Billing and Claims Overview:
New York Medicaid and Wellness4Me Rest of State

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

BH593_05172016

Wellness4Me Plan (HARP) and Mainstream Medicaid

Covered Benefits for HARP and Behavioral Health Benefit		
Services	**HARP Enrolled Members**	**Medicaid Behavioral Health Benefit**
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
PROS	Covered	Covered
ACT	Covered	Covered
Intensive case management/ supportive case management	Covered	Covered
Health Home Care Coordination and 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
Rehabilitation services for residents of community residences	Covered	Covered

Wellness4Me Plan (HARP) vs. Behavioral Health Benefit

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

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

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Managed Care Technical Assistance Center

The Community Technical Assistance Center of New York (CTAC) and the Managed Care Technical Assistance Center (MCTAC) are a training, consultation, and educational resource center serving all behavioral health agencies 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
  - Billing Tool
  - Interactive online FAQ
  - MCO Plan Comparison Matrix
- Website: ctacny.org

Billing requirements

Requirements

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

Location of state billing and coding manual:

omh.ny.gov/omhweb/bho/billing-services.html

Mainstream Medicaid

New Carved-In Services

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

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 day
  - 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)
- Claim 2 – Rate code 4525 in the header (field 39 on UB-04) plus T1015HE and 1unit at the line level (fields 44 and 46)

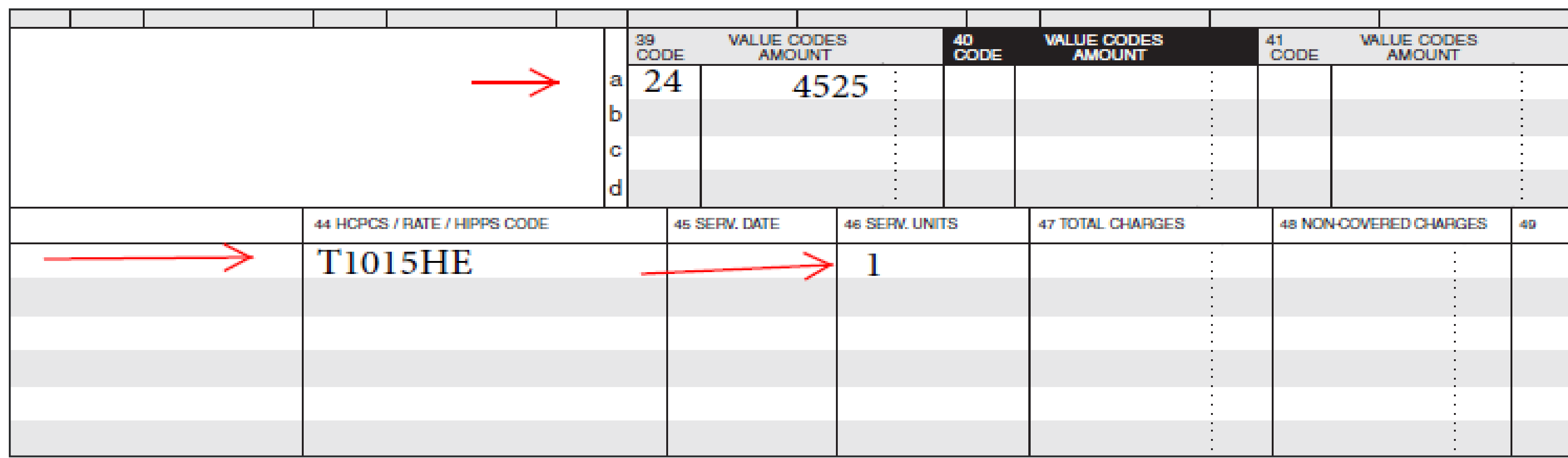
PROS example, UB-04

	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)

PROS example, UB-04 continued



	39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
a	24	4525				
b						
c						
d						

44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
T1015HE		1			

- Claim 2 – Value Code 24 and Rate code 4525 in the header (field 39 on UB-04) plus T1015HE and 1unit 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

OASAS Certified Substance Use Disorder (SUD) Services /Programs

- Outpatient Services
  - Setting: outpatient clinic
- Opioid Treatment Services
  - Setting: Opioid Treatment Programs (OTP)
- Intensive Outpatient Treatment
  - Setting: outpatient rehabilitation

Billing requirements

OASAS claims are reimbursed based on APG methodology

- UB-04 claim form; 837i
- Value code “24”
- 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

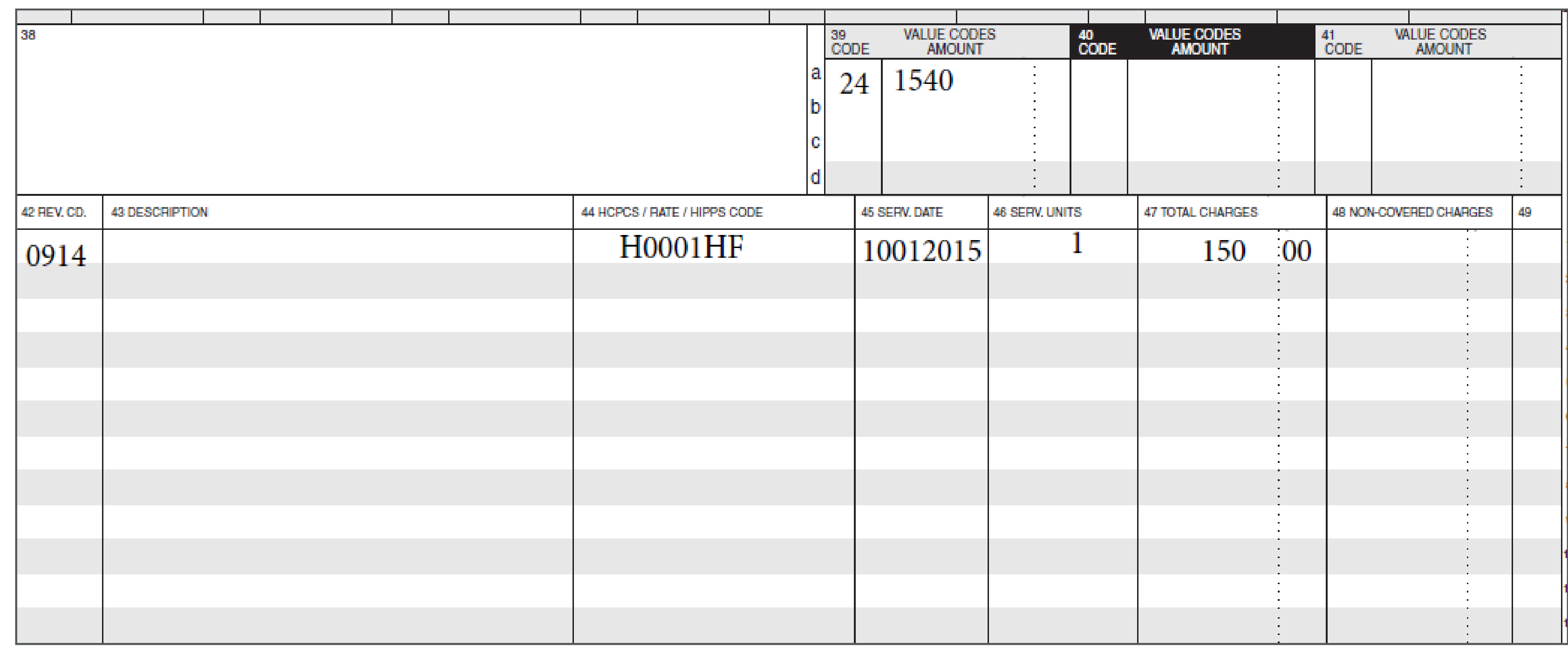
Title 14 NYCRR Part 822 Hospital Based OASAS Certified Outpatient (Article 28 /Article 32)

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

OASAS example

Table Two – Providers will enter the line level coding for SUD outpatient services including: CPT / HCPCS codes; unit (if applicable); **and, the HF modifier on each service line**					
APG	**OASAS Service Category Description**	**CPT Codes ☑**	**CPT Code Description**	**HCPCS Codes ☑**	**HCPCS description**
318	Group Therapy 60 minute minimum	90853	Alcohol &/or Drug Services (group counseling by a clinician)	H0005	Alcohol/Substance; group counseling by a clinician
318	Group Therapy 60 minute minimum	90849	Multiple Family Group (adolescent patients) (60-90 minutes)	N/A	
322	Medication Administration & Observation No minimum time		N/A	H0033	Oral Medication, direct observation
322	Medication Administration & Observation No minimum time		N/A	H0020	Alcohol / drug services methadone admin
323	Assessment – Normative 30 minute minimum		N/A	H0001	Alcohol / drug assessment

OASAS example, UB-04



38		39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
	a	24	1540				
	b						
	c						
	d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
0914		H0001HF	10012015	1	150 00		

References for slides 22-24:
NYS HARP/Mainstream Behavioral Health Billing & Coding Manual
Rate code – Table One: OASAS Outpatient Rate Codes
Procedure Code – Table Two: Outpatient CPT/HCPCS Coding

Wellness4Me: Home and Community Based Services (HCBS)

Covered 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 billing requirements

Requirements

- 837i claim form (institutional) electronic form
- UB-04 (institutional) paper form
- Value code “24”
- Medicaid Fee-For-Service rate code
- Revenue code 0911
- Valid procedure code(s)
- Procedure code modifiers (as needed)
- Units of service

HCBS utilization parameters

Behavioral Health HCBS services will be subject to utilization caps at the Member level that apply in a calendar year.

- 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

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Psychosocial Rehabilitation (PSR)

Three different types of sessions

- Individual, per 15 minutes:
  - Billed in 15 minute units with a limit of 8 units per day (2 hours)
  - May be billed the same day as a PSR group session; can't be billed on the same day as a PSR individual per diem
  - May be provided on or off-site
  - Staff transportation is billed separately as appropriate
- Individual, per diem:
  - Billed daily with a max of 1 unit
  - May not be billed the same day as a PSR group session or an individual per 15 minutes
  - May be billed on or off-site
  - Staff transportation billed separately as appropriate
- Group:
  - Billed daily in 15 minute units with a limit of 4 units per day (1 Hour)

Community Psychiatric Support & Treatment (CPST)

- Billed daily in 15 minute increments
- Payment is broken into various levels through the use of the procedure codes and, when applicable modifier codes, that indicate the type of staff providing the service
- No group sessions
- May only be provided off-site
- Staff transportation is billed separately as appropriate: transportation billing is done at the Member level and then is only for a single staff member, regardless of the number of persons involved in providing the service

Habilitation/Residential Support Services

- Billed daily in 15 minute increments with a limit of 12 units (3 hours) per day
- There are no group sessions for this service
- May be provided on or off-site
- Staff transportation is billed separately as appropriate

Family Support and Training (FST)

Session provided to one family:

- Billed daily in 15 minute increments with a limit of 12 units per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate

Group (consists of 2-3 families):

- Billed daily in 15 minute increments with a limit of 12 units per day
- May be billed on the same day as a FST one family session
- May be provided on or off-site

Short Term Crisis Respite

- Billed daily with a max unit of 1 per day
- Stays may be no longer than 7 days per episode, not to exceed a maximum of 21 days per year (some exceptions apply, see HCBS manual)
- May only be provided in facilities dedicated to this purpose
- Fee includes transportation, do not bill transportation separately

Intensive Crisis Respite

- Billed daily with a max unit of 1 per day
- Stays may be no longer than 7 days per episode, not to exceed a maximum of 21 days per year (some exceptions apply, see HCBS manual)
- May only be provided in facilities dedicated to this purpose
- Fee includes transportation, do not bill transportation separately

Additional services, continued

Education Support Services

- Billed daily in 1 hour units with a max units of 2 (2 hours)
- May be provided on or off-site
- Staff transportation is billed separately as appropriate

Empowerment Services, Peer Supports

- Billed daily in 15 minute units with a limit of 16 units (4 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate

Additional services, continued

Pre-Vocational Services

- Billed daily in 1 hour units with a limit of 2 units (2 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate: transportation billing is done at the Member level and then is only for a single staff member, regardless of the number of persons involved in providing the service

Transitional Employment

- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate: transportation billing is done at the Member level and then is only for a single staff member, regardless of the number of persons involved in providing the service

Additional services, continued

Intensive Supportive Employment

- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate
- Modifier is used to indicate “Complex Level of Care”

On-Going Supported Employment

- Billed daily in 15 minute units with a limit of 12 units (3 hours) per day
- May be provided on or off-site
- Staff transportation is billed separately as appropriate

Transportation

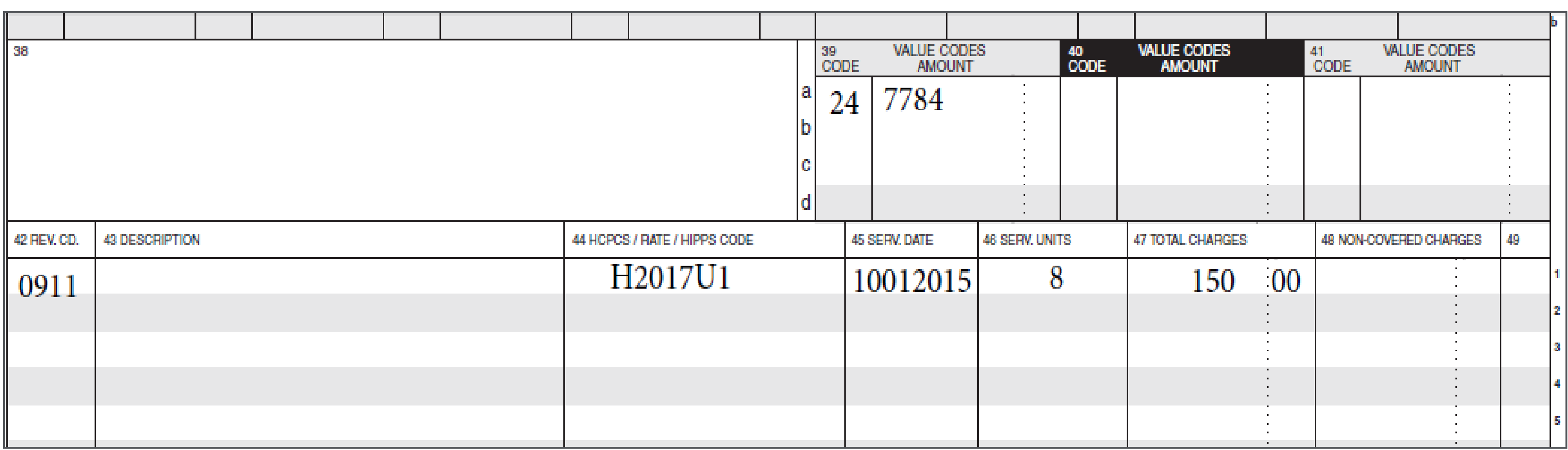
Staff transportation, non-emergency

- Per mile:
  - Billed daily in per mile units with a limit of 60 miles for a round trip
  - 0.58 cents per mile (per federal guidelines)
- Per round trip:
  - Billed monthly using the first day of the month as date of service
  - Each round trip counts as one unit, with a limit of 31 units per calendar month

HARP HCBS crosswalk example

Rate Code	Rate Code Description	Px Code	Px Code Description	Modi-fiers	Unit Measure	Units Limits (Claim Line Level)	Other rate codes prohibited on same day (combination edits)
7784	HARP HCBS Psychosocial Rehab - Indv - on-site	H2017	Psychosocial rehabilitation services; per 15 minutes	U1	Per 15 min	8	7785, 7789
7785	HARP HCBS Psychosocial Rehab - Indv - off-site	H2017	Psychosocial rehabilitation services; per 15 minutes	U2	Per 15 min	8	7784, 7789
7786	HARP HCBS Psychosocial Rehab - Group 2-3	H2017	Psychosocial rehabilitation services; per 15 minutes	UN or UP	Per 15 min	4	7787, 7788, 7789
7787	HARP HCBS Psychosocial Rehab - Group 4-5	H2017	Psychosocial rehabilitation services; per 15 minutes	UQ or UR	Per 15 min	4	7786, 7788, 7789
7788	HARP HCBS Psychosocial Rehab - Group 6-10	H2017	Psychosocial rehabilitation services; per 15 minutes	US	Per 15 min	4	7786, 7787, 7789

HARP HCBS example, UB-04



38		39 CODE	VALUE CODES AMOUNT	40 CODE	VALUE CODES AMOUNT	41 CODE	VALUE CODES AMOUNT
	a	24	7784				
	b						
	c						
	d						

42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
0911		H2017U1	10012015	8	150 00			1
								2
								3
								4
								5

Other rate codes prohibited on same day (combination edits): 7785 and 7789

Required fields, UB-04, top

Billing Provider Information
Billing provider designated Pay-To
Type of Bill
TIN
From and Through dates
Patient's name
Patient's address
Birthdate & Sex
Value code & rate code
Revenue code
Procedure code & Modifier(s)
Service date
Service units
Total charges

1
2
3a PAT. CNTL #
b. MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME a
b
9 PATIENT ADDRESS
b c d e
10 BIRTHDATE
11 SEX
12 DATE
ADMISSION 13 HR 14 TYPE 15 SRC
16 DHR
17 STAT
CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28
29 ACDT STATE
30
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
a
b
38
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
a
b
c
d
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
1
2
3
4

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Required fields, UB-04, bottom

PAGE ____ OF ____ CREATION DATE TOTALS

50 PAYER NAME | 51 HEALTH PLAN ID | 52 REL INFO | 53 ASG BEN. | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 NPI

Program NPI

57 OTHER PRV ID

58 INSURED'S NAME | 59 P.REL | 60 INSURED'S UNIQUE ID | 61 GROUP NAME | 62 INSURANCE GROUP NO.

Insured ID #

63 TREATMENT AUTHORIZATION CODES | 64 DOCUMENT CONTROL NUMBER | 65 EMPLOYER NAME

66 DX

ICD-10-CM

Attending NPI, last and first name

Unlicensed practitioners (i.e CASAC)

69 ADM DX | 70 PATIENT REASON DX | 71 PPS CODE | 72 ECI

74 PRINCIPAL PROCEDURE CODE DATE | a. OTHER PROCEDURE CODE DATE | b. OTHER PROCEDURE CODE DATE | 75

c. OTHER PROCEDURE CODE DATE | d. OTHER PROCEDURE CODE DATE | e. OTHER PROCEDURE CODE DATE

76 ATTENDING NPI QUAL LAST FIRST

77 OPERATING NPI QUAL LAST FIRST

78 OTHER NPI QUAL LAST FIRST

Referring provider

79 OTHER NPI QUAL LAST FIRST

80 REMARKS | 81CC a b c d

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997 THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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

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

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 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 UHCCommunityplan.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 unitedhealthcareonline.com

Electronic Payments & Statements (EPS)

UnitedHealthcare ONLINE | About Us | Contact Us | Physician Directory | Practice/Facility Profile | Help | Sign In | New User

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

Home > Claims & Payments > Electronic Payments & Statements (EPS) > Electronic Payments & Statements (EPS)

- Claim Estimator
- Claim Reconsideration
- Claim Research Project
- Claim Status
- Claim Submission
- Electronic Payments & Statements (EPS)
  - Electronic Payments & Statements (EPS)
- Fee Schedule Lookup
- Outpatient Procedure Grouper (OPG)
- UnitedHealthcare Online All-Payer Gateway

Electronic Payments & Statements (EPS)

Print Friendly Version

EPS is our solution for electronic remittance advice (ERA) and electronic funds transfer (EFT). EPS allows you to access your explanation of benefits (EOBs) online and receive direct deposit of claim payments into your checking or savings account.

Faster payments, better cash flow
Eliminate mail delivery and check-clearing time to receive your payments 5 to 7 days faster.

Less work, more time
No more envelopes to open, paper checks to track or trips to the bank. More than 850,000 physicians, health care professionals, facilities and billing companies use EPS today for its easier reconciliation experience, reduced paperwork and the greater efficiency it brings to administration.

No need to change your current posting process
With EPS all you need is a computer and internet connection; no special software or system upgrades are necessary. Here's how it works:

1. You and your designees receive email notifications when payments are deposited.
2. View the deposit amount and all EOBs associated with that deposit by logging onto EPS.
3. Choose your posting method. Online remittance advices mirror paper remits so you can post from the screen, download a copy, or print EOBs. If you wish, autopost using the free electronic remittance file (835).

Enrollment in EPS currently applies to payments from UnitedHealthcare Commercial, UnitedHealthcare Medicare Solutions, UnitedHealthcare Oxford, UnitedHealthcare Community Plan of Arizona, California*, Delaware, Florida, Hawaii, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Nebraska, New Jersey New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Washington and Wisconsin.

*Jan. 1, 2016

Use the links below to learn more, or call 866-842-3278, option 5.

Enroll Now

Viewing Electronic Remittance Advice (ERA), 835

optumhealthfinancial.com

Quick reminders

- Verify member eligibility
- Obtain prior authorization for those services that require it
- 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
- Home and Community Based Services require authorization except:
  - Short term crisis respite up to 72 hours
  - Staff transportation

Common errors/mistakes

- Submitting claims to the wrong payer
- Member not eligible/not active with plan
- Authorization not obtained
- NPI missing or invalid
- TIN missing or invalid
- Denied for timely filing
- Missing value code required for APG
- Wrong procedure code billed
- Duplicate claim – original paid
- Diagnosis or CPT code missing or invalid

Links to resource documents

New York State - Office of Mental (OMH) Health:

- Health and Recovery Plan (HARP) Mainstream Billing and Coding Manual
  omh.ny.gov/omhweb/bho/billing-services.html

- Home and Community Based Services (HCBS) Manual
  omh.ny.gov/omhweb/bho/hcbs-manual.html

- Fee Schedule and Rate Codes
  omh.ny.gov/omhweb/bho/phase2.html

Contact us

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Questions

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Thank you for attending today

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