Provider Orientation: Virginia Commonwealth Coordinated Care Plus

Virginia Commonwealth Coordinated Care Plus, Behavioral Health

Go Live: Tidewater – 8/1

Central – 9/1

Charlottesville/Western – 10/1

Roanoke/Southwest – 11/1

Northern Virginia – 12/1

Thank you so much for joining today! We will be getting started momentarily.

OPTUM®

UnitedHealthcare® Community Plan

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 both United Behavioral Health and Optum in our communications to you
- UnitedHealthcare Community Plan of Virginia has contracted with Optum to administer the behavioral health portion of the Virginia Commonwealth Coordinated Care Plus Plan to include mental health and substance use disorders

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.

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

Our United Culture

Our mission is to help people live healthier lives.
Our role is to make health care work for everyone.

Integrity.	Honor commitments Never compromise ethics
Compassion.	Walk in the shoes of people we serve and those with whom we work
Relationships.	Build trust through collaboration
Innovation.	Invent the future, learn from the past
Performance.	Demonstrate excellence in everything we do

Optum Philosophy of Care

Our managed care plan:

- Integrates medical and behavioral health delivery system
- Focuses on member involvement in identifying his or her needs
- Supports for 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

Integrated Care

Better care through Integrated Care Delivery System (ICDS)

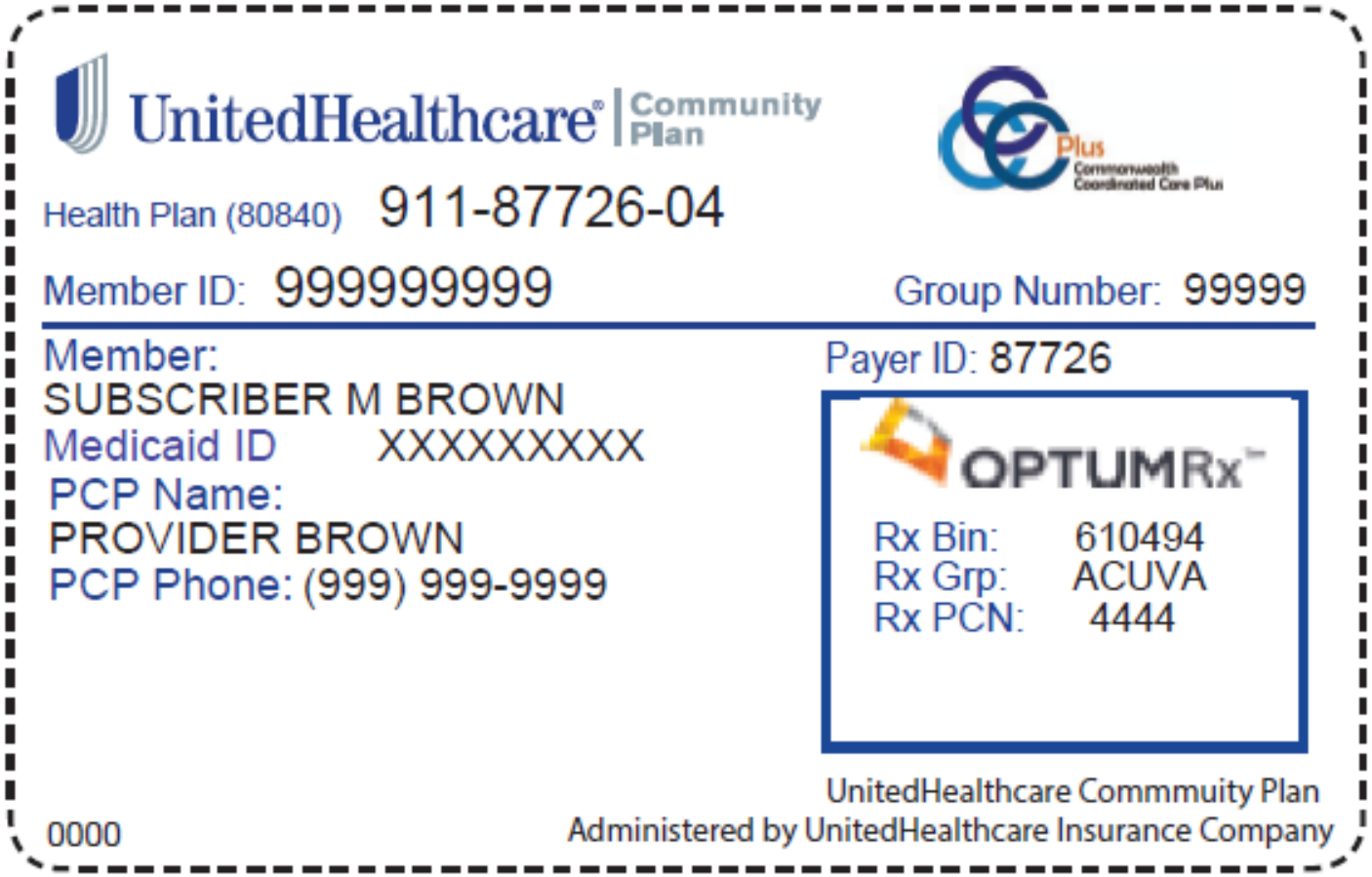
New Program:

- Virginia has created a new demonstration health benefits program to coordinate the physical, behavioral, and long-term supports and services (LTSS) needs for individuals who are eligible for Medicaid and the CCC Plus program
- The Combined Benefit Package includes all traditional benefits available through Medicaid programs, including Specialized Behavioral Health Services

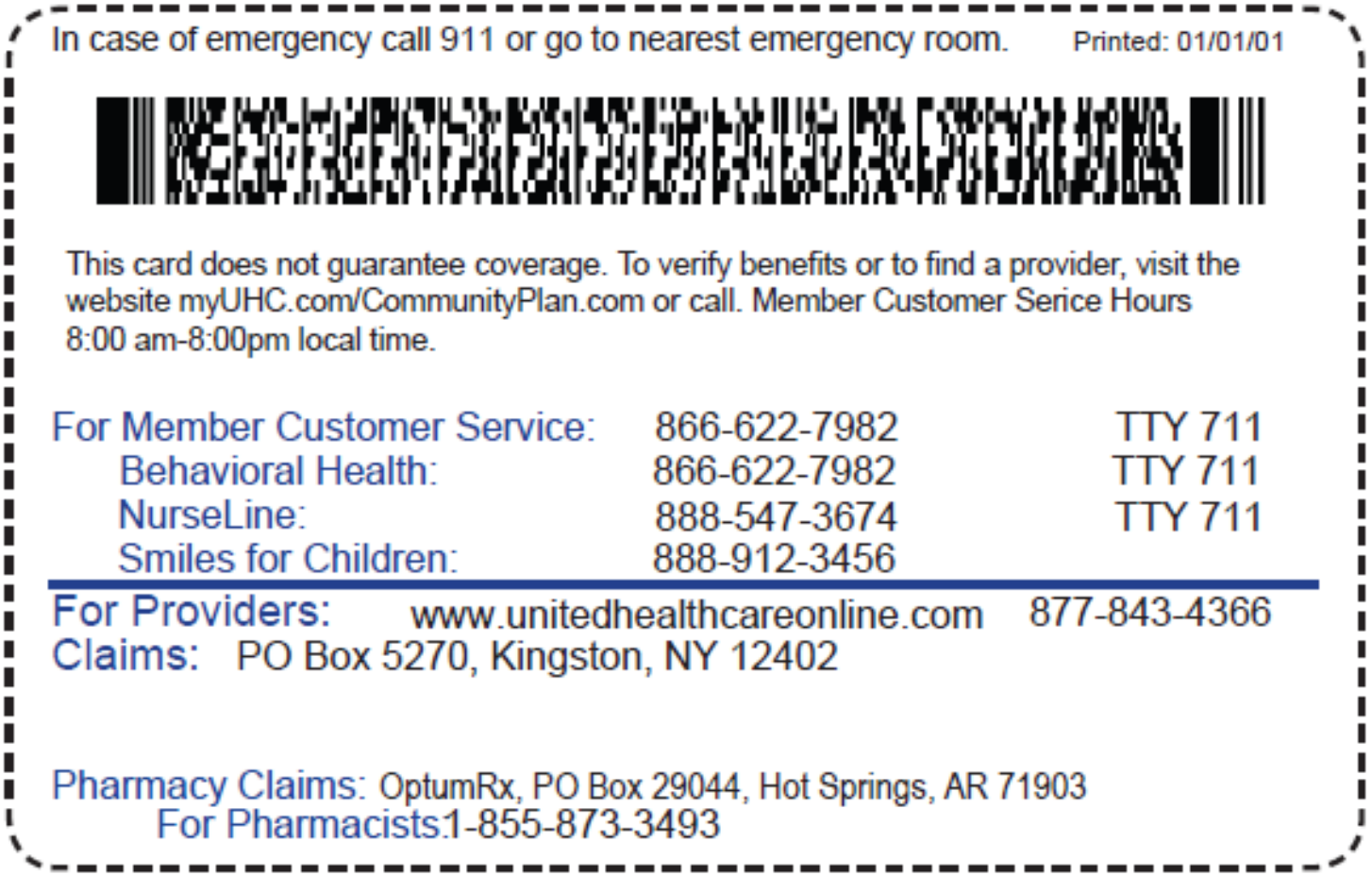
Team Members Involved in Care Coordination:

- Member and their family/caregiver
- Care Advocate
- Member's Primary Care Coordinator
- Primary care provider
- Specialists and other providers as applicable

Member Identification Card, front



Member Identification Card, back



Behavioral Health Clinical Model

Six key principles behind the Behavioral Health Clinical Model center on a change from traditional to integrated care

1. Moving from a disease-centric model to a Member-Driven, Medical-Behavioral-Social Health Model by operating with a collaborative team approach to deliver care using a standardized protocol
2. Treating Members in a holistic manner by using a single Member driven treatment plan, including helping the Member access their natural community supports based on their strengths and preferences
3. Use of clinical systems and claims platforms that allow for a seamless coordination across inter-disciplinary care teams of the Member's needs
4. Focused on multimorbidities in patients with chronic clinical conditions to improve health outcomes and affordability
5. Improved screening and treatment of Mental Health and Substance Use Disorder diagnoses
6. Treating individuals at the point of care where they are comfortable

Behavioral and Medical Integration

Our Goal: Increase medical and behavioral health care integration

- Providers are asked to refer Members with known or suspected and untreated physical health problems or disorders to their Primary Care Physician for examination and treatment

Our Goal: Increase integration of treatment for mental health and substance use disorder conditions

- Our care management program assists members with complex medical and/or behavioral health needs in the coordination of their care
- All Members are expected to be treated from a holistic standpoint, including high-risk, high-service utilizers with complex needs

Types of Providers in the Behavioral Health Network

Licensed Mental Health Professionals

- Psychiatrist
- Advanced Psychiatric Nurse Practitioner
- Registered Nurse Authorization to Prescribe
- Clinical Nurse Specialist
- Doctor of Osteopathic Medicine
- Licensed Behavior Analyst
- Licensed Nurse Practitioner
- Medical Doctor
- Physician Assistant
- Registered Nurse
- Licensed Psychologist
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Licensed Addiction Counselor
- Licensed Marriage and Family Therapist

Other Types of Providers

- Peer Support Specialist
- Case Manager

Types of Providers in the Behavioral Health Network

Licensed Mental Health Professionals from:

- FQHCs
- Agencies
- CSBs
- Groups
- Free-Standing Psychiatric Facilities
- ARTS/OBOT/OTP Providers

Link to DMAS CCC+ Overview Presentation:

http://www.dmas.virginia.gov/Content_atchs/mltss/CCC%20Plus%20program%20overview%20June%202017.pptx

Covered Behavioral Services

- Psychological Testing
- Neurobehavioral Status Exam
- Office Emergency Services
- Observation Care Discharge
- Initial Observation Care
- Subsequent Hospital Care
- Observation or Inpatient Care
- ER Consultation
- Smoking and Tobacco Cessation Counseling
- ARTS/ASAM Levels 0.5 – 4.0
- (OBOT) Medication Assisted Treatment (MAT) care coordination
- Opioid Treatment

- Case Management Substance Abuse
- Crisis Intervention Substance Abuse
- Medication Assisted Treatment (MAT)
- Residential Substance Abuse
- Alcohol and/or Drug Training
- Intensive Outpatient, Substance Abuse
- Telemental Health
- Peer Support Services
- Inpatient Psychiatric Hospitalization in Freestanding Psychiatric Hospital
- Inpatient Psychiatric Hospitalization in General Hospital
- Peer Support Services, Individual
- SUD Crisis Intervention

Link to DMAS Covered Services Manual:

http://www.dmas.virginia.gov/content_atchs/bh/ARTS%20Provider%20Manual%20Chapter%20IV%20Updates%20to%20FINAL%2004192017.pdf

Carved In Services

Community Mental Health Rehabilitation Services will be carved in as of January 1, 2018.

Services include:

- Mental Health Case Management
- Therapeutic Day Treatment (TDT) for Children
- Day Treatment/ Partial Hospitalization for Adults
- Crisis Intervention and Stabilization
- Intensive Community Treatment
- Mental Health Skill-building Services (MHSS)
- Intensive In-Home
- Psychosocial Rehab
- Behavioral Therapy
- Mental Health Peer Supports

Services continued to be covered FFS through Magellan (not carved in to the MCO's) :

- Level A and B Group Home
- Treatment Foster Care Case Management

Registration vs. Authorization

Community Mental Health Rehabilitation Services	Procedure Code	Registration vs. Authorization INTIAL REQUEST	Registration vs. Authorization CONTINUED STAY REQUEST
Mental Health Case Management	H0023	R	R
Mental Health Peer Support Services – Individual	H0025	R	A
Mental Health Peer Support Services – Group	H0024	R	A
Crisis Intervention	H0036	R	A
Crisis Stabilization	H2019	R	A
Intensive Community Treatment	H0039	A	R
Intensive In-Home	H2012	A	A
Therapeutic Day Treatment (TDT) for Children *TDT School Day	H0035 *HA	A	A
Therapeutic Day Treatment (TDT) for Children *TDT Afterschool	H0035 *HA *UG	A	A
Therapeutic Day Treatment (TDT) for Children *TDT Summer	H0035 *HA *U7	A	A
Day Treatment/ Partial Hospitalization *Adults	H0035 *HB	A	A
Mental Health Skill-building Services (MHSS)	H0046	A	A
Psychosocial Rehab	H2017	A	A
EPSDT Behavioral Therapy (ABA)	H2033	A	A

Registration vs. Authorization, cont.

- **Registration:** notification process
- **Authorization:** formal request with clinical review
- **Link to Authorization and Registration Forms**: http://www.dmas.virginia.gov/Content_pgs/mltss-trn.aspx
- **Provider Quick Reference Guide:** http://www.dmas.virginia.gov/Content_atchs/mltss/Provider%20Quick%20Reference%20for%20CCC%20Plus%20--%20CMHRS%20Update.pdf

CONTACT INFORMATION			
Commonwealth Coordinated Care (CCC) Plus	Phone Number	Fax Number	**Web Portal**
United Healthcare	**(877) 843-4366**	**(855) 368-1542**	**www.providerexpress.com**

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

DMAS website DBHDS Licensing and ASAM Level of Care Crosswalk

Outpatient Management

Reduced administrative burden

- We have removed precertification requirements for in-scope services

Management strategy

- Algorithms for Effective Reporting and Treatment (ALERT)
- Practice Management

In-scope services

- Individual/Group/Family Therapy
- Psychosocial Rehabilitation
- Community Psychiatric Supportive Treatment
- Homebuilders
- Multi-Systemic Therapy
- Functional Family Therapy
- Outpatient Addiction Services (ASAM level 1)

ALERT Program

Member identification	Licensed care advocate reach out telephonically to treating provider to:	Potential outcome of review:
• Claims data • Service combinations • Frequency and/or duration that is higher than expected	• Review eligibility for the service(s) • Review the treatment plan/plan of care • Review the case against applicable medical necessity guidelines	• Close case (member is eligible, treatment plan/plan of care is appropriate, care is medically necessary) • Modification to plan (e.g., current care is not evidence- based but there is agreement to correct) • Referral to Peer Review (e.g., member appears ineligible for service; treatment does not appear to be evidence based; duration/frequency of care does not appear to be medically necessary)

Practice Management Program

As an alternative to requiring precertification for routine and community-based outpatient services, we will provide oversight of service provision through our practice management program.

Program Components

- Regular and comprehensive analysis of claims data by provider/provider group
  - Service/diagnostic/age distribution
  - Proper application of eligibility criteria
  - Appropriate frequency of service/duration of service
- Outreach to provider group when appropriate to discuss any potential concerns that arose from the claims analysis
- Potential outcomes from discussion
  - No additional action necessary
  - Program audit including record review
  - Corrective Action Plan (CAP)
  - Targeted precertification as part of CAP

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
- Discharge planning begins at the onset of care and should be documented and reviewed over the course of treatment
- Discharge planning will focus 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

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 utilizes natural supports in the Member's community

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 and health care beliefs
  - Understand the role of the Member's family and 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 are:

  - www.cms.hhs.gov/ocr – Office of Civil Rights
  - www.LEP.gov – Promotes importance of language access to federal programs and federally assisted programs
  - www.diversityrx.org – Promotes language and cultural competency to improve the quality of health care for minorities
  - www.ncihc.org – Organization to promote culturally competent health care

Importance and Value of Cultural Competence

- Given the diverse ethnic population in Virginia, 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 experience
- Emphasizing individualized goals and self-sufficiency encourages Members to live their lives to the fullest

Provider Quality Audits

- Provider audits are completed for a variety of reasons:
  - High volume Licensed Mental Health Professional (LMHP) office and agency treatment record reviews
  - At the time of Credentialing and Recredentialing for providers 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

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

Audit Tools

- There are four (4) audit tools for Medicaid:
  - Organizational Provider Site Tool
  - Case Management Record Audit Tool
  - Psychosocial Rehab Record Audit Tool
  - Treatment Record Audit Tool

- The audit tools are posted to providerexpress.com: from the home page, choose Our Network > Welcome to the Network > Virginia > Audit Tool Names

Documentation Standards

- Information regarding documentation standards for behavioral health providers can be located in 3 places:
  - Optum Network Manual (located on providerexpress.com): from the home page, choose Clinical Resources > Guidelines/Policies & Manuals > Optum Network Manual
  - Virginia Commonwealth Coordinated Care Plus Provider Manual (located on providerexpress.com): from the home page choose Clinical Resources > Guidelines/Policies & Manuals > Manuals > State-Specific Manuals and Addendums
  - Audit tools

Documentation Standards, (continued)

Highlights of documentation standards

- A psychiatric history, including the presenting problem, is documented
- A 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-term 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)

- Discharge planning should be on-going and a discharge summary is documented when services are completed
- 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)
- Medical necessity for services that are rendered is clearly documented

Documentation Standards, (continued)

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)

Optum expects that all state and federal guidelines related to confidentiality are followed. For more information regarding documentation and storage of records, refer to the Optum Network Manual.

Integration of Physical and Behavioral Health

- It is essential to integrate physical and behavioral health services
- We require that coordination of care occur on a routine basis
- At the beginning of treatment, appropriate releases of information should be obtained to support coordination of care activities
- 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
  - The member needs to be educated regarding how coordination of care is beneficial to their overall treatment

Claims Submission Option 1 – **Online**

Entry through www.unitedhealthcareonline.com:

- Secure HIPAA-compliant transaction features streamline the claim submission process
- Performs well on all connection speeds
- Submitting claims closely mirrors the process of manually completing a CMS-1500 form
- Allows claims to be paid quickly and accurately

You must have a registered user ID and password to gain access to the online claim submission function:

- To obtain a user ID, call toll-free **(866) 842-3278**

Claims Submission Option 2 – **EDI/ Electronically**

- Electronic Data Interchange (EDI) is an exchange of information

- Performing claim submission electronically offers distinct benefits:
  - **It's fast** - eliminates mail and paper processing delays
  - **It's convenient** - easy set-up and intuitive process, even for those new to computers
  - **It's secure** - data security is higher than with paper-based claims
  - **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; provides claim error reports for claims that fail submission
  - **It's cost-efficient** - you eliminate mailing costs, the solutions are free or low-cost

Claims Submission Option 2 – **EDI/ Electronically**, (continued)

- You may use any clearinghouse vendor to submit claims
- Payer ID for submitting claims is 87726
- Additional information regarding EDI is available on

  http://www.uhccommunityplan.com/content/communityplan/homepage/health-professionals/va.html

  and

  www.unitedhealthcareonline.com

Claims Submission Option 3 – **Paper**

- **Use the CMS Form 1500 claim form:**
  - Claim elements include but are not limited to diagnosis (**DSM-5**)
  - Member name, Member date of birth, Member identification number, dates of service, type and duration of service, name of clinician (e.g., individual who actually provided the service), provider credentials, tax ID and NPI numbers
  - Paper claims submitted via U.S. Postal Service should be mailed to:

United Healthcare Community Plan
P.O. Box 5270
Kingston, NY 12402

- Use DSM-5 for assessment and the associated ICD-10 coding for billing
- Institutional claims must be submitted using the UB-04 claim form

Electronic Payment & Statements (EPS)

With EPS, you receive electronic funds transfer (EFT) for claim payments, plus your Provider Remittance Advice (PRA) is delivered online:

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

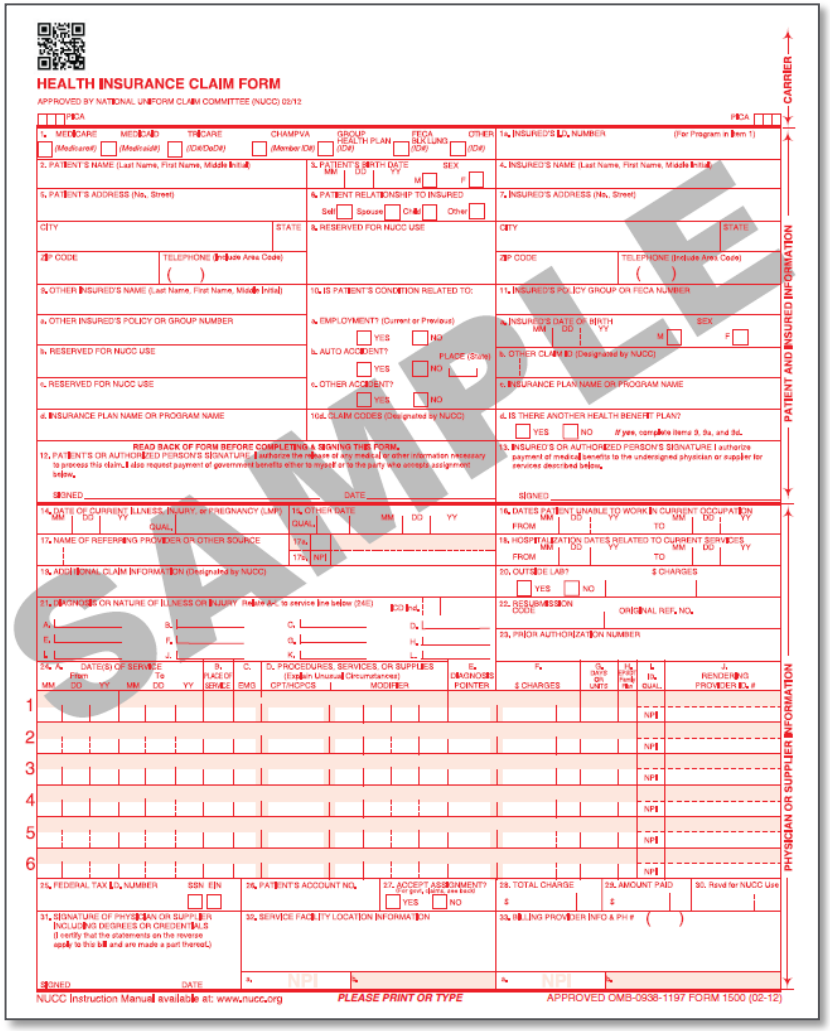
To receive direct deposit and electronic statements through EPS you need to enroll at myservices.optumhealthpaymentservices.com. Here's what you'll need:

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

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

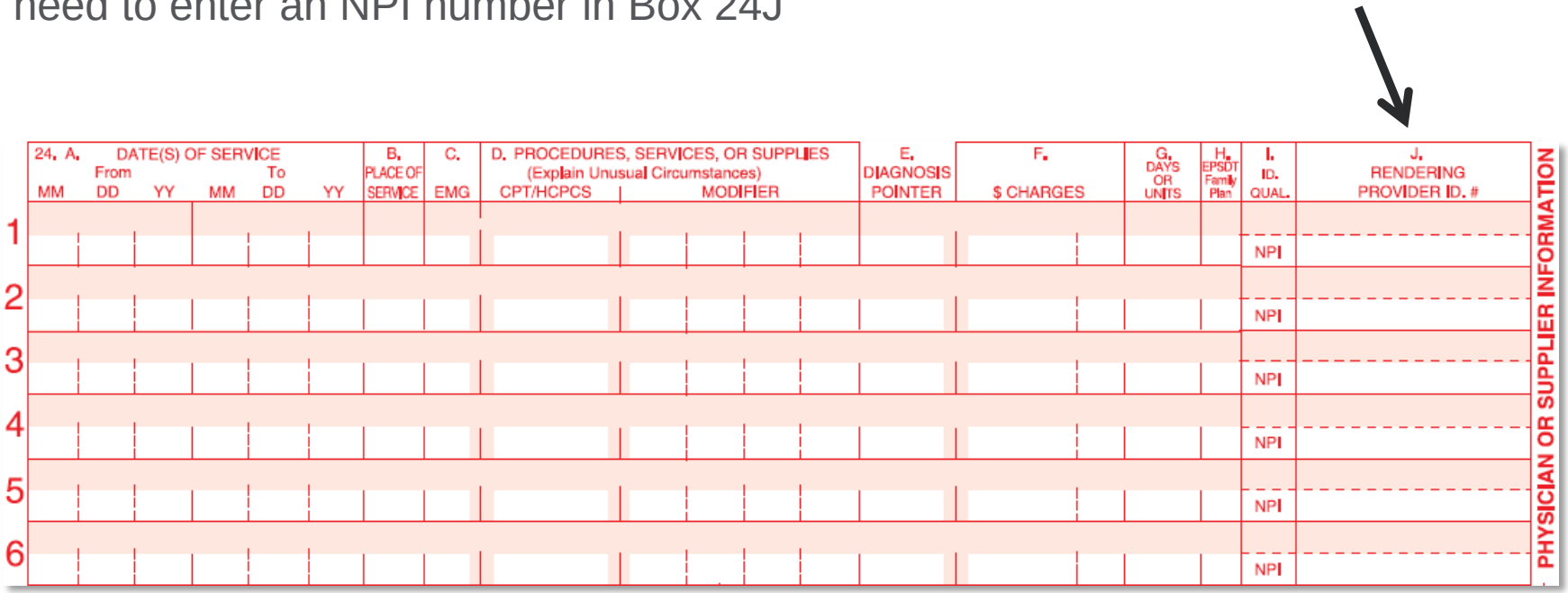
*Note: For more information, please call **(866) 842-3278**, option 5, or go to **UnitedHealthcareOnline.com** > Quick Links > Electronic Payments and Statements.*

Claims form – CMS 1500 (v02/12)



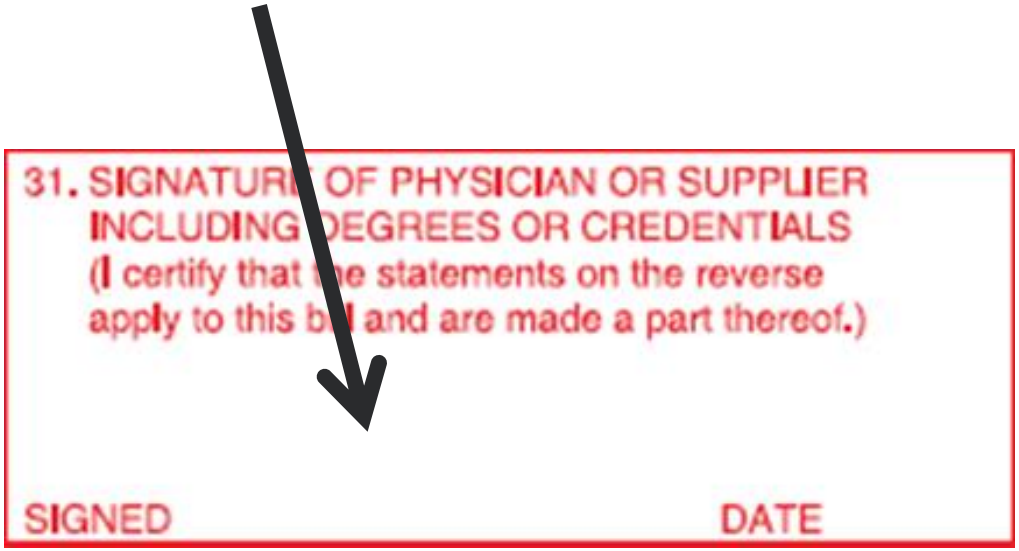
Claim form – CMS Form 1500 provider section, (continued)

- **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



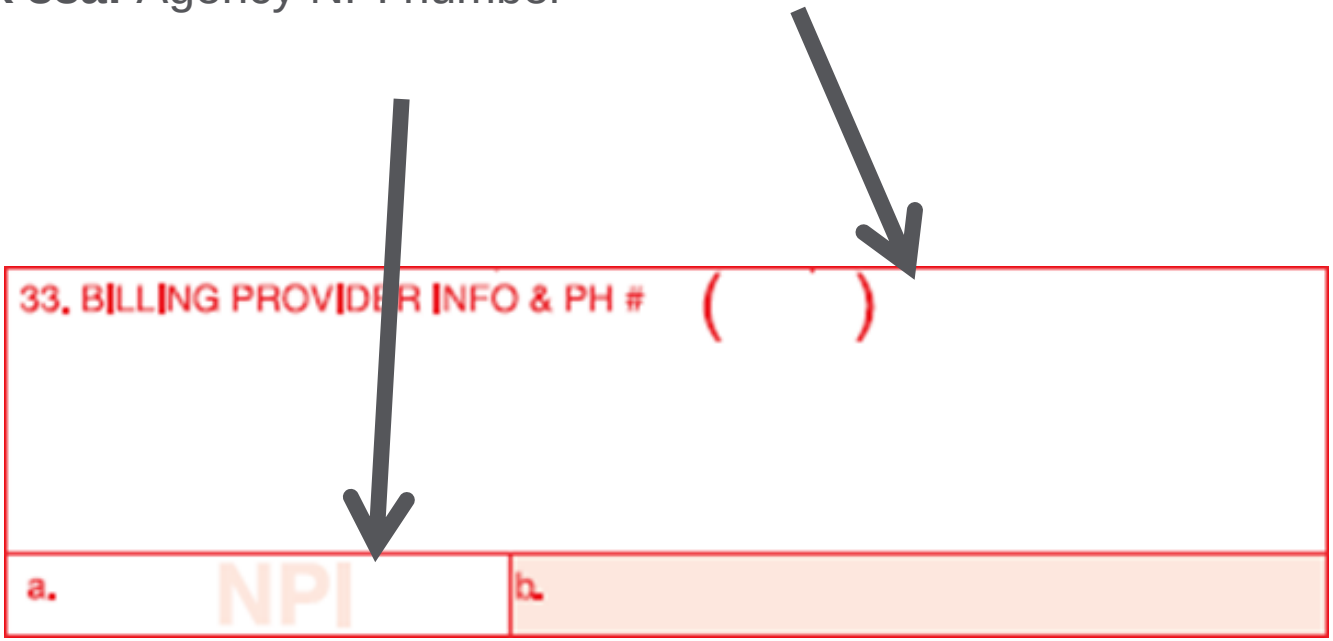
Claims form – CMS Form 1500 provider section, (continued)

- **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**



Claims form – CMS Form 1500 provider section, (continued)

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



Claim Tips

To ensure clean claims remember:

- NPI numbers are always required on all claims
- A complete diagnosis is required on all claims

Claims filing deadline:

- Virginia Commonwealth Coordinated Care Plus allows claims submission of up to 365 days from the date of service

Claims Processing:

- Clean claims, including adjustments, will be adjudicated within 30 days of receipt.
- The following exceptions shall apply:
  The Contractor shall ensure clean claims from NFs, community LTSS providers (including providers who provide community LTSS services when covered under ESPDT) and community behavioral health and SUD providers are processed within fourteen (14) days of receipt of the clean 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 unitedhealthcareonline.com

Examples of coding Issues related to claims denials:

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

Overview of Fraud, Waste, Abuse, and Error (FWAE)

In a managed care environment it can be a challenge to make sure that the goal of right care, right time & right place is met across the full system of care

- **Difficult and necessary program**: We are all charged with applying the most appropriate use of resources to support necessary care
- The Program and Network Integrity (PNI) Team identifies potential FWAE through tips and standardized review processes
- Appropriate corrective action, when necessary, occurs on a continuum commensurate with the range of questionable activity; actions may include addressing simple mistakes through education to referral to law enforcement when required
- **How we do it is key:** It is essential to strike a balance between the rare fraudulent practice and the vast majority of other cases reviewed. We must be vigilant and work together to improve any practice that impedes care and wastes valuable dollars anywhere within the system of care

Definitions

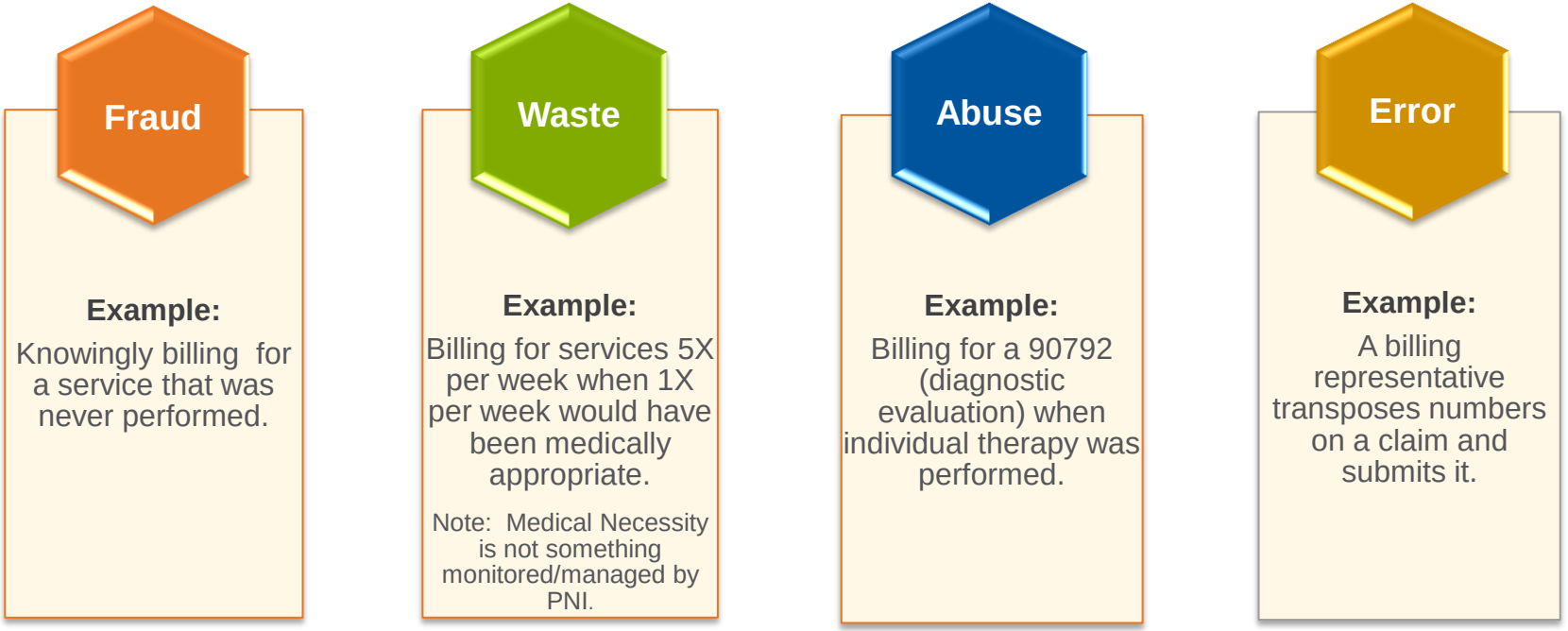
Intentional misrepresentation to gain a benefit

Any unnecessary consumption of health care resources

Unsound business practice that can include inappropriate utilization and/or inefficient use of resources

Mistakes, inaccuracies or misunderstandings that can usually be identified and fixed quickly

Examples of FWAE



PNI will:

- Carefully monitor for and take action to prevent FWAE
- Appropriately & consistently evaluate suspected FWAE
- Tailor corrective action to effectively stop/change the outlier behavior
- Offer a robust education program that engages the provider in changing outlier billing and coding behavior to accurately reflect the services rendered

Member Website and Resources

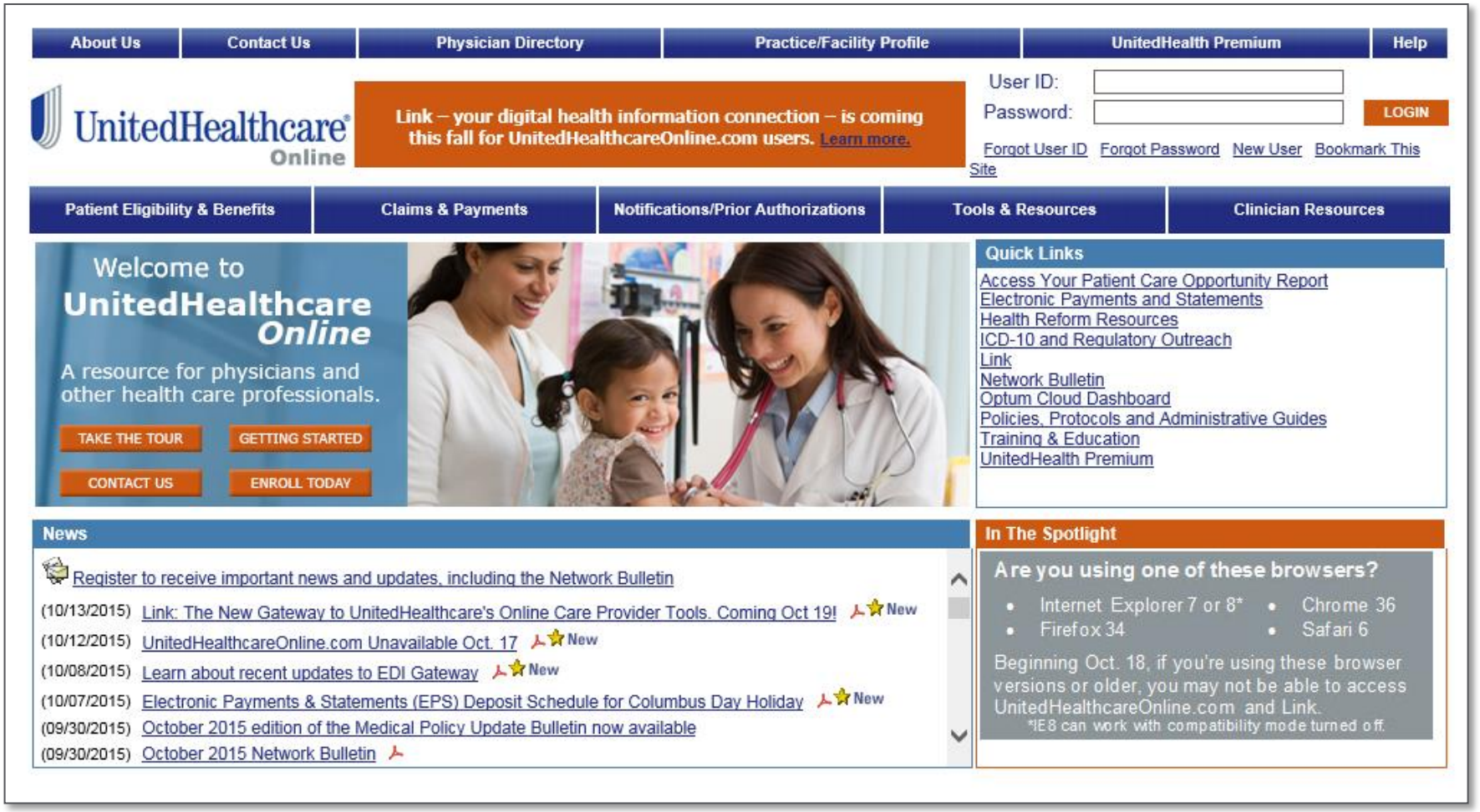
- www.myuhc.com/communityplan makes it simple for members to:
  - Identify participating providers:
    - Geographic location
    - Provider specialty type/areas of expertise
    - License type
  - Locate community resources
  - Find articles on a variety of wellness and work topics
  - Complete self-assessments
- The website has an area designed to help members manage and take control of life challenges

UnitedHealthcare Provider Website

unitedhealthcareonline.com

- **Secure transactions for Medicaid include:**
  - Check eligibility and authorization or notification of benefits requirements
  - Submit professional claims and view claim status
  - Make claim adjustment requests
  - Register for Electronic Payments and Statements (EPS)
  - To request a user ID to the secure transactions on the unitedhealthcareonline.com, select New User from the Home Page; you may obtain additional information through the Help Desk at **(866) 842-3278**
- For member eligibility, claim status, and reference materials, go to UnitedHealthcareOnline.com > Tools and Resources > UnitedHealthcare Community Plan Resources
- Customer Service for website support: **(800) 600-9007**

UnitedHealthcare Online – Login Page



Provider Resources

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 Virginia Medicaid providers access to provider-specific information.

Provider Resources, (continued)

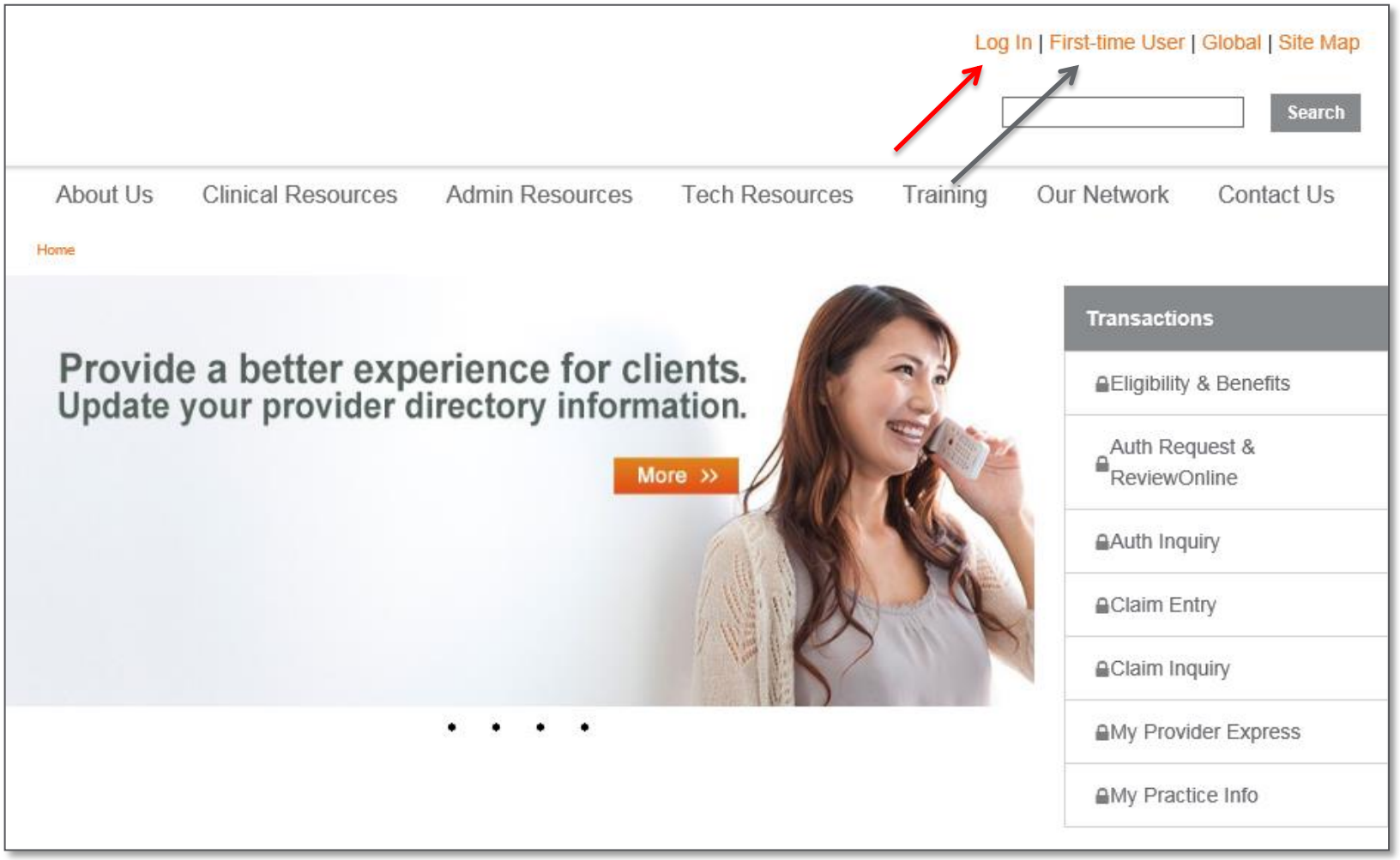
Public Pages include general updates and other useful information:

- Download standard forms (e.g., provider demographic updates, authorization forms, psych testing authorization forms)
- Find network contacts
- Review clinical guidelines
- Access archived issues of Network Notes, the provider newsletter
- Level of Care Guidelines
- Training/Webinar offerings
- Virginia page (from the Home Page, choose Our Network > Welcome to the Network > Virginia)

Provider Resources, (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 8 a.m. to 10 p.m. Eastern time, or chat with a tech support representative online

Provider Express Home Page – Log In



Provider Responsibilities

- Render services to Members in a non-discriminatory manner:
  - Maintain availability for a routine level of need for services
  - Offer routine non-urgent appointments within 14 days of the request for services
  - Provide after-hours coverage
  - Support Members in ways that are culturally and linguistically appropriate
- Determine if Members have benefits through other insurance coverage
- Advocate for Members as needed
- 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

Access to Care Standards

Urgent If not addressed in a timely way could escalate to an emergency situation	Members will be offered an appointment within 24 hours
Life threatening emergencies Imminent risk of harm or death to self or others due to a medical or psychiatric condition	Referral is Immediate

Join Our Network – Clinicians

- 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
  - Providers complete Network Request form
  - 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)
  - Signed Virginia Medicaid Addendum:
    - One per clinician pursuing individual contracting
    - One per agency/group if pursuing a group contract
- Approval by Optum Credentialing Committee 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

Join Our Network, (continued)

FQHCs, CSBs, Agencies and Groups:

- For FQHC agencies that employ licensed professional staff to render services under the umbrella of the agency, Optum will execute group contracts with the agency as the contracting entity

- Agencies must submit the Optum agency application, indicating the services being provided and the licensed clinical professionals on the staff roster

- The individual licensed clinicians on staff do not need to submit CAQH applications or be individually credentialed when they work for the agency under an Optum group contract

Supervisory Protocol Addendum

The Supervisory Protocol addendum allows for non-credentialed clinicians to render services while under the supervision of an independently licensed clinician:

- 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

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

Contact Information

Important Phone Numbers, Emails, and Fax Numbers:

- Virginia Provider Services: (877) 843-4366
- Pharmacy Help Line (OptumRx): (877) 305-8952
- For BH Authorizations: (877) 843-4366 or Fax: (844) 881-4926
- Psychological Testing Request Form: https://optumpeeraccess.secure.force.com/psych/
- Claims: (877) 843-4366 and UnitedHealthcareOnline.com

Important Addresses:

- Behavioral Health or Medical Claims – P.O. Box 5270, Kingston, NY 12402
- Pharmacy Claims - OptumRx P.O. Box 29044, Hot Springs, AR 71903
- Website – unitedhealthcareonline.com
- Website – providerexpress.com

Behavioral Network Services, Virginia
Contact Information

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Thank you.

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