after the date of the service
- Paper clean claims will be paid within 45 days of receipt
- Electronic clean claims will be paid within 30 days of receipt
- If a provider wants to appeal a claim payment or denial, the appeal must be submitted within 90 days (pending confirmation) after receipt of the Provider Remittance Advice (PRA)

Claims submission option 1: EDI/Electronically

- Electronic Data Interchange (EDI) is an electronic-based exchange of information
- Performing claim submission electronically offers distinct benefits
 - It's fast – eliminates mail and paper processing delays
 - It's efficient – electronic processing helps catch and reduce pre-submission errors, so more claims auto-adjudicate
 - It's complete - you get feedback that your claim was received by the payer
 - It's cost-efficient - you eliminate mailing costs, the solutions are free or low-cost
- You may use any clearinghouse vendor to submit claims
- Payer ID for submitting claims is 87726
- Additional information regarding EDI is available on UHCommunityplan.com

Claims submission option 2: hardcopy

Paper claims submitted via U.S. Postal Service should be mailed to:

**Optum Behavioral Health
P.O. Box 30760
Salt Lake City, UT 84130-0760**

Appeals submitted via U.S. Postal Service should be mailed to:

**United Healthcare Community Plan, Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364**

Electronic Payments & Statements (EPS)

- Faster Payments, better cash flow
- Less work, more time
- No need to change your current posting process
 - For more information call 866-842-3278, option 5
 - Or visit <https://www.unitedhealthcareonline.com>



Provider Express
UnitedHealthcare Online

Missy Lerma, LCSW, Director of Network Management
Lisa Camardo, Director of NY Behavioral Health Operations
Eunice Hudson, Provider Education Specialist

Provider portals

Provider Express - providerexpress.com

Our industry-leading provider website includes both public and secure pages for behavioral health providers. Public pages include general updates and useful information. Secure pages require registration and are available only to network providers. The password-protected “secure transactions” provides New York Medicaid providers access to provider-specific information.

Provider portals

Public Pages include general updates and other useful information:

- Download standard forms (i.e. provider demographic updates, psych testing forms)
- Find network contacts
- Review clinical guidelines
- Access archived issues of Network Notes, the provider newsletter
- Level of Care Guidelines
- Training/Webinar offerings

Provider portals, continued

- Secure pages are available only to Optum in-network providers and require registration
- Providers will be able to update their practice information using the “My Practice Info” feature
- To request a User ID, select the “First-time User” link in the upper right corner of the home page
- If you need assistance or have questions about the registration process, call the Provider Express Support Center at **866-209-9320** (toll-free) from 7 a.m. to 9 p.m. Central time, or chat with a tech support representative online

Provider Express – Home Page



[Log In](#) | [First-time User](#) | [Global](#) | [Site Map](#)

- [About Us](#)
- [Clinical Resources](#)
- [Admin Resources](#)
- [Tech Resources](#)
- [Training](#)
- [Our Network](#)
- [Contact Us](#)

Home

It's coming up fast, are you up to speed?



[More >>](#)

- #### Transactions
- [Eligibility & Benefits](#)
 - [Auth Request & ReviewOnline](#)
 - [Auth Inquiry](#)
 - [Claim Entry](#)
 - [Claim Inquiry](#)
 - [My Provider Express](#)
 - [My Practice Info](#)



Provider Express Home Page – Log In

OPTUM™ Provider Express

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Home

It's coming up fast, are you up to speed?

ICD-10 TRANSITION

October 2015

More >>

Transactions

- Eligibility & Benefits
- Auth Request & ReviewOnline
- Auth Inquiry
- Claim Entry
- Claim Inquiry
- My Provider Express
- My Practice Info

Provider Express Home Page – First-time User



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Search

[About Us](#) [Clinical Resources](#) [Admin Resources](#) [Tech Resources](#) [Training](#) [Our Network](#) [Contact Us](#)








Home

It's coming up fast, are you up to speed?



More >>

Transactions

-  [Eligibility & Benefits](#)
-  [Auth Request & ReviewOnline](#)
-  [Auth Inquiry](#)
-  [Claim Entry](#)
-  [Claim Inquiry](#)
-  [My Provider Express](#)
-  [My Practice Info](#)



Provider Express – Tech Support Live Chat feature

If you are contracted in the Optum/OHBS-CA network, you can use the registration process to create your account within Provider Express.

[Register](#) 

The following information is required to register:

Providers (individually-contracted clinicians):

1. Provider First Name
2. Provider Last Name
3. Tax ID
4. NPI (Type I - Individual)
5. Last 4 digits of Provider's SSN

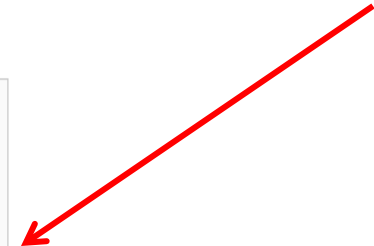
Groups/Practices (contracted for outpatient, professional services):

1. Group/Practice Name
2. Tax ID
3. NPI (Type II - Organization)

Facilities (contracted for inpatient, IOP and other facility-related services):

1. Facility Name
2. Federal Tax ID
3. NPI (Type II - Organization)

If you need assistance or have questions about the registration process, call the Provider Express Support Center at 1 866-209-9320 (toll-free) from 7 A.M. to 9 P.M. Central time or chat with a tech support representative online.



[Security Notice](#) | [Privacy](#) | [Site Use Agreement](#) | [Site Map](#)

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My Practice Info – Review Clinician Profile

- My Practice Info allows users to view demographic and other information on their practice
 - Much of the information can be updated via an online request, rather than making a telephone call
- Users can click on the pencil icons to make updates
- Users can click on the Tax ID in the “Practice Addresses by Tax ID” section, to view and make any changes to address information

My Practice Info – Review Clinician Profile

My Practice Info - Review Clinician Profile

Clinician Name:	<input type="text" value="John Doe"/>
NPI:	<input type="text" value="not on file"/>
Taxonomy code:	View Taxonomy Code(s)
Licensure:	<input type="text" value="MD - Medical Doctor"/>
Language(s):	<input type="text" value="ENGLISH"/>
Clinician E-mail Address:	<input type="text" value="email@email.com"/>
Gender:	<input type="text" value="M"/>
Medicaid Number:	<input type="text"/>
Medicare Number:	<input type="text"/>
Expertise:	<div style="border: 1px solid #ccc; padding: 5px; min-height: 50px;">Expertises listed here</div>
Ethnicity:	<input type="text" value="none listed"/>
Tax Id(s):	<input type="text" value="999999999"/>

Practice Addresses by Tax ID

Please select a Tax ID:

Tax ID	Practice Name	Primary Address
999999999	Doe, John A.	123 Anywhere Street Somewhere USA 55555

*If you need to change your tax identification number, add a new practice under a different tax identification number, inform us of your move to another state, or inform us of a new practice in another state, please complete the [Clinician Add/Change Application](#) and fax or mail it to the [Network Manager](#) for your state.

Credentialing Address

Our records indicate that you would like correspondence related to your credentialing sent to the address shown below. Click on the address below. Changing your credentialing address will not change primary practice address information. **Please click on the Tax ID in the section above.**

Please note: P.O. Boxes cannot be used unless you are able to attest that certified mail can be signed for at that address.

Please click on your Credentialing Address to update.

[123 Anywhere Street](#)
[Somewhere USA 55555](#)

My Practice Info – Clinician Addresses

- The Clinician Addresses page allows users to view and update current address information on file for the practice/TIN

My Practice Info - Clinician Addresses

Click an address to edit.
Please make all of your updates (including adding new or deleting addresses) before clicking the Submit All Changes button below.
Changes will be reflected on your profile within 3 to 5 business days after the submission of your request.

Primary	Primary practice address	Remit	Remit address
Mailing	Primary mailing address	Practice	Secondary practice address
1099	1099 mailing address	Accepting?	Accepting new patients?

Tax ID : 999999999 - Doe, John A.

Add New Address

Delete	Address	Primary	Mailing	Remit	Practice	Accepting?	Phone	Secured Fax	Address Conditions
		Only one per column			Select all that apply				
<input type="checkbox"/>	123 Anywhere Street Somewhere USA 55555	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="checkbox"/>	Yes	555-555-5555	666-555-5555	None Listed

1099 Address

Address	Phone
123 Anywhere Street Somewhere USA 55555	(555)555-5555

Submit All Changes

Remember to click the "Submit All Changes" button when you are done making your updates.

My Practice Info – Group Login

- Group logins will see a difference in the My Practice Info page due to how they are set up in the internal system
- Clicking on the “View Address Info” button will display the locations page specific to that group

My Practice Info - Review Practice Profile

Practice Name: Practice Name

Tax ID Number: 999999999 [update](#)

NPI: 1111111111

Medicaid Number: [add](#)

Medicare Number: [add](#)

[View Address Info](#)

Our records indicate that Diamond Grove Center has the following contact information.

Contact Name	Contact Phone Number	Action
First Last Name	555-555-5555	update

Our records indicate that the following list of providers are in the practice. To update the list of providers below, please contact your [Provider Network Manager](#).

One item found.1

Providers	NPI
Name, Provider	1234567890

My Practice Info – Practice Locations for Group Logins

- The Practice Locations page for group logins also looks different from individual logins
- Users can click on the “update” or “delete” links to the right of any address, and/or can click on the Add New Location button at the bottom
- With any of these updates, if there are individually-contracted providers for that group, there are options to choose which provider(s) the update/delete/add affects

My Practice Info - Practice Locations

Our records indicate that Diamond Grove Center has the following locations. To add a new location, click **Add New Location**.

Any requested changes will be reflected in 3 to 5 business days from the time of request.

Address	Address Type	Phone	Secured Fax	Conditions of Address	Action
123 Anywhere Street Somewhere USA 55555	Remit. Practice. Primary	(555)555-5555		None Listed	update delete

[Add New Location](#)

Example from DSM-5

Obsessive-Compulsive Disorder 237

DSM-5: Diagnosis → **Obsessive-Compulsive Disorder**

Diagnostic Criteria **300.3 (F42)**

A. Presence of obsessions, compulsions, or both:

Obsessions are defined by (1) and (2):

1. Recurrent and persistent thoughts, impulses, or images that are intrusive, unwanted, and cause marked anxiety or distress.
2. The individual attempts to ignore or suppress such thoughts, impulses, or images, or to neutralize them with some other thought or action.

Compulsions are defined by (1) and (2):

1. Repetitive behaviors (e.g., hand washing, ordering, checking) or mental acts (e.g., praying, counting, repeating words silently) that the individual feels driven to perform in response to an obsession or according to rules that must be applied rigidly.
2. The behaviors or mental acts are aimed at preventing or reducing anxiety or distress, or preventing some dreaded event or situation; however, these behaviors or mental acts are not connected in a realistic way with what they are designed to neutralize or prevent, or are clearly excessive.

Note: Young children may not be able to articulate the aims of these behaviors or mental acts.

B. The obsessions or compulsions are time-consuming (e.g., take more than 1 hour per day) or cause marked distress or impairment in social or occupational functioning.

Billing Codes: the ICD-9 code is bolded, the ICD-10 code is grey and offset by parentheses.

The International Classification of Disease (ICD) is maintained by the World Health Organization (WHO). It is used to track and trend morbidity and mortality world-wide. The DSM, published by the APA, has historically mapped to the ICD-CM codes used in the U.S. for billing.

The current edition, DSM-5, maps conditions to both the ICD-9-CM and ICD-10-CM codes.

Diagnostic Label and Criteria: APA/DSM

- Obsessive-Compulsive Disorder
- Criteria outlined A-D with specifiers to include in documentation

Diagnostic Billing Codes: WHO/ICD

- 300.3
 - ICD-9-CM
 - Use through dates of service 9/30/15
- (F42)
 - ICD-10-CM
 - Use beginning dates of service 10/1/15 and later

Special Call-Out
DSM-5 has had some coding updates, these are available online from the APA:
www.psychiatry.org/dsm5 > **DSM-5 Coding Update**

Timeline and Dates of Service

This is a “flip-of-the-switch” change for our industry.

The legislation requires full and immediate transition to ICD-10 for billing for all Dates of Service October 1, 2015 and later. There is no transitional grace period for ICD-10.

What about services spanning the transition date?

- A single claim cannot include both ICD-9 and ICD-10 code sets
- The Outpatient Date of Service (DOS) *or* Inpatient date of discharge determines which ICD code set (ICD-9-CM or ICD-10-CM) should be used
 - Neither the date of claim submission nor the date of receipt matter in terms of ICD code set selection



Date of Service (DOS) key to ICD code set selection

Outpatient Services

Client A

- Seen for services on 9/3, 9/10, 9/17 and 9/24: All DOS may be filed on a single claim using ICD-9-CM codes

Client B

- Seen for services on 10/1, /10/8, 10/15 and 10/22: All DOS may be filed on a single claim using ICD-10-CM

Client C

- Seen for services on 9/17, 9/24, 10/1 and 10/8: The September DOS may be filed on a single claim using ICD-9-CM, and the October DOS will need to be submitted on a second separate claim using ICD-10-CM

Date of Discharge key to ICD code set selection, continued

Inpatient and Residential Services

For services spanning September into October 2015, the Date of Discharge determines which ICD code set to apply. Regardless of admission date:

- Client discharges on or before 9/30/15: bill using ICD-9-CM
- Client discharges on or after 10/1/15: bill using ICD-10-CM

Electronic Data Interchange (EDI) / 837 submissions:

You can submit a batch of claims/encounters within a file that contain both ICD-9 and ICD-10 transactions but each claim or encounter is limited to either ICD-9-CM or ICD-10-CM.

Regardless of your method of claim submission you must indicate whether the specific claim filed is using ICD-9-CM or ICD-10-CM codes.

Only one code set (ICD-9 or -10) may be used on a single claim

Resource Links

Provider Express

[ICD-10 and DSM-5 Resources](#)

[ICD-10 Transition Webinar](#)

American Psychiatric Association (DSM-5)

[APA Practice: DSM-5](#)

[APA Coding Update: March 2014](#)


[APA DSM-5 Implementation and Support](#)

[APA Understanding ICD-10-CM and DSM-5: A Quick Guide](#) (Feb 2014)



UnitedHealthcare Online – login page

About Us	Contact Us	Physician Directory	Practice/Facility Profile	UnitedHealth Premium	Help
--------------------------	----------------------------	-------------------------------------	---	--------------------------------------	----------------------



User ID:
Password: [LOGIN](#)


[Forgot User ID](#) [Forgot Password](#) [New User](#) [Bookmark This Site](#)

Patient Eligibility & Benefits	Claims & Payments	Notifications/Prior Authorizations	Tools & Resources	Clinician Resources
--	---------------------------------------	--	---------------------------------------	-------------------------------------

Welcome to UnitedHealthcare Online

A resource for physicians and other healthcare professionals.

[TAKE THE TOUR](#) [GETTING STARTED](#)
[CONTACT US](#) [REGISTER TODAY](#)



image

Quick Links

- [Policies, Protocols and Administrative Guides](#)
- [HIPAA 5010 and ICD-10](#)
- [Prescription Drug Lists](#)
- [Training & Education](#)
- [View Your UnitedHealth Premium Assessment Report](#)
- [Network Bulletin](#)
- [Electronic Payments and Statements](#)


News

 [Register to receive important news and updates, including the Network Bulletin](#)

- (08/27/2012) [UnitedHealthcare West Eligibility, Benefits and Claims Status on UnitedHealthcareOnline.com](#) ★ New
- (08/27/2012) [Important Changes In Notification and Prior Authorization Procedures](#) ★ New
- (08/27/2012) [Website Training for UnitedHealthcare Community Plan of Nebraska Providers](#) ★ New
- (08/26/2012) [Urgent Alert to Providers in Preparation for Hurricane Isaac](#) ★ New
- (08/20/2012) [UnitedHealthcare West Electronic Data Interchange \(EDI\) Information](#) ★ New

In The Spotlight

Invitation For:
Texas Physicians




The HealthSelectSM of Texas health insurance plan will be administered by UnitedHealthcare beginning on September 1, 2012.

[Sign up to learn more](#) about Navigate[®] the product for HealthSelect of Texas members or attend a

Home page, post login

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 Welcome,

[Logout](#) | [My Account](#) | [Not](#) | [Bookmark This Site](#)

Patient Eligibility & Benefits | **Claims & Payments** | **Notifications/Prior Authorizations** | **Tools & Resources** | **Clinician Resources**

Check Eligibility & Benefits

Enrollee#, DOB Search Enrollee#, Name Search

Alpha Search Swipe/Scan Health Care ID Card

*Enrollee Number:

*Date of Birth:(mm/dd/yyyy)

*Date to Check:(mm/dd/yyyy)

*Search for:

Family Information Individual Information

* Subscriber information required to complete a Family Search.

[Search for Multiple Enrollees](#)

Check Claim Status

Quick Search

*Corporate Tax ID Owner:

*Physician/Provider Tax ID:

*Physician/Provider Name:

Time Period:


All Paid Payable Pending Denied
















[More Search Options...](#)

Quick Links

- [Policies, Protocols and Administrative Guides](#)
- [HIPAA 5010 and ICD-10](#)
- [Prescription Drug Lists](#)
- [Training & Education](#)
- [View Your UnitedHealth Premium Assessment Report](#)
- [Network Bulletin](#)
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News

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- (08/26/2012) [Urgent Alert to Providers in Preparation for Hurricane Isaac](#)   
- (08/20/2012) [UnitedHealthcare West Electronic Data Interchange \(EDI\) Information](#)   

In The Spotlight

Invitation For:
Texas Physicians



The HealthSelectSM of Texas health insurance plan will be administered by UnitedHealthcare beginning on September 1, 2012.

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Search:

Check eligibility and benefits

Patient Eligibility

[Help](#) [Printer Friendly Page](#)

Patient Search

Search by: Enrollee#, DOB Search Enrollee#, Name Search
 Alpha Search Swipe/Scan Health Care ID Card

* Indicates Required Field

* Subscriber information required to complete a Family Search.

* Enrollee Number	* Date of Birth (mm/dd/yyyy)	* Enrollee Number	* Date of Birth (mm/dd/yyyy)
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>

*Search for: Family Information Individual Information

*Date to check: (mm/dd/yyyy)

By using this search function you represent to us that you have obtained authorization from the patient whose name is being searched, to view his or her personal information in connection with the provision of medical services.

Related Links

- [Consumer Driven Health Plans](#)
- [HIPAA 5010 and ICD-10](#)
- [Herceptin Policy Notice](#)
- [I Speak Cards \(interpretive services in CA\)](#)
- [Integrated Card](#)
- [Issue: Family Deductibles of \\$10,000 or More](#)
- [Medical Policies](#)
- [Network Contacts](#)
- [Patient Eligibility](#)
- [Patient Eligibility and Benefits Quick Reference](#)
- [Prescription Drug List](#)
- [Products and Services](#)
- [Reimbursement Policies](#)
- [Swipe Health Care ID Cards Quick Reference](#)
- [Tutorial](#)

Check eligibility and benefits, continued

Patient Eligibility

Help Printer Friendly Page

Patient Search

Other Transactions for this Patient

Eligible for:

Subscriber Number:

Group Number:

Product:

Insurance Type:

Electronic Payer ID:

Claims Address:

Effective Date:

Termination Date:

Eligible for Language Assistance:

Verbal Language Preference:

Written Language Preference:

Service Coordinator:

Phone Number:

Email Address:

Message: A future timeline may be available for this member. For future coverage please call the telephone number located on the back of the member's Medical ID card.

Eligibility Details
Deductibles & Out of Pocket
Copays & Coinsurance
Additional Benefits Information

Eligibility Details

Patient Details	Primary Care Physician Details
Name: <input type="text"/>	Provider Name: <input type="text"/>
Date of Birth: <input type="text"/>	Provider Number: <input type="text"/>
Gender: <input type="text"/>	Phone Number: <input type="text"/>
Relationship: <input type="text"/>	Address: <input type="text"/>
Address: <input type="text"/>	Start Date: <input type="text"/>
	End Date: <input type="text"/>

Coordination of Benefits

Carrier Name: Date COB verified:

UnitedHealthcare Primary:

Lab Information	Radiology Information
Lab Name	Radiology Name
Start Date	Start Date
End Date	End Date

HEDIS/EPST

Refer to [Community Plan Reports](#)

[BACK TO SEARCH PAGE](#)

Eligibility details tab

Notifications/Prior Authorizations

Notification/Prior Authorization Submission

 [Help](#)  [Printer Friendly Page](#)

1 — 2 — 3 — 4 — 5

Note: Unitedhealthcare Online now supports most notifications/prior authorizations online. For further information on Advance, Admission and other notification/prior authorization requirements, visit the [Advance & Admission Notification](#) page or consult the notification/prior authorization list in the Provider Notification/Prior Authorization Guide. For further assistance, please call the number on the back of the member's health care ID Card.

Note: Submit radiology notifications via [Radiology Notification Submission & Status](#).

Note: Swipe/Scan ID card option may not work for all members. Please select a different search type if you have difficulty with the Swipe/Scan ID card feature.

Note: Submit Medicare Specialty Drug authorizations via [Specialty Drug Prior Authorization Submission & Status \(Medicare Part B\)](#).

Notification/Prior Authorization Type

*Notification/Prior Authorization Type:

Admitting/Attending Physician

Search for: Admitting/Attending Physician Facility (e.g. hospitals and skilled nursing facilities)

*Corporate Tax ID Owner:

*Physician/Provider Tax ID:

*Physician/Provider Name:

*Physician/Provider Address:

SEARCH

Electronic Payments & Statement

Electronic Payments & Statements (EPS)

 [Help](#)  [Printer Friendly Page](#)

Note: If you receive a pop-up blocker message from your internet browser, you will need to disable this feature in order to continue to use Electronic Payments and Statements. Go to "Related Links" on the right side of this page and select "How to turn off pop-up blockers" for instructions.

Electronic Payments & Statements (EPS)

- Eliminate paper checks and receive electronic claims payments
- View and print **multiple EOBs**


*Indicates Required Field

*Corporate Tax ID Owner: 
CONTINUE



Single Explanation of Benefit (EOB) Search

*Indicates Required Field

Search by: Status and Date Payment Number

*Corporate Tax ID Owner: 





*Physician/Provider Tax ID:  *Status: 

*EOB Start Date:  *EOB End Date: 
(mm/dd/yyyy) (mm/dd/yyyy)

Note: EOB Date is the date that appears on the EOB/check. If you are unsure of the EOB date, enter a range starting from when the claim was submitted through 4 weeks past that date.

SEARCH

Related Links

- [Administrative Guides](#)
- [EPS Enrollment Form](#) 
- [EPS FAQs](#)
- [EPS NPI Addendum Form](#) 
- [EPS Program Overview](#) 
- [EPS User Guide](#) 
- [Electronic Payments & EOB Quick Reference](#) 
- [HIPAA 5010 and ICD-10](#)
- [How to Secure an 835](#)
- [How to turn off pop-up blockers](#) 
- [Medicare Non-contracted Provider Appeal & Dispute](#)
- [Rights](#) 
- [National Provider Identifier EPS FAQs](#)
- [UnitedHealthcare Community Plan Electronic Payments \(EFT\)](#)
- [Welcome to EPS Demo](#)

Live and Work Well

The screenshot shows the liveandworkwell website. At the top, there is a navigation bar with the logo and links for Home, LiveWell (Life, Family & Relationships), BeWell (Health & Well-Being), and WorkWell (Education, Work & Career). A search bar and a language dropdown are also present. The main content area features a featured article titled "Bouncing Back: Learning to be Resilient" with a sub-image of a hand painting the word "POSSIBLE" on a wall. Below this are three smaller images representing different categories: Life, Family & Relationships; Health & Well-Being; and Education, Work & Career. A "Welcome UHC Community Plan - Wellness4Me Members!" section provides popular wellbeing resources, my health family links, and other useful links. A "Clinician Search" section lists various conditions with associated FAQs and toolkits. A "Contact Us" section provides information on 24/7 support and a phone number. The footer includes the UnitedHealthcare Community Plan logo and a URAC Accredited Health Web Site seal.

Live and Work Well, continued

Clinician Vetted Education, Programs and Tools:

- Cognitive behavioral therapy based programs on depression, anxiety, stress, drinking, drug use
- Articles, newsletters, multimedia and guides
- Health calculators
- Mental health screeners
- eCards
- Forums
- Webinars
- NY-specific resource database
- Additional searchable databases to lookup information/resources on childcare, eldercare, health conditions, alternative medicine, drug interactions and more!

Practical parenting information and news

Parents Enter

Homework help, games and information for kids

Kids Enter

Answers, advice and straight talk for teens

Teens Enter

Breathe

The Breathe tool lets you take a moment to tune in to what's going on for you.

Rating: Easy
Duration: 2 min 18s
Download: [MP3](#)



00:00 00:00


Personal Empowerment Kits

No matter where you are on your journey to well-being, it's important that you build your resiliency. You might be prescribed medication that will help you, but you need to do more to achieve your long-term recovery and well-being. These toolkits offer a range of different tools you can use depending on your personal preferences. Do you like the idea of using a game to build resiliency? How about a graphic novel approach? Perhaps you prefer journaling or meditation? How about tracking your journey to long-term recovery and well-being?




You'll find all that and more in these toolkits:

- ▶ [Addiction Recovery Tools](#) 
- ▶ [Family Recovery and Resiliency Tools](#) 
- ▶ [Recovery, Resiliency and Empowerment Tools](#) 
- ▶ [Smartphone Apps for Substance Use Disorder Treatment/Recovery](#) 
- ▶ [Tools You Can Use](#) 

 [Register or login to access benefits & manage claims](#)

 [Search for Clinician](#)

 [Get care and services](#)

 [Contact us](#)

Hot Topics

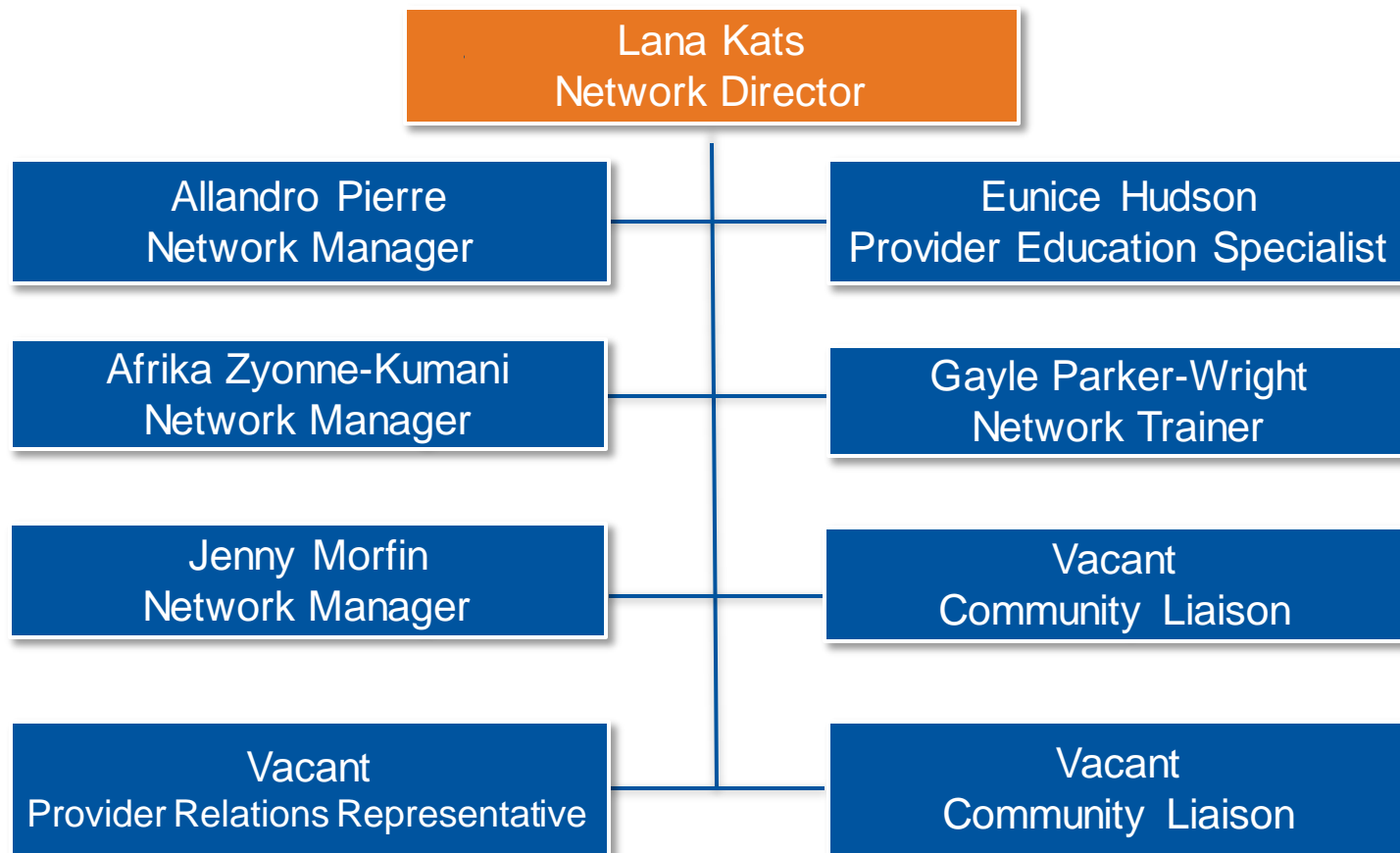
- ▶ [Mental Health](#)
- ▶ [Drinking, Drugs and Addictions](#)
- ▶ [Personal Empowerment Kits](#)
- ▶ [Building Your Way to Wellness](#)
- ▶ [Self-Help Programs](#)
- ▶ [WorkLife Balance](#)
- ▶ [Video Voices of Hope](#)
- ▶ [Important Notice on Payment of Out-of-Network Benefits](#)
- ▶ [Aviso Importante sobre el Pago de Beneficios Fuera de la Red](#)



Network Services

Lana Kats, MBA, Director of Network Management for NY Public Sector

New York Medicaid Network Services team



Appointment availability standards

Time frames represent requirements based on the date of the appointment request.

- MH Outpatient Clinic/PROS Clinic
 - Urgent Care: within 24 hours
 - Non Urgent MH/SUD: within 1 week
 - Follow-up to emergency or hospital discharge: within 5 days
 - Follow-up to jail/prison discharge: within 5 days
- ACT
 - Urgent Care: within 24 hours for Assisted Outpatient Treatment (AOT)
 - Follow-up to emergency or hospital discharge: within 5 days
- PROS
 - Non Urgent MH/SUD: within 2 weeks
 - Follow-up to emergency or hospital discharge: within 5 days

Appointment availability standards, continued

Time frames represent requirements based on the date of the appointment request.

- Continuing Day Treatment
 - Behavioral Health Specialist: 2 to 4 weeks
- Intensive Psychiatric Rehabilitation Treatment (IPRT)
 - Behavioral Health Specialist: 2 to 4 weeks
- Partial Hospitalization:
 - Follow-up to emergency or hospital discharge: within 5 days
- OASAS Outpatient Clinic
 - Urgent Care: within 24 hours
 - Non Urgent MH/SUD: within 1 week
 - Follow-up to emergency or hospital discharge: within 5 days

Appointment availability standards, continued

Time frames represent requirements based on the date of the appointment request.

- MH Outpatient Clinic/PROS Clinic
 - Urgent Care: within 24 hours
 - Non Urgent MH/SUD: within 1 week
 - Follow-up to emergency or hospital discharge: within 5 days
 - Follow-up to jail/prison discharge: within 5 days
 - Detoxification
 - Emergency: upon presentation
 - Substance Use Disorder Inpatient Rehabilitation
 - Emergency: upon presentation
 - Urgent MH/SUD: within 24 hours
 - Opioid Treatment Program
 - Urgent MH/SUD: within 24 hours
-

Appointment availability standards, continued

Time frames represent requirements based on the date of the appointment request.

- Crisis Intervention/Respite
 - Emergency: immediately
 - Urgent MH/SUD: within 24 hours for short term respite
 - Follow-up to emergency or hospital discharge: immediately
- Rehabilitation services for residential SUD treatment supports
 - Behavioral Health Specialist: 2 to 4 weeks
 - Follow-up to emergency or hospital discharge: within 5 days
- Comprehensive Psychiatric Emergency Program (CPEP)
 - Emergency: upon presentation
- Inpatient Psychiatric Services
 - Emergency: upon presentation

Appointment availability standards, continued

Time frames represent requirements based on the date of the appointment request.

- Rehabilitation and Habilitation
 - Non Urgent MH/SUD: within 2 weeks
 - Follow-up to emergency or hospital discharge: within 5 days
- Educational and Employment Support Services
 - Non Urgent MH/SUD: within 2 weeks
- Peer Supports Services (PSS)
 - Urgent Care: within 24 hours
 - Non Urgent MH/SUD: within 1 week*
 - Follow-up to emergency or hospital discharge: within 5 days

*Unless appointment is pursuant to emergency or hospital discharge, in which case the standard is within 5 days; or if PSS are needed more urgently for symptom management, the standard is within 24 hours

Appointment availability standards, continued

Time frames represent requirements based on the date of the appointment request.

- Psychosocial Rehabilitation*
 - Non Urgent MH/SUD: within 2 weeks
- Community Psychiatric Support and Training*
 - Non Urgent MH/SUD: within 2 weeks
- Family Support and Training*
 - Non Urgent MH/SUD: within 2 weeks
- Educational and Employment Support Services
 - Non Urgent MH/SUD: within 2 weeks

*Unless appointment is pursuant to an emergency or hospital discharge or release from incarceration, in which case the standard is within 5 days of request

Provider Service Quick Guide, page 1



Provider Service Quick Guide Mainstream Medicaid & Wellness4Me

Call Center for UnitedHealthcare	1-866-362-3368
Websites & What's Available	<p>providerexpress.com</p> <ul style="list-style-type: none"> ▪ Demographic Updates ▪ Guidelines and Policies ▪ Best Practice Guidelines ▪ Level of Care Guidelines ▪ Recovery & Resiliency Toolkit ▪ Network Manual ▪ Trainings and Webinars ▪ Sentinel Events Reporting Form <p>uhcommunityplan.com</p> <ul style="list-style-type: none"> ▪ A website for Health Care Professionals, Community Organizations and Members ▪ For providers the links will direct you to important information in your state ▪ Directs you to our secure provider site UnitedHealthcare Online® <p>unitedhealthcareonline.com</p> <ul style="list-style-type: none"> ▪ Check member eligibility ▪ Check claim status & payments ▪ Claims Reconsideration ▪ Electronic Data Interchange (EDI) information ▪ Tools & Resources ▪ Tutorials
Claims Submission	<p>Paper Claim submission: Optum Behavioral Health P.O. Box 30760 Salt Lake City, UT 84130-0760</p> <p>Claims must be submitted within 120 days from the date of service</p>
EDI	<p>Payer ID : 87726 EDI Support: 800-210-8315 or email ac_edi_ops@uhc.com</p>



Provider Service Quick Guide, page 2

Electronic Payments & Statements (EPS)	It's quick and easy, go to UnitedHealthcare Electronic Payments & Statements (www.unitedhealthcareonline.com) > Claims & Payments > Electronic Payments & Statements Questions - 866-842-3278, option 5
Appeals	UnitedHealthcare Community Plan, Appeals P.O. Box 31364 Salt Lake City, UT 84131
Care Advocacy	1-866-362-3368
Best Practice Guidelines	We have adopted Best Practice Guidelines, which were developed by nationally recognized organizations. Provider Express > Guidelines/Policies & Manuals > Best Practice Guidelines
Utilization Management Guidelines	<p>Additional details about utilization management guidelines are located in the New York Medicaid Behavioral Health Manual</p> <p>Prior Authorization is not required for:</p> <ul style="list-style-type: none"> ▪ Outpatient mental health and substance use clinic services ▪ Initial medically necessary emergency and post-stabilization services, including emergency behavioral health care ▪ Urgent care ▪ Crisis stabilization, including mental health ▪ Post-stabilization care services ▪ Personalized Recovery Oriented Services (PROS) pre-admission status ▪ Opioid Treatment Program (OTP) ▪ Substance use disorder intensive outpatient ▪ Substance use disorder day rehabilitation ▪ Medically supervised outpatient substance withdrawal <p>Prior Authorization is required for:</p> <ul style="list-style-type: none"> ▪ Facility-based care ▪ Non-routine outpatient care including but not limited to, psychological testing and extended sessions of 53 minutes or more ▪ Home and Community Based Services (HCBS) ▪ Personalized Recovery Oriented Services (PROS) admission (60 days) & active rehabilitation status ▪ Continuing Day Treatment (CDT) ▪ Mental Health Intensive Outpatient Program (MH IOP) ▪ Assertive Community Treatment (ACT) ▪ Partial Hospitalization ▪ Residential substance use treatment
Medical Transportation	UnitedHealthcare Community Plan Transportation Reservation line: 1-866-913-2497 UnitedHealthcare Community Plan Ride Assistance (Where's my ride): 1-866-913-2498

Future training opportunities and communications

- Webinars of this presentation will be available throughout September and October
- Targeted HCBS Provider training (prior to 1/1/16 go-live date)
- Additional billing training (pending state approval of the billing manual)

We look forward to feedback from you to help us identify potential future training topics

Provider Alerts will be used to inform providers about future trainings, changes to processes, and posting of information to Provider Express

Contact us

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Thank you for attending today

Questions
