

A photograph of two men in business suits shaking hands in an office. The man on the left is standing and smiling, while the man on the right is seated at a desk with a tablet. The background shows a window with greenery outside.

Provider Orientation AllWays Health Partners

Updated January 13, 2020



Go Live Date: January 1, 2019

Thank you so much for joining today.

We will be getting started momentarily.

Agenda topics

- Introduction
- Covered members, eligibility and benefits
- Clinical overview
- Covered services and authorizations
- Residential Rehabilitation Services (RRS)
- Children's Behavioral Health Initiative (CBHI) and outpatient management
- Cultural Competency
- Clinical Audits
- Adverse Incident Reporting
- Claims
- Appeals
- Program and Network Integrity
- Websites
- Network Management

Introduction

Reminder

Effective January 1, 2019, Neighborhood Health Plan, Massachusetts will become AllWays Health Partners



This presentation will use AllWays Health Partners rather than Neighborhood Health Plan

Medicaid: My Care FamilySM

My Care Family is an Accountable Care Organization (ACO) Partnership Plan for MassHealth (Medicaid). The logo below is associated with My Care Family.



Who is Optum?

Optum is a leading health services organization dedicated to making the health system work better for everyone



Our core values:

Integrity | **Compassion** | **Relationships** | **Innovation** | **Performance**

UNITEDHEALTH GROUP®



**Making the health system work
better for everyone**

**Information and technology-
enabled health services:**

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

Optum philosophy of care

Our managed care plan:

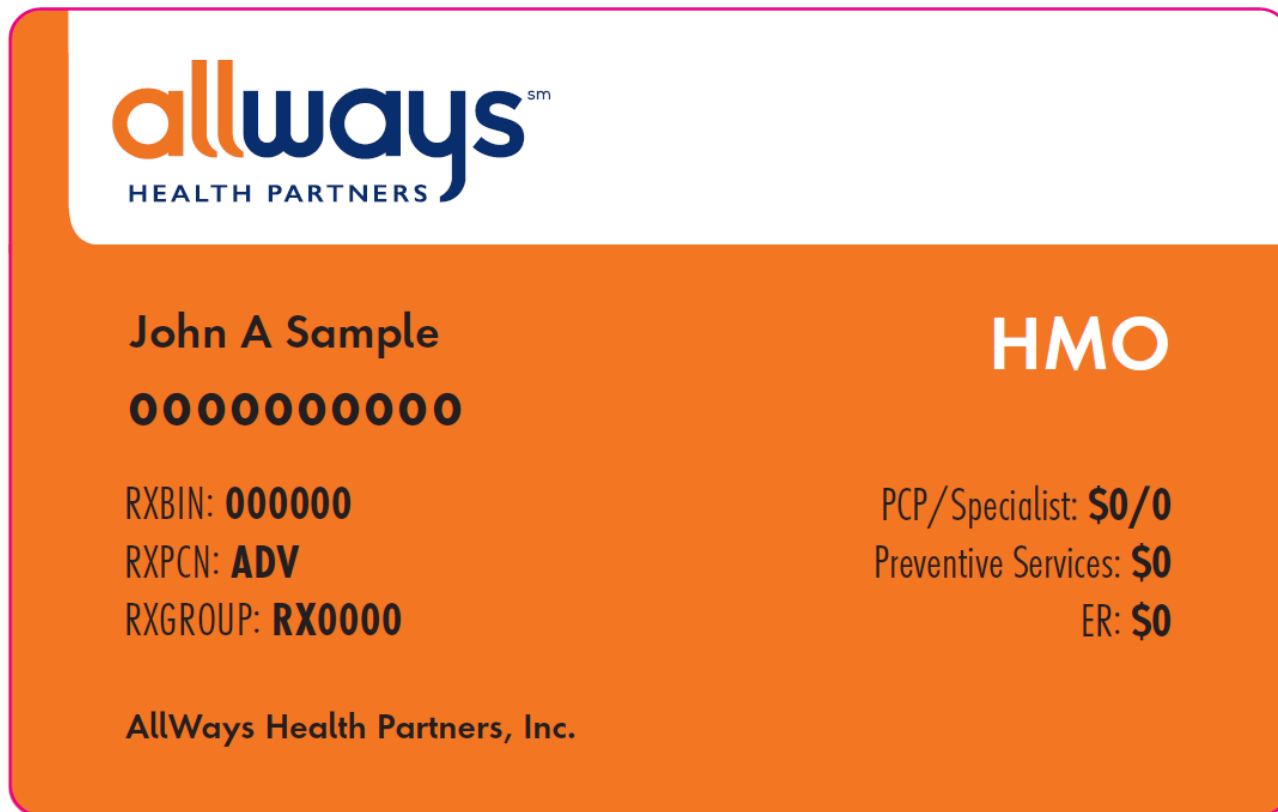
- Integrates medical and behavioral health delivery systems
- Focuses on member involvement in identifying needs
- Supports collaboration

Six key goals:

1. Improve screening and treatment of mental health and substance use disorder diagnoses
2. Treat individuals at the point of care where they are comfortable
3. Treat individuals in a holistic manner, using a single treatment plan, helping each individual access his/her natural community supports based on personal strengths and preferences
4. Improve communication and collaboration between behavioral health and medical clinicians
5. Operate with a collaborative team approach to deliver care using a standardized protocol
6. Establish the necessary permissions from the individual to coordinate care

Covered Members, Eligibility and Benefits

Member identification card, front, Health Maintenance Organization (HMO) plan



Member identification card, back, HMO plan

MEMBERS

Customer Service: **1-866-414-5533** (TTY 711)

Optum Behavioral Health Services:
1-844-451-3518 (TTY 711)

Secure Member Portal: **allwaysmember.org**
for detailed plan and provider information

Call your treating provider within 48 hours of an emergency visit.

PROVIDERS

Claims Info and Provider Manual:
allwaysprovider.org

Provider Services: **1-855-444-4647**

Behavioral Health: **1-844-451-3518**

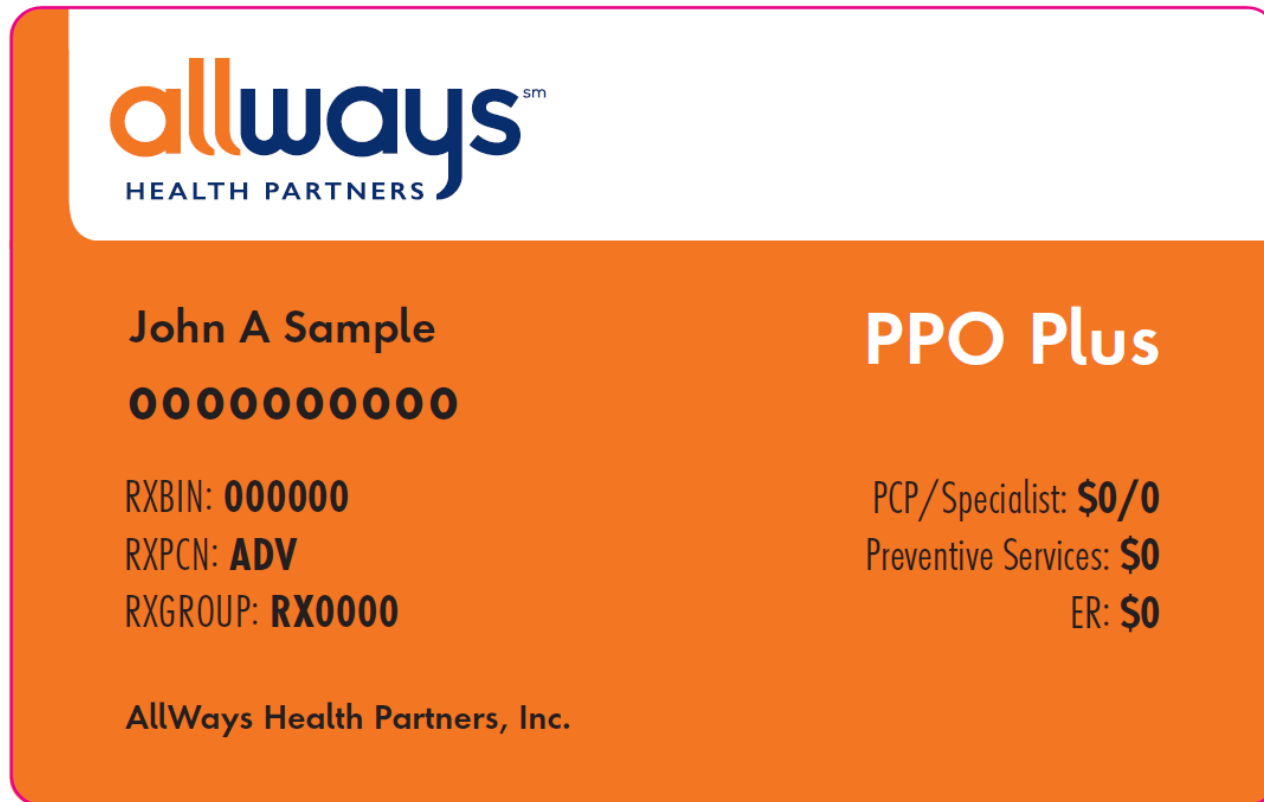
Pharmacy: **1-800-421-2342**

allwaysmember.org

This card does not guarantee coverage.

ID-51 (08/18)

Member identification card, front, Preferred Provider Organization (PPO) Plus plan



Member identification card, back, PPO Plus plan

MEMBERS

Customer Service: **1-866-414-5533** (TTY 711)

Optum Behavioral Health Services:
1-844-451-3518 (TTY 711)

Secure Member Portal: **allwaysmember.org**
for detailed plan and provider information

Out-of-network services may require a Prior
Authorization.

*Call your treating provider within 48 hours of an
emergency visit.*

PROVIDERS



Claims Info and Provider Manual:
allwaysprovider.org

Provider Services: **1-855-444-4647**

Behavioral Health: **1-844-451-3518**

Pharmacy: **1-800-421-2342**

Submit paper medical claims to:
P.O. Box 852099
Richardson, TX 75085-2099

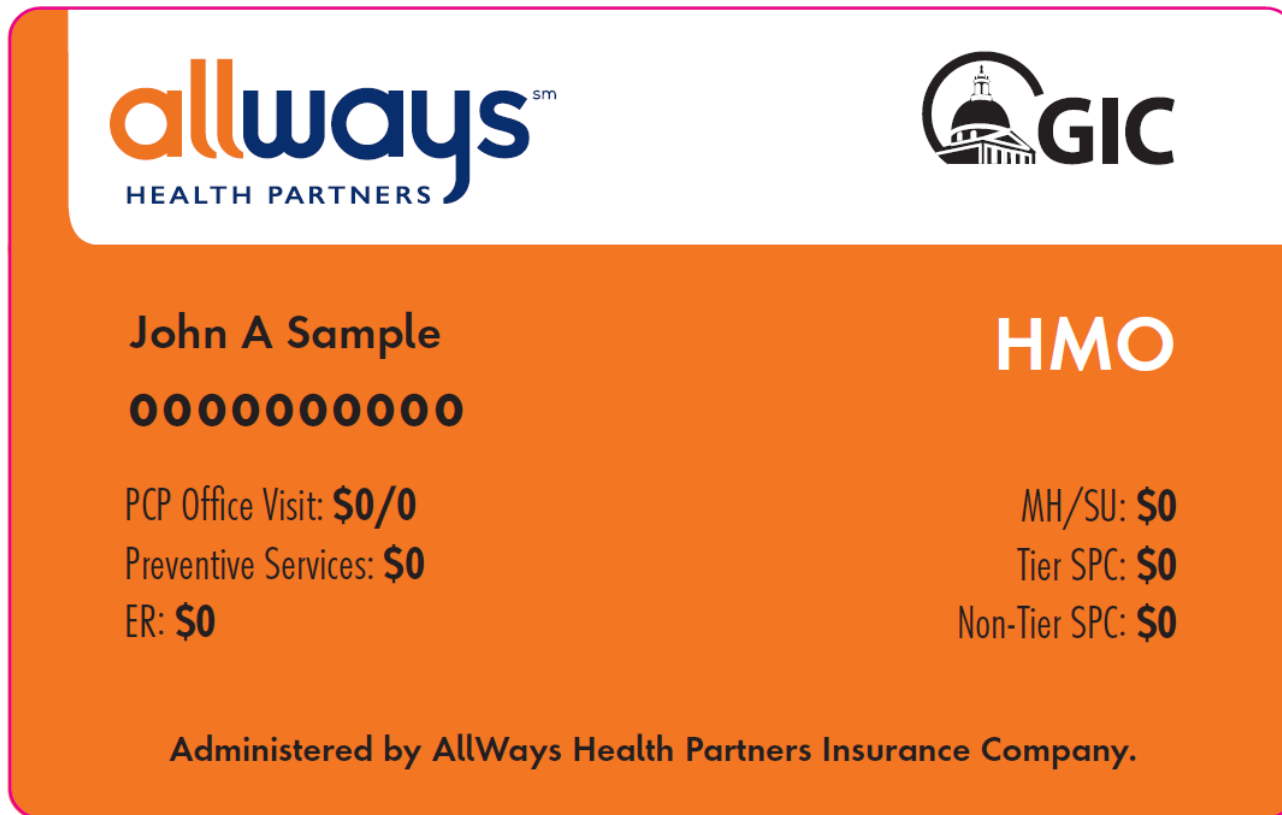
Submit paper behavioral health claims to:
P.O. Box 30757
Salt Lake City, UT 84130-0757

allwaysmember.org

This card does not guarantee coverage.

ID-57 (08/18)

Member identification card, front, Group Insurance Commission (GIC) plan



Member identification card, back, GIC plan

MEMBERS

Customer Service: **1-866-567-9175** (TTY 711)

Optum Behavioral Health Services:
1-844-875-5722 (TTY 711)

Secure Member Portal: **allwaysmember.org**
for detailed plan and provider information

*Call your treating provider within 48 hours of an
emergency visit.*

PROVIDERS

Claims Info and Provider Manual:
allwaysprovider.org

Provider Services: **1-844-875-5722**

Behavioral Health: **1-844-451-3518**

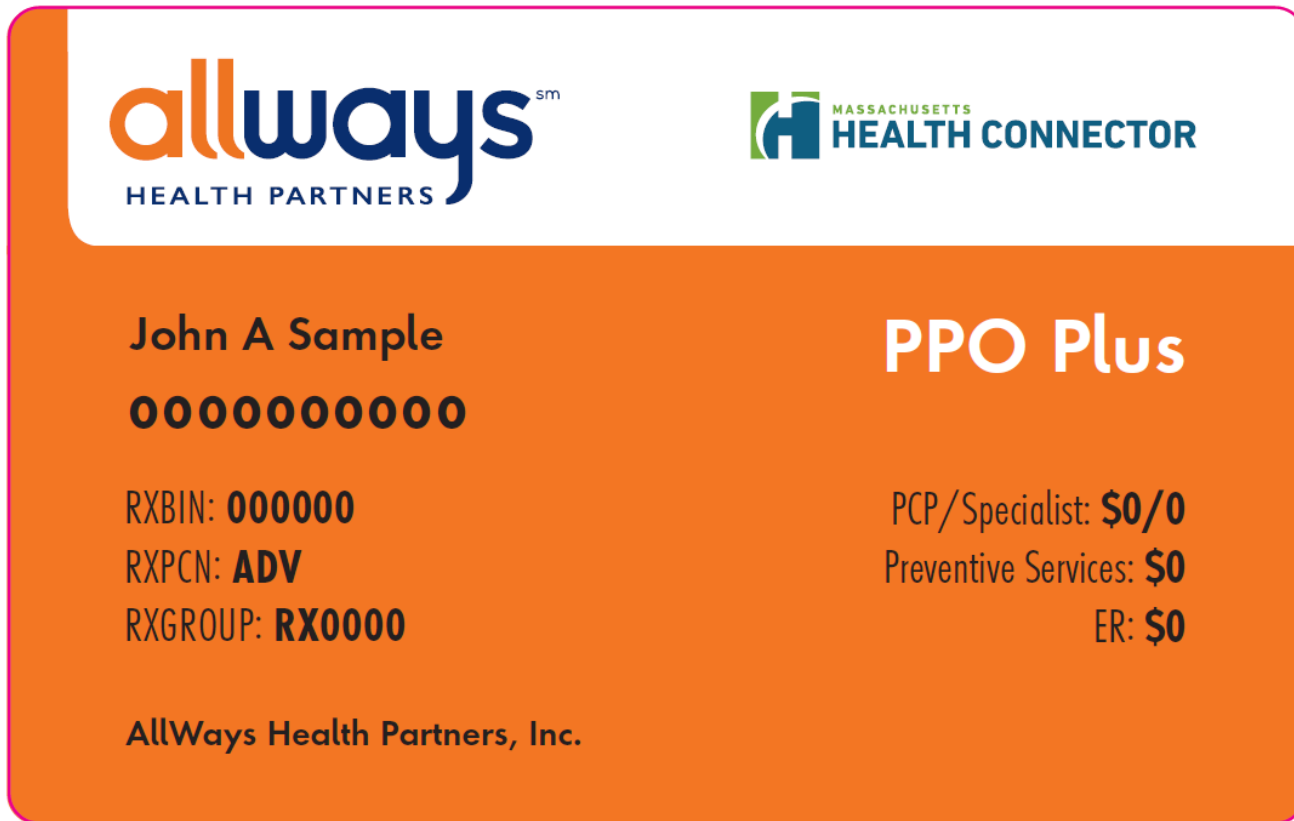
allwaysmember.org

This card does not guarantee coverage.

ID-65 (08/18)

Member identification card, front, Health Connector plan

Health Connector may be a PPO or an HMO



Member identification card, back, Health Connector plan

Health Connector may be a PPO or an HMO

MEMBERS

Customer Service: **1-866-414-5533** (TTY 711)

Optum Behavioral Health Services:
1-844-451-3518 (TTY 711)

Secure Member Portal: **allwaysmember.org**
for detailed plan and provider information

Out-of-network services may require a Prior
Authorization.

*Call your treating provider within 48 hours of an
emergency visit.*

PROVIDERS



Claims Info and Provider Manual:
allwaysprovider.org

Provider Services: **1-855-444-4647**

Behavioral Health: **1-844-451-3518**

Pharmacy: **1-800-421-2342**

Submit paper medical claims to:
P.O. Box 852099
Richardson, TX 75085-2099



Submit paper behavioral health claims to:
P.O. Box 30757
Salt Lake City, UT 84130-0757

allwaysmember.org

This card does not guarantee coverage.

ID-54 (08/18)

Member identification card, front, My Care Family (Medicaid)



My Care FamilySM
MI FAMILIA DE CUIDADORES

John A Sample
0000000000
MassHealth#

RXBIN: 004336	PCP/Specialist: \$0/0
RXPCN: ADV	Preventive Services: \$0
RXGROUP: RX1653	ER: \$0

Care and coverage through MassHealth by the Greater Lawrence Family Health Center, Lawrence General Hospital, and AllWays Health Partners

Member identification card, front, My Care Family (Medicaid)

MEMBERS

Customer Service: **1-800-462-5449**
(TTY 711)

For behavioral health services (mental health or substance use) call Optum Behavioral Health Services: **1-844-451-3519** (TTY 711)

CVS Caremark Prescription Services: **1-866-546-0662**

Visit **mycarefamily.org**, a secure member portal for detailed plan and provider information

Call your treating provider within 48 hours of an emergency visit.

PROVIDERS

Claims Info and Provider Manual:
alwaysprovider.org

Provider Services: **1-855-444-4647**

Behavioral Health: **1-844-451-3519**

Pharmacy: **1-800-421-2342**

mycarefamily.org

This card does not guarantee coverage.

ID-50 (08/18)

Understanding covered benefits



Coverage Determination Guidelines standardize the interpretation and application of terms of the Member's Benefit Plan including terms of coverage, exclusions and limitations



Coverage Determination Guidelines can be found on *Provider Express*, our industry leading provider website



Optum Members have a variety of benefits available to them



Check a Member's benefits and eligibility on *Provider Express* through secure Transactions

Benefits will be different for commercial and My Care Family members; it is essential to verify benefits before rendering services.

Eligibility and benefits verification using Provider Express

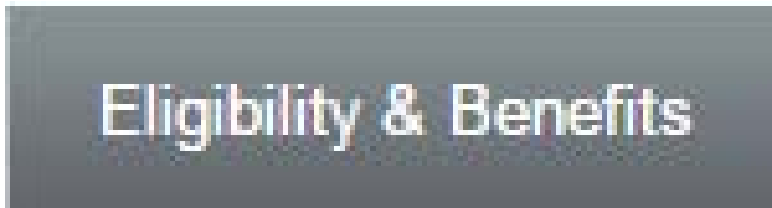
Provider Express - providerexpress.com

Our industry-leading provider website:

- Includes both public and secure pages for behavioral health providers

Eligibility & Benefits allow users to search for a member's eligibility by using My Patients list, Member ID Search or the Name/DOB Search:

- The My Patients list is also built using this transaction



Eligibility and benefits, member search

Provider Express offers three methods for searching eligibility:

- My Patients (a list you build yourself)
- Member ID
- Name/DOB

OPTUM | Provider Express

Elig & Benefits ▾ Claims ▾ Auths ▾ Appeals ▾ My Practice Info ▾ More ▾

Welcome to Provider Express!

Find Member Eligibility & Benefits

My Patients | Member ID Search | Name/DOB Search

Please select one or more patients

<input type="checkbox"/> Select All	First Name	Last Name	Member ID	Birth Date	State
<input type="checkbox"/>					OH
<input type="checkbox"/>					OH
<input type="checkbox"/>					OH
<input type="checkbox"/>					OH
<input type="checkbox"/>					OH
<input type="checkbox"/>					OH
<input type="checkbox"/>					OH
<input type="checkbox"/>					OH

Remove Patients Refresh Search

Eligibility and benefits, member search (continued)

If multiple members are selected from the My Patients list, the results show in rows. The triangle to the left of the name expands/collapses the eligibility details.

The screenshot displays a web interface for 'Elig & Benefit Inquiry'. It features a section titled 'Eligibility Search Results' containing three rows of member information. Each row includes a right-pointing triangle icon next to a blurred name and an 'Effective' date range with a status in parentheses. Below the results is a 'Search Again' button. At the bottom, there is a footer with copyright information and links for 'Copyright & License Information', 'Privacy Policy', and 'Terms of Use'.

Member Name	Effective Date Range	Status
[Blurred Name]	Effective 01/01/2014 to 12/31/2099	(Still Active)
[Blurred Name]	Effective 11/05/2015 to 01/31/2041	(Still Active)
[Blurred Name]	Effective 01/01/2014 to 12/31/2099	(Still Active)

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Eligibility and benefits, eligibility information

Regardless of the search method, if a matching member record is found, the eligibility information will display.

Here you will find the group number, plan name (when available), relationship, the most recent effective date of coverage, and the termination date (if applicable).

Eligibility Search Results

▼ [Redacted Name] Effective 01/01/2018 to 12/31/2099 (Still Active) [+ Add to My Patients](#)

Relationship	Member ID	Alternate ID	Gender	Date of Birth
Spouse	[Redacted]	[Redacted]	Female	[Redacted]

Demographic Information

Address	Phone Number
[Redacted]	[Redacted]

040923732

Plan Information

Group Number	Plan Name	Benefit Year	Plan Type	Product Type
0700228	N/A	N/A	N/A	N/A

[View Benefits](#) [Search Again](#)

Eligibility and benefits, viewing benefits

The Member details section includes the Member ID, Alternate ID (if applicable), Group Number, State and if the California Language Assistance Program (CA LAP) is applicable, the Spoken Language and Written Language the member identified. For some members, a Plan ID will display.

Elig & Benefit Inquiry

Benefit Information

Disclaimer: Inquiries of coverage through Provider Express are not a guarantee of benefits. Failure to obtain an authorization, when required, may result in reduced or no benefits.

Member Details for [Redacted] **Effective 01/01/2014 to 12/31/2099 (Still Active)**

Relationship	Member ID	Alternate ID	Group Number	State
Subscriber	[Redacted]	[Redacted]	12641-0001	OH
CA LAP	Spoken Language	Written Language		
Yes	Non-Specified	Non-Specified		

Eligibility and benefits, benefits information (continued)

The plan deductibles and maximums section summarizes deductibles, out of pocket and copayment maximums for both the individual and family.

Plan Deductibles and Maximums			
In Network	Out of Network		
As of 11/27/2018			
Deductible ⓘ			
	Individual	Family	
Plan Amount	\$0.00	\$0.00	
Met Year To Date	NA	NA	
Remaining Amount	\$0.00	\$0.00	
Out of Pocket ⓘ			
	Individual	Family	
Plan Amount	\$700.00	\$1,400.00	
Met Year To Date	NA	\$105.00	
Remaining Amount	\$700.00	\$1,295.00	
Out of Pocket 2 ⓘ			
	Individual	Family	
Plan Amount	\$0.00	\$0.00	
Met Year To Date	NA	NA	
Remaining Amount	\$0.00	\$0.00	
Copayment Maximum ⓘ			
	Individual	Family	
Plan Amount	\$0.00	\$0.00	
Met Year To Date	NA	NA	
Remaining Amount	\$0.00	\$0.00	

Eligibility and benefits, benefits information (continued)

The plan deductibles and maximums displays year-to-date accumulators for both deductible and out-of-pocket (if applicable). If there are plan specific requirements, an asterisk will be visible along with a footnote.

	Individual	Family*
Plan Amount	\$750.00	\$2,000.00
Met Year To Date	\$200.00	\$200.00
Remaining Amount	\$550.00	\$1,800.00

*Plan requires the 'Family' max to be paid out of pocket before insurance starts paying for the services

Eligibility and benefits, benefits information (continued)

The benefits summary section includes all levels of care and services based on the member's benefit plan.

Benefits Summary

This is only a summary, for detailed information on coverage and costs, see the medical policy. If there is difference between this summary and the policy, the terms of the policy apply.

Detox	Emergency Room	Home Therapy	IOP	Inpatient	Med Checks	Outpatient	Outpatient ECT	Outpatient Psych Testing	Partial/Day	Residential	EAP
-------	----------------	--------------	-----	-----------	------------	-------------------	----------------	--------------------------	-------------	-------------	-----

Mental Health

- ▶ In Network
- ▶ Out Of Network

Substance Use Disorder

- ▶ In Network
- ▶ Out Of Network

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Eligibility and benefits, benefits information, (continued)

After selecting a service to view, clicking on the triangle next to the In Network or Out of Network rows expands the section to show the details.

Benefits Summary

This is only a summary, for detailed information on coverage and costs, see the medical policy. If there is difference between this summary and the policy, the terms of the policy apply.

Detox Emergency Room Home Therapy IOP Inpatient Med Checks **Outpatient** Outpatient ECT Outpatient Psych Testing Partial/Day Residential EAP

Mental Health

▼ **In Network**

Auth Rule	Auth Required
Copayment	Indv: \$35.00, Grp: \$35.00
OOP Annual	\$700.00 Individual / \$1,400.00 Family
Session Limit	MH Visits: 365
Notes	
No records found	

▶ **Out Of Network**

Substance Use Disorder

▶ **In Network**

Clinical Overview

Progressing members towards healthier

Optum Behavioral Health's clinical model helps members become healthier by approaching them holistically to improve behavioral and medical outcomes.



Utilization management care advocacy model



Ensure members receive **evidenced-based treatment** in the **least restrictive setting**



Stage **all aspects of care** to influence key players (facility, providers, family) and **facilitate care plans**



Align resources and meaningful interventions for **high-risk members**



Promote **member self direction** and **engagement in care**

Covered Services and Authorizations

Covered Services, Inpatient

Inpatient services: *24-hour services, delivered in a licensed hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both.*

- Inpatient Mental Health Services
- Inpatient Substance Use Disorder Services (Level 4)
- Observation/Holding Beds
- Administratively Necessary Day (AND) Services:
 - Available to *My Care Family (MassHealth)* Members only
 - AND Services must be requested and authorized through a single case agreement
 - Reimbursement will be at the published state Medicaid rate for Administrative Days
 - Billing must be done using revenue code 0169

Covered Services, Diversionary Services

Diversionary Services: these services provide clinically appropriate alternatives to Behavioral Health Inpatient Services, or support returning to the community following a 24-hour acute placement; or provide intensive support to maintain functioning in the community

24-hour diversionary services:

- Community Crisis Stabilization (CCS)
- Community-Based Acute Treatment for Children and Adolescents (CBAT)
- Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)
- Clinical Support Services (CSS) for Substance Use Disorders (Level 3.5)
- Residential Rehab Services (RRS), High Intensity, Population Specific (Level 3.3), My Care Family (MassHealth) members only
- Residential Rehab Services (RRS), Low Intensity (Level 3.1), My Care Family (MassHealth) members only
- Transitional Care Unit (TCU) for DCF Youth, My Care Family (MassHealth) members only

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- Transitional Care Unit (TCU) for DCF Youth, My Care Family (MassHealth) members only

Covered Services, Diversionary Services

Non 24-hour diversionary services:

- Community Support Program (CSP)
- Partial Hospitalization (PHP)
- Psychiatric Day
- Structured Outpatient Addiction Program (SOAP)
- Intensive Outpatient Program (IOP)
- Recovery Support Navigators, My Care Health (MassHealth) members only
- Recovery Coaches, My Care Health (MassHealth) members only

Covered Services, Standard Outpatient Services

- Family Consultation
- Case Consultation
- Diagnostic Evaluation
- Dialectical Behavioral Therapy (DBT)
- Psychiatric Consultation on an Inpatient Medical Unit
- Medication Management (office based)
- Medication Administration
- Couples/Family Treatment
- Group Treatment
- Individual Treatment
- Inpatient-Outpatient Bridge Visit
- Assessment for Safe and Appropriate Placement (ASAP) for DCF Youth
- Collateral Contact
- Opioid Treatment Services
- Ambulatory Detoxification (Level 2.WD)
- Psychological Testing
- Special Education Psychological Testing for My Care Family (MassHealth) members
- ECT at DMH Licensed Facilities

Authorization requirements

Services that require authorization

Acute Inpatient Hospitalization

Partial Hospitalization

Intensive Outpatient

- Providers must call for prior authorization
- Contracted providers may also request authorization online: providerexpress.com

Non-Routine Outpatient Services

- Providers must call for prior authorization for non-routine services, including but not limited to:
 - Electroconvulsive Treatment
 - Transcranial Magnetic Stimulation

Services that do not require authorization

Most CBHI Services (for My Care Family, MassHealth members) including:

- Family Support and Training
- Therapeutic Mentoring
- Intensive Care Coordination (ICC)
- In-Home Therapy Services
- Youth Mobile Crisis Intervention
- In-Home Behavioral Services:
 - Behavior Management Therapy
 - Behavior Management Monitoring

Routine Outpatient Services:

- Standard Office Visits for Therapy or medication management
- Psychological Testing under 5 hours
- Extended Outpatient Treatment

Reminder: Services for Partners members seeing a contracted provider will not require authorization

Authorization process for RRS

Substance Use Disorder (SUD) Residential Rehabilitation Services: Optum complies with all requirements outlined in [Session Laws, Acts \(2014\), Chapter 258](#).

- SUD Residential Rehabilitation Services Level 3.1: no authorization is required for the first ninety (90) days
- SUD Residential Rehabilitation Services, all other Levels: no authorization is required for the first fourteen (14) days

Authorizations can be requested in two ways:

- Contracted providers can request authorizations for most services via the online portal system on Provider Express (providerexpress.com). You will need to log-in to request authorizations. The previous slide includes information about which services can be requested online and which require a phone call.
- Calling Optum via the number on the member's card

ASAM Criteria will inform the concurrent review process.

Authorization process

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- Contracted providers can request authorizations for most services via the online portal system on Provider Express (providerexpress.com). You will need to log-in to request authorizations. The previous slide includes information about which services can be requested online and which require a phone call.
- Calling Optum via the number on the member's card:

AllWays Commercial	1-844-451-3518
AllWays MassHealth/ACO (aka My Care Family)	1-844-451-3519
Partners Health Plan	1-844-451-3520
Group Insurance Commission (GIC), City of Boston and Plumbers	1-844-875-5722

Check authorization status online

Once you have obtained authorization for clinical services, you have the capability in the secure Transactions on *Provider Express* to:

- Look up authorizations, even if the authorization was not generated through *Provider Express*
- View authorization details



Discharge planning

- Effective discharge planning:
 - Addresses how a Member's needs are met during a level of care transition or change to a different treating provider
 - Begins at the onset of care and should be documented and reviewed over the course of treatment
 - Focuses on achieving and maintaining a desirable level of functioning after the completion of the current episode of care
- Discharge instructions should be specific, clearly documented and provided to the member prior to discharge:
 - Members discharged from an acute inpatient program must have a follow-up appointment scheduled prior to discharge for a date that is **within seven (7) days of the date of discharge**
- Throughout the treatment and discharge planning process, it is essential that Members be educated regarding:
 - The importance of enlisting community support services
 - Communicating treatment recommendations to all treating professionals
 - Adhering to follow-up care

Medical necessity

Medically necessary services, as outlined in 130 CMR 450.204, are those services:

- Which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity
- For which there is no other medical service or site of service, comparable in effect, available and suitable for the member requesting the service, that is more conservative or less costly

Medically necessary services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality.

Utilization management statement

Care Management decision-making is based only on the appropriateness of care as defined by:

- Optum Level of Care Guidelines
- Optum Psychological and Neuropsychological Testing Guidelines
- Behavioral Health Clinical Policies
- American Society of Addiction Medicine (ASAM) Criteria

Level of Care Guidelines can be found at providerexpress.com:

- Path: Provider Express > Clinical Resources > Level of Care Guidelines

Residential Rehabilitation Services (RRS), for Medicaid Members

Residential Rehabilitation Services (RRS)

Optum will use ASAM criteria as the basis for determining medical necessity for RRS.

The 6 dimensions of ASAM include:

- Dimension 1: Acute Intoxication and Withdrawal Potential
- Dimension 2: Biomedical Conditions and Complications
- Dimension 3: Emotional, Behavioral, or Cognitive Conditions or Complications
- Dimension 4: Readiness to Change
- Dimension 5: Relapse, Continued Use, or Continued Problem Potential
- Dimension 6: Recovery Environment

RRS, Authorization and Concurrent Review

- During the 90 day transition period, no authorization is required
- After the transition period, authorizations are required
- ASAM Criteria will inform the concurrent review process

Billing and coding for RRS

RRS will be billed as *professional* claims on the Form1500 claim form using the Claim Entry tool on Provider Express. On the claim form, facility information (not individual clinician information) should be entered.

The following codes and modifiers are to be used when billing for RRS:

Billing Code and Modifier	Services
H0019	Adult RRS
H0019 – HA	Youth RRS
H0019 – HF	TAYYA (Transition Age Youth and Young Adults) RRS
H0019 – HR	Family RRS
H0019 – TH	Pregnant RRS
H0019 – HH	Co-occurring Enhanced RRS

Children's Behavioral Health Initiative (CBHI) and Outpatient Management, for Medicaid Members

Covered Services: Intensive Home or Community Based Services for Youth (CBHI)

The Children's Behavioral Health Initiative (CBHI) is an interagency undertaking whose mission is to strengthen, expand and integrate behavioral health services for children.

Mental health and substance use disorder services provided to My Care Family (MassHealth) youth members up to age 21 in a community-based setting such as home, school, or community. (e.g., CBHI Services):

- Family Support and Training
- Therapeutic Mentoring
- Intensive Care Coordination (ICC)
- In-Home Behavioral Services
 - Behavior Management Therapy
 - Behavior Management Monitoring
- In-Home Therapy Services
- Youth Mobile Crisis Intervention
- ABA Services for Members with Autism Spectrum Disorder

Outpatient management strategy for CBHI

Certain services within this initiative will not require an authorization and will be managed using our outpatient management strategy.

There is additional information available about the outpatient management strategy for CBHI on Provider Express. From the home page, select Our Network > Welcome to the Network > Massachusetts > AllWays Health Partners > ALERT.

There is also more detailed information about the ALERT program is located [here](#) on Provider Express. From the home page, select Clinical Resources > ALERT Program.

Cultural Competency

Cultural competency

- As a health care provider, it is important for you to remember to be culturally sensitive to the diverse population you serve:
 - There are diverse cultural preferences that we ask providers to keep in mind when serving members
 - All services should be conducted in accordance with Title VI of the Civil Rights Act of 1964 and should be provided in a manner that respects the Member's cultural heritage and appropriately uses natural supports in the Member's community

Provider Express Resources:
Provider Express > Clinical Resources > [Cultural Competency](#)

Cultural competency, (continued)

- Providers are required to deliver services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, and to provide for interpreters in accordance with 42 CFR §438.206
- All providers shall comply with any state or federal law which mandates that all persons, regardless of race, creed, color, religion, sex, age, income, sexual orientation, gender identity, national origin, political affiliation, or disability, shall have equal access to employment opportunities, and all other applicable federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI

Cultural competency, (continued)

- Providers shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, age, income, sexual orientation, gender identity, national origin, political affiliation, or disability. Some cultural preferences to remember include:
 - Ask what language the Member prefers to help eliminate communication barriers and, when necessary, use the interpretation services available to you
 - Understand the Member's religious beliefs
 - Understand the role of the Member's family in their decision-making process
- Providers should collect Member demographic data, including, but not limited to ethnicity, race, gender, sexual orientation, religion, and social class
 - Members must be given the opportunity to voluntarily provide this information, it cannot be required

Cultural competency, (continued)

Some additional resources for information on Cultural Competency:

- [cms.hhs.gov/ocr](https://www.cms.hhs.gov/ocr) – Office of Civil Rights
- [LEP.gov](https://www.lep.gov) – Limited English Proficiency (LEP): Site promotes importance of language access to federal programs and federally assisted programs
- [diversityrx.org](https://www.diversityrx.org) – Promotes language and cultural competency to improve the quality of health care for minorities
- [ncihc.org](https://www.ncihc.org) – National Council on Interpreting in Health Care: Organization promotes culturally competent health care

Importance and value of cultural competence

- Given the diverse ethnic population in Massachusetts, 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 use issues is an important step to reduce the stigma many individuals experience
- Emphasizing individualized goals and self-sufficiency encourages Members to live their lives to the fullest

Provider Clinical Audits

Provider audits

Organizational providers (including facility based services, partial hospital programs, intensive outpatient programs, residential programs and most agencies) that do not have a national accreditation (such as The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), etc.) will require on-site clinical audits at the time of credentialing and recredentialing.

Clinical audits may also be completed to investigate a quality of care (QOC) concern or a sentinel event.

Clinical audits will be completed for Children's Behavioral Health Initiative (CBHI) Providers as required by the state:

- On-site audits are completed as part of the bi-annual network review; audit frequency may be higher than bi-annual when indicated by audit outcomes

Record review audits are completed of providers who render services to AllWays members of any age:

- A sample of providers are randomly selected for review on an annual basis

Documentation standards

Documentation requirements for AllWays Health Partners providers are described in the AllWays Health Partners Addendum to the Optum National Manual. From the home page, select Our Network > Welcome to the Network > Massachusetts > AllWays Health Partners > Provider Manual Addendum. This manual addendum will be posted prior to January 1, 2019.

Reminders: Release of Information (42 CFR §431.306):

- Providers must have criteria outlining the conditions for release of information about Members
- Providers must have a signed release of information to respond to an outside request for information
- All staff members within the provider agency/group are subject to the same confidentiality requirements
- A release of information should be obtained to allow communication and collaboration with other treating providers (including previous treating providers)

Adverse Incident Reporting

Behavioral health adverse incident reporting

Behavioral Health reportable adverse incidents include, but are not limited to, the following:

- Any death (include cause of death if known)
- Any absence without authorization (AWA)
- Any serious injury resulting in hospitalization
- Any sexual assault or alleged sexual assault
- Any sexual activity in a 24-hour level of care facility
- Any violation or alleged violation of the Department of Mental Health physical restraint and/or seclusion regulations
- Any physical assault or alleged physical assault on or by a covered individual or by staff
- Any contraband found prohibited by provider policy
- Any injury or illness requiring transportation to an acute care hospital for treatment while in a 24 hour program

(continued on next page)

Report submission instructions

- When an adverse incident occurs, the provider must complete the applicable Adverse Incident Report form and submit it to Optum within 24 hours of discovery of the incident; if the incident occurs on a holiday or weekend, the form must be submitted on the next business day
- All forms are faxed to Optum; we will provide a fax number with the form when we post it to Provider Express
- The form will be available on Provider Express approximately one week before 1/1/19; from the Home page, select Our Network > Welcome to the Network > Massachusetts > AllWays Health Partners > Adverse Incident Report Forms

Adverse incident report form, MassHealth

AllWays Health Partners – MassHealth Daily Adverse Incident Report	
Notifications: DMH ___ DCF ___ DYS ___ DPPC ___ DDS ___ Other ___	
Client: _____ Medicaid RID #: _____	
M ___ F ___ DOB: _____ Age: _____	
Facility: _____ Unit: _____ City: _____	
24-hour facility: _____ Non 24-hour facility: _____	
Date and Time of Incident: _____	
Date and Time of Discovery: _____	
Type of Incident: _____	
Describe Incident. If AWA, please include search, notification and commitment status:	

Describe Immediate Response to the Incident:	

Restraints Used? None: ___ Mechanical: ___ Chemical: ___ Physical: ___ Time in Restraints: _____	
Please Check if Recommended: Internal Investigation _____ Policy and Procedure Review _____	
Staff training _____ Disciplinary action to staff _____	
Please check if additional information is attached. _____	
Person Reporting: _____	Telephone #: _____
Title: _____	
Signature: _____	Date: _____

Date Revised: 11/20/18

Adverse incident report form, Care Plus MassHealth

CarePlus Plans - Please send by secure email to MassHealth Office of Behavioral Health

AllWays Health Partners Care Plus – MassHealth Daily Adverse Incident Report

Notifications: DMH ___ DCF ___ DYS ___ DPPC ___ DDS ___ Other ___

Client: _____ Medicaid RID #: _____

M ___ F ___ DOB: _____ Age: _____

Facility: _____ Unit: _____ City: _____

24-hour facility: ___ Non 24-hour facility: ___

Date and Time of Incident: _____

Date and Time of Discovery: _____

Type of Incident: _____

Describe Incident. If AWA, please include search, notification and commitment status:

Describe Immediate Response to the Incident:

Restraints Used? None: ___ Mechanical: ___ Chemical: ___ Physical: ___ Time in Restraints: _____

Please Check if Recommended: Internal Investigation _____ Policy and Procedure Review _____

Staff training _____ Disciplinary action to staff _____

Please check if additional information is attached. ___

Person Reporting: _____ Telephone #: _____

Title: _____

Signature: _____ Date: _____

Revised: 11/20/18.

Adverse incident report form, commercial

Adverse Incident Report

Please type or print legibly and fax on the day of incident to: _____

Notifications: DSS ___ DMH ___ DYS ___ DPC ___ DMR ___ Other - Please Specify: _____

Client: _____ Social Security #: _____

Male ___ Female ___ DOB _____ Age _____

Facility: _____ Unit: _____ City: _____ 24hr/Non-24hr _____

Date and Time of Incident _____ Date and Time of Discovery: _____

Type of Incident: _____

Describe Incident: AWA, include search, notification and commitment status. (Attach additional information if necessary)

Describe immediate response to the incident: (Attach additional information if necessary):

Restraints Used? None ___ Mechanical ___ Chemical ___ Physical Time in restraints: _____

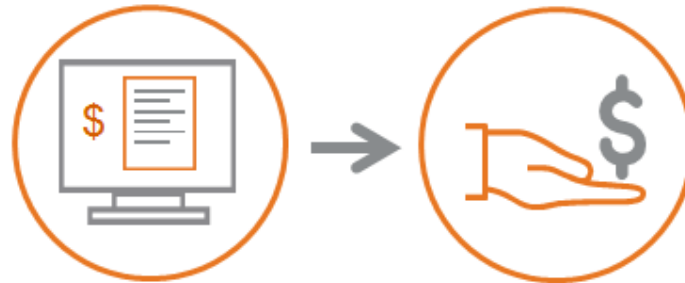
Please check if recommended: Internal investigation ___ Policy and Procedure Review ___ Staff training ___
Disciplinary action to staff _____

Person Reporting _____ Telephone #: _____
Signature: _____ Date: _____

Claims

Claims filing made easy

File your claim electronically for a fast, secure and convenient claims experience



Benefits of Electronic Filing:

- **It's fast** - Eliminate mail and paper processing delays
- **It's convenient** - Easy set-up and intuitive process
- **It's secure** - Data security is higher than with paper-based claims
- **It's efficient** - Electronic processing helps prevent errors
- **It's cost-efficient** - you eliminate mailing costs and the solutions are free or low-cost

Claims submission option 1, Online: Provider Express

Our network clinicians report the highest level of satisfaction when they submit claims online through *Provider Express*:



- Free
- Available 24/7
- Intuitive and easy-to-use
- HIPAA Compliant
- Real-time, quick claims processing
- Available to clinicians and groups
- Outpatient behavioral and EAP claims

Get started today with your Optum ID:

- Register for an Optum ID today by clicking this [First-time User link](#)
- Need help registering for an Optum ID? Watch this [quick video](#)

Tips for timely and accurate payments, Provider Express

Filing claims electronically on Provider Express can help prevent these common errors.

Missing or incomplete information

Provider Express "Claim Entry" prevents the submission of claim if required fields are blank

Examples: NPI number, ICD-10 derived diagnosis code

Member demographic info has errors

Member information is auto-populated when you use *"Claim Entry"* on *Provider Express*

Examples: Name, DOB, ID number

Unclear or illegible information

The Claim Entry form on *Provider Express* ensures legibility

Examples: Provider or Member information illegible, diagnosis code unclear

Claims submission option 2: **EDI/ Electronically**

Submit batches of claims electronically, right out your practice management system software:



- Ideal for high volume Providers
- Can be configured for multiple payers
- Clearinghouse may charge small fee

To learn more about Electronic Data Interchange, visit Provider Express. From the Home Page, select Admin Resources > Claim Tips > EDI/Electronic Claims

Claims submission option 3: Paper

If you are unable to file electronically, follow these tips to ensure smooth processing of your paper claim:

- Use an original 02/12 Form 1500 claim form (no photocopies)
- Type information to ensure legibility
- Use a DSM-5 derived ICD-10 code for primary diagnosis (Hint: the DSM-5 includes ICD codes along with the DSM diagnostic info)
- Complete all required fields (including ICD indicator and NPI number)



Claims submission option 3: **Paper**

- Institutional claims must be submitted using the UB-04 claim form
- Paper claims submitted via U.S. Postal Service should be mailed to:

Commercial	Medicaid
Optum P.O. Box 30757 Salt Lake City, UT 84130-0760	Optum P.O. Box 30760 Salt Lake City, UT 84130-0760

Receive payments faster

Benefits of Electronic Payments and Statements (EPS)



- Easy set-up, free to use
- Payments deposited into your bank
- Simplified claims reconciliation
- 24/7 access to your information
- Secure payment and remittance advice

Registering for EPS is easy!

- Login to *Provider Express* with your Optum ID
- Select “EPS” under the “More” heading and follow the prompts to enroll
- Contact Optum Financial Services for assistance: 1-877-620-6194

Claim form – Form 1500 provider section, (continued)

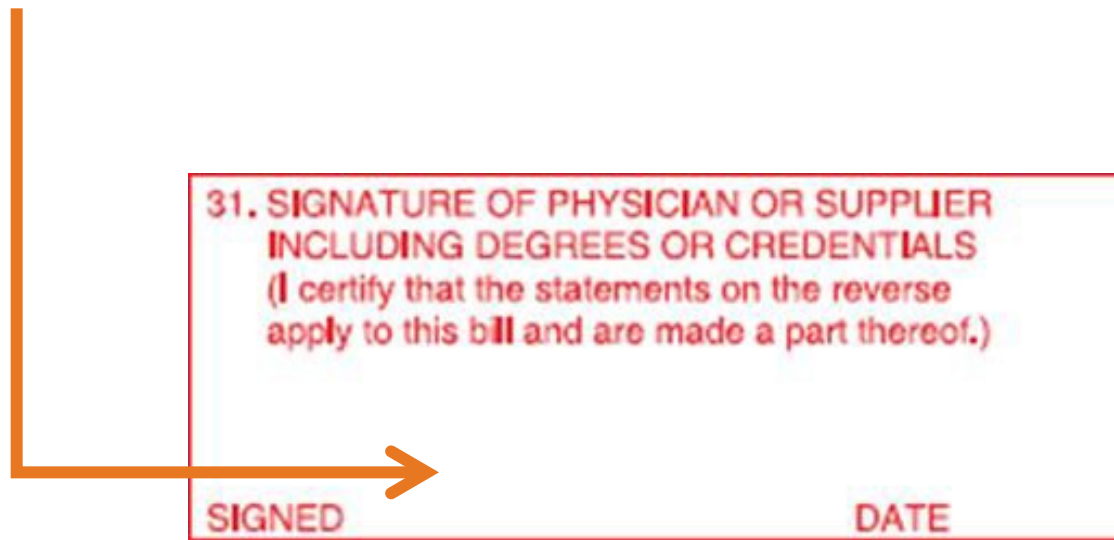
- **Box 24J:** Independently licensed clinicians who render services enter their **NPI number** in the non-shaded portion
- **Box 24J:** Non-independently licensed clinicians who render services do not need to enter an NPI number in Box 24J (Medicaid claims)



	24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	PHYSICIAN OR SUPPLIER INFORMATION
	From	To			CPT/HCPCS	MODIFIER			MM	DD							
1																	
2																	
3																	
4																	
5																	
6																	

Claim form – Form 1500 provider section, (continued)

- **Box 31:** Independently licensed clinicians who render services enter their name and licensure in Box 31
- **Box 31:** Non-independently licensed clinicians who render services enter the name of the agency in Box 31 (Medicaid claims)



The diagram shows a red-bordered rectangular box representing Box 31. Inside the box, the text reads: "31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)". Below the main text, there are two labels: "SIGNED" on the left and "DATE" on the right. An orange L-shaped line with an arrowhead at the end of the horizontal segment points from the top-left corner of the box towards the "SIGNED" label.

Claims form – Form 1500 provider section, (continued)

For Medicaid claims with non-independently licensed clinicians:

- **Box 33:** Agency name, address, and phone number
- **Box 33a:** Agency NPI number

The diagram shows a red-bordered box representing Form 1500 Box 33. The top of the box contains the text "33. BILLING PROVIDER INFO & PH # ()". Below this, the box is divided into two sub-sections: "a. NPI" and "b.". An orange arrow points from the text "Agency name, address, and phone number" in the list above to the top of the box. Another orange arrow points from the text "Agency NPI number" in the list above to the "a. NPI" sub-section. A third orange arrow points from the top of the box down to the "a. NPI" sub-section. A fourth orange arrow points from the top of the box down to the "b." sub-section.

Claim tips

To support clean claim submissions remember:

- NPI numbers are always required on all claims
- A complete diagnosis is required on all claims
- The correct date of service corresponding to the date the service occurred must be listed on the claim form; do not list the claim submission date as the date of service

Claims filing deadline:

- AllWays Health Partners allows claim submissions up to ninety (90) days from the date of service

Claims Processing:

- Clean claims, including adjustments, will be adjudicated within forty-five (45) days of receipt of the claim

Balance Billing:

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

Claim tips, (continued)

Member Eligibility:

- Provider is responsible to verify member eligibility through providerexpress.com

Examples of coding Issues related to claim denials:

- Incomplete or missing diagnosis
- Invalid or missing HCPCS/CPT codes and modifiers
- Use of codes that are not covered services
- Required data elements missing, (e.g., number of units)
- Provider information is missing or incorrect
- Required authorization missing
- Units exceed authorization (e.g., 10 inpatient days were authorized, facility billed for 11 days)

Appeals

Appeals

Provider Disputes

Optum has a formal process for handling practitioner/facility disputes that is compliant with the standards and regulations set forth by National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) and state/federal regulations. These standards and regulations serve as guidelines to ensure that:

- Review turnaround time requirements are met;
- Appropriately qualified professionals are involved in the review of practitioner/facility disputes;
- Relevant clinical/administrative information is consistently gathered and reviewed as part of the investigation;
- Practitioners/facilities are informed of the rationale for disputes that are upheld, in whole or in part.

One (1) level of internal dispute review is available through Optum, unless required by state law or contractual requirement.

Appeals: standard and expedited

Non-Urgent (Standard)

- Commercial: must be requested within 180 days from receipt of the notice of adverse determination.
- MassHealth (Medicaid): must be requested within 60 calendar days from receipt of the notice of adverse determination.
- Optum will make an appeal determination and notify the in writing within 30 calendar days of receipt of request.

Urgent (Expedited)

- Practitioner/facilities can file an urgent appeal on behalf of a member
- Must be requested as soon as possible after the adverse determination
- Optum will make a reasonable effort to contact you prior to making a determination on the appeal. If Optum is unsuccessful in reaching you, an urgent appeal determination will be made based on the information available to Optum at that time
- Notification will occur as expeditiously as the member's health condition requires, not exceeding 72 hours of the receipt of the request.

Appeals: contact information

**Optum
Appeals & Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512**

Fax: 1-855-312-1470

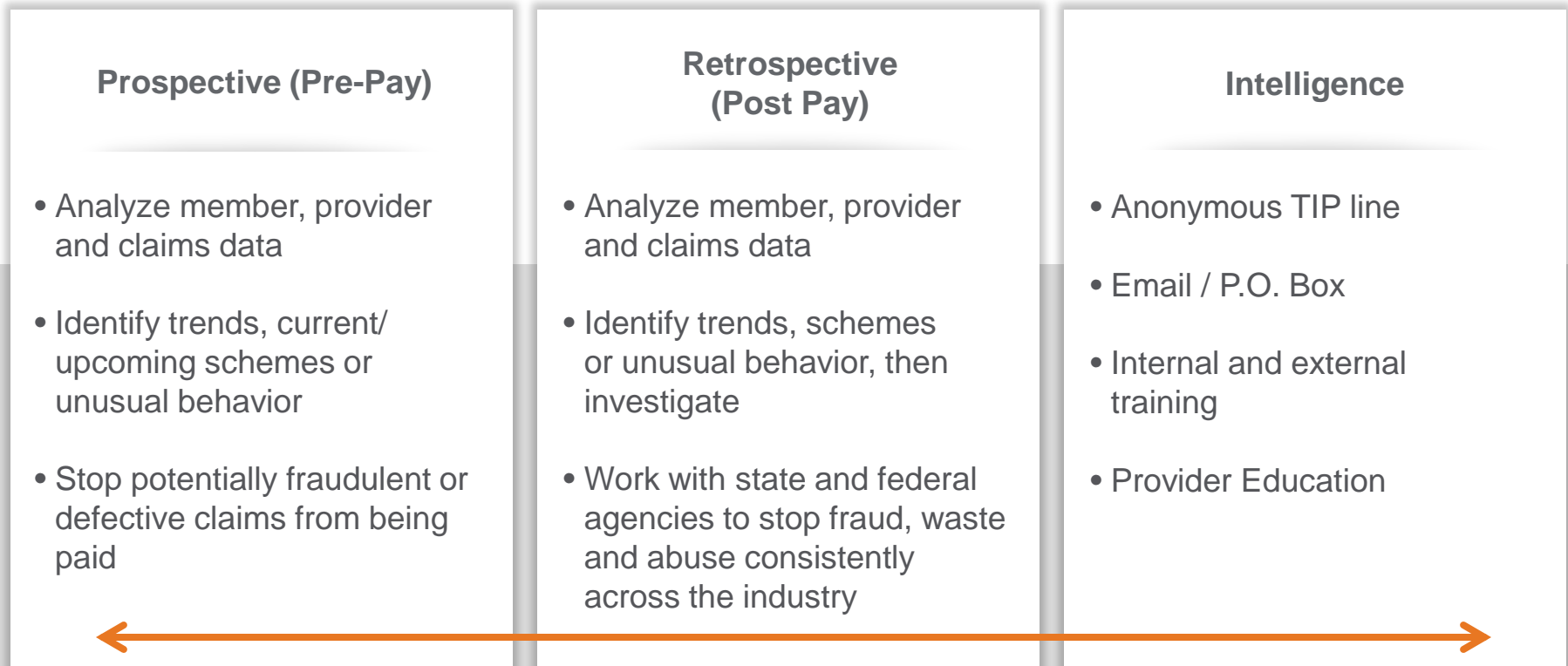
Phone: 1-866-556-8166

Fraud, Waste, Abuse and Error (FWAE)

Optum Program & Network Integrity (PNI) Department

- A dedicated group responsible for working with providers to prevent, detect, investigate and ultimately resolve potential issues of fraud, waste, abuse and error (FWAE)
- Skilled and trained investigators, clinicians, data analysts and medical coding personnel

The department consists of three main investigative pathways:



What PNI (FWAE) looks for...



Inconsistent coding patterns within a group practice

Coding at high levels for Evaluation and Management (E&M) Services

Services not rendered due to no records submitted, incorrect name of member, incorrect date of service or illegible records

Unbundling of procedures and services

Diagnosis concerns -
- does diagnosis make sense to documentation studied?

Inadequate documentation -- missing pages, no member name on every page submitted, dates of service are missing or appear altered

Misrepresentation of rendering provider -- different provider then billing provider

Misrepresentation of non-covered services as covered

Double billing

Improper use of modifiers

(Medical Record Auditor, AMA 3rd Edition, 2011)

FWAE market research and collaboration



General Market Research (all markets)

Prospective Flagging & Retro Investigations

- Identification of “hot spot” trends in claims data on nationwide, state-by-state, or plan basis
- Specific analytics are created from research trends, pooling potential FWAE providers & members
- Provider flags / tips placed based on outcome of provider and member reviews, thereby requiring the provider submit additional documentation
- Projects revamped on periodic basis to adjust for current trends and market asks

Algorithms and Analytics

- Specific activities identified by policy or code that should not occur are placed into an algorithm to either prospectively prevent such actions from occurring, or retrospectively identify and recoup
- These actions do not require additional records, as they are a strict deny or recoup activity



Customer Collaboration

- Program and Network Integrity works alongside of the customer to assist in identifying potential FWAE activity in schemes or trends that may be specific to the market
- Insight and referrals from the customer are put through our due diligence process to validate and identify if actual FWAE potential exists
- A PNI specific point of contact will be given for all FWAE concerns and questions, should any arise at any point

Websites

Member Website: Live and Work Well (LAWW)

Self-help programs and tools

- Cognitive therapy-based programs
- Self-assessments with immediate feedback
- Quick-search databases
- Caring eCards
- Financial tools and legal templates

Educational information

- Over 100 specially-designed Centers of information to address all aspects of life
- More than 5,000 clinician-reviewed articles, discussion boards, videos, webinars and newsletters in English and Spanish
- Kid and teen wellness-related tools, articles, stories, movies and games

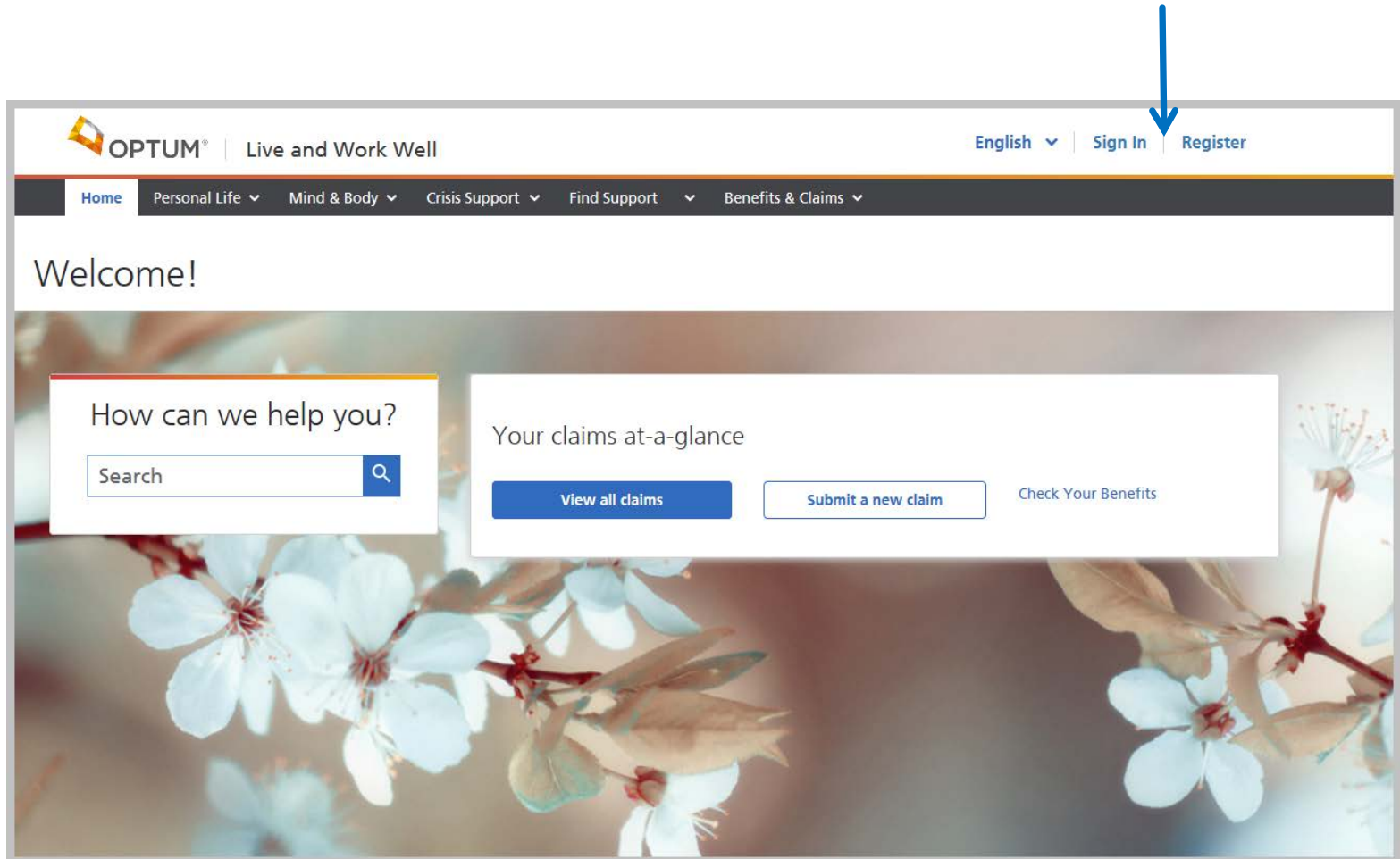
Access to professional services

- Clinician search tool (web and mobile)
- Benefit coverage toolkit
- Legal and financial consultation

URAC accredited and global

- 1 of only 10 URAC accredited health websites and the only accredited behavioral site
- Global versions available in sixteen languages

LAWW home page



Provider resources

Provider Express - providerexpress.com

Our industry-leading provider website:

- Includes both public and secure pages for behavioral health providers
- Public pages
 - General updates and useful information
 - [Behavioral Health Toolkit for Medical Providers](#)
- Secure pages:
 - Require registration
 - The password-protected “secure transactions” offers providers access to provider-specific information including the ability to update your practice information

Provider resources, (continued)

Public Pages: general updates and other useful information:

- Access forms library
- Find network contacts
- Review clinical guidelines
- Access *Network Notes*, the provider newsletter
- Level of Care Guidelines
- Training/Webinar offerings
- AllWays Health Partners page: from the home page, Our Network > Welcome to the Network > Massachusetts:
 - Information for AllWays Health Partners is on the right side of the screen

AllWays Health Partners Provider Express page

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

Contact Us

Home
Our Network
Welcome to the Network
Welcome MA

Welcome to the Optum Network!

Massachusetts Provider Resources

Optum Network Manual

- Network Manual

Level of Care Guidelines

- LOC Guidelines

AllWays Health Partners

- ▶ Adverse Incident Reporting Forms
- ▶ ALERT
- ▶ Provider Manual Addendum
- ▶ Training Materials

Provider resources, (continued)

- Secure pages require registration
- Providers will be able to update their practice information using the “My Practice Info” feature
- To request an Optum 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, click on “Contact Us” and refer to the Website Technical Support section
- The Video Channel includes multiple brief videos on the various functions in the secure transactions area of Provider Express

Provider Express

The screenshot shows the top navigation area of the Provider Express website. At the top right, there are links for [Log In](#), [First-time User](#), [Global](#), and [Site Map](#). Below these links is a search bar with the placeholder text "Search" and a "Search" button. A blue arrow points to the "Log In" link, and a green arrow points to the "First-time User" link. Below the search bar is a horizontal navigation menu with the following items: [Home](#), [About Us](#), [Clinical Resources](#), [Admin Resources](#), [Video Channel](#), [Training](#), and [Our Network](#). Below this menu is a "Contact Us" link. The main content area features a large banner with a photograph of a man and a woman looking at a computer monitor. The banner text reads: **Check it out.** Streamlined new look in our **Secure Transactions area.** Below the text is an orange button with the text "More >>". To the right of the banner is a sidebar titled "Transactions" with a list of items: [Eligibility & Benefits](#), [Claims](#), [Authorizations](#), [Appeals](#), [My Practice Info](#), and [and More....](#). Below the banner are five small black dots, with the first one being orange.

Provider Express Video Channel

Home About Us Clinical Resources Admin Resources **Video Channel** Training Our Network

Contact Us

Home
Video Channel

Welcome to the Provider Express Provider Video Channel

Here's what providers are watching now

First Time Registering on Provider Express

Welcome to the Provider Express Message Center

Check out our latest videos

Sign Up for Electronic Payments & Statements
Optum's Electronic Payments & Statements, the fastest way to get paid and helps your revenue stream keep flowing. Runtime: 2:49

Wellness Assessment Form
This brief guided tour demonstrates how to create and pre-populate a Wellness Assessment Form. Runtime: 2:11

Navigating Optum Webinar
Get up and running quickly with this informative on-demand webinar. Runtime: 30:37

Eligibility & Benefits
Brief overview covers various member search options, viewing eligibility results, benefit

Optum Authorization Inquiry
Quick overview for checking the status of an Authorization for

Claim Entry on Provider Express
Submitting claims using both the short form and the long form. Runtime: 8:25

Provider Relations

Provider responsibilities

- Render services to Members in a non-discriminatory manner:
 - Maintain availability for a routine level of need for services
 - Provide after-hours coverage
- Determine if Members have benefits through other insurance coverage
- Advocate for Members as needed
- Respond in a timely manner to requests from Optum (this includes requests for record submissions and requests for information relation to a member complaint)
- Notify us at providerexpress.com within ten (10) calendar days whenever you make changes to your office location, billing address, phone number, Tax ID number, entity name, or active status (e.g., close your business or retire); this includes roster management

Supervisory protocol addendum

The **Supervisory Protocol Addendum** allows **non-credentialed clinicians** to render services while under the supervision of an independently licensed clinician for My Care Family (MassHealth) Members.

- Clinicians rendering psychotherapy services must have a minimum of a master's degree
- All services that are rendered must be within the scope of the clinician's training
- Supervision must:
 - Occur regularly on a one-to-one basis
 - Be documented

Join our network

- The participation process begins with submission of the provider application:
 - Go to Provider Express home page > [Our Network](#). Under “Join Our Network” select “Individually-Contracted Clinicians” and respond to prompts.
 - Clinicians contracting on an individual basis complete the CAQH universal application online at caqh.org
 - Agencies pursuing group contracts complete the Optum Agency application
- Additional required application materials include:
 - Signed Optum Provider Agreement
 - State required credentialing documents (attestation forms, licensures)
- Approval by Optum Credentialing
- Credentialing requirements can be found at providerexpress.com under “Join Our Network”
- Orientation to Optum clinical and administrative protocols via webinars or review of provider resources posted on providerexpress.com

Recredentialing

- Recredentialing is completed every 36 months (3 years):
 - Time line is established by NCQA
- Several months prior to the recredentialing date, a recredentialing packet will be sent to the primary address on file for 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

Provider customer service

Because the customer service phone number is different based on the type of business or employer, when calling customer service, you should call the phone number that corresponds to the line of business you have questions about.

Below are the phone numbers dedicated to a specific line of business:

- Partners Health Plan: 1-844-451-3520
- AllWays Mass/Health ACO (Medicaid), My Care Family: 1-844-451-3519
- AllWays Commercial: 1-844-451-3518
- Group Insurance Commission (GIC), City of Boston and Plumbers: 1-844-875-5722

Provider Relations contact information

Jennifer Laroche

LICSW Director, Provider Services

Phone: 1-763-361-8851

Email Address: jennifer.laroche@optum.com

Gabriel Nathan

Senior Network Manager, Massachusetts

Phone: 1-877-614-0484

Email Address: gabriel.nathan@optum.com

Janet Choup

Network Manager, Massachusetts

Phone: 1-877-614-0484

Email Address: janet.choup@optum.com

Thank you.

Contact information:

Jennifer Laroche, LICSW Director, Provider Services

Gabriel Nathan, Senior Network Manager

Janet Choup, Network Manager