



New York Medicaid

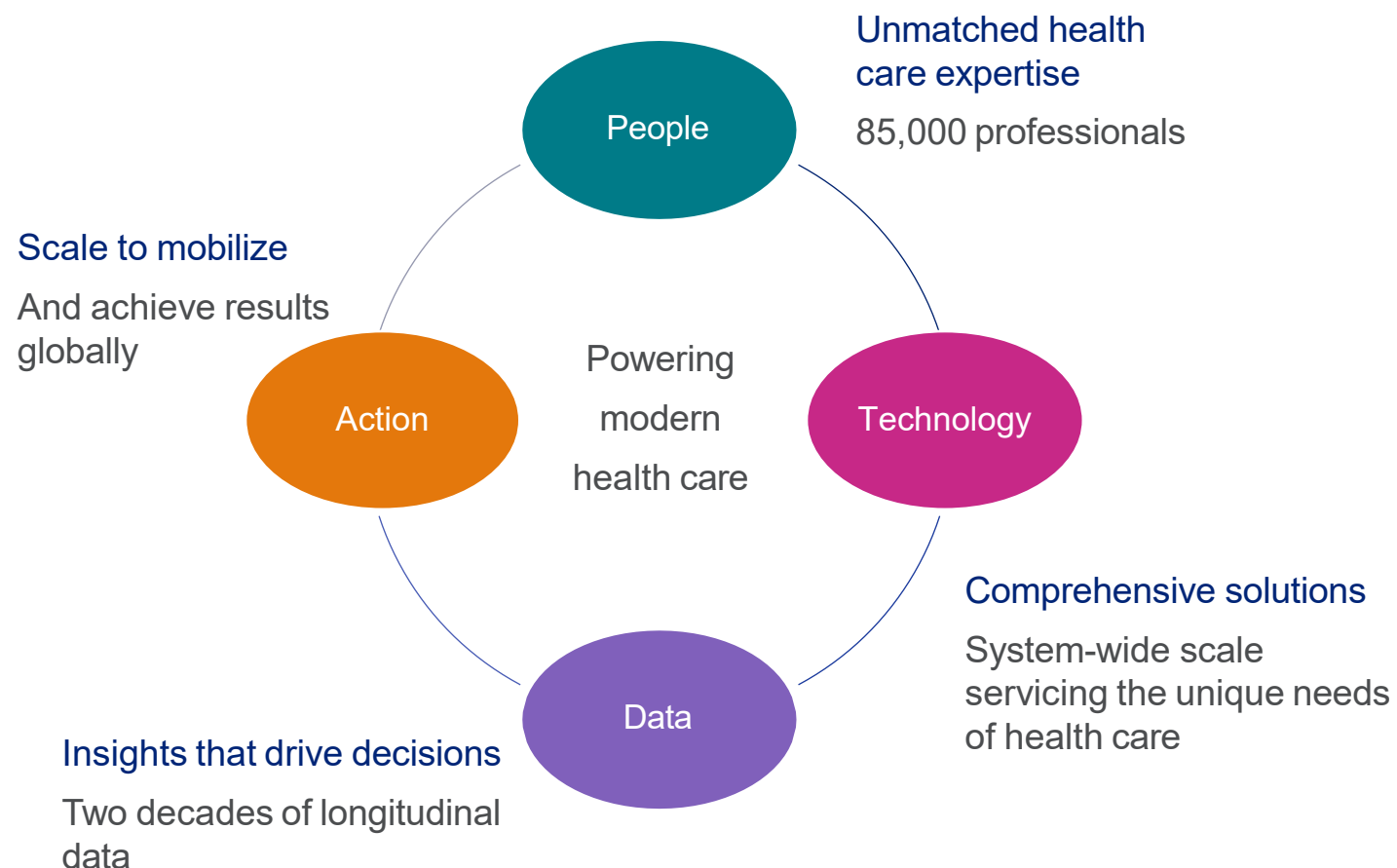
ABA Provider Orientation
Optum with UnitedHealthcare Community
Plan New York

2025



Who is Optum?

- Optum is a collection of people, capabilities, competencies, technologies, perspectives and partners sharing the same simple goal: to make the healthcare system work better for everyone
- Optum works collaboratively across the health system to improve care delivery, quality, and cost effectiveness
- We focus on three key drivers of transformative change:
 1. Engaging the consumer
 2. Aligning care delivery
 3. Modernizing the health system infrastructure



UnitedHealth Group structure



Our United Culture

When we follow our Mission and live our Values, we deliver Quality.
Quality is reflected in all the ways we work and infused across our Values.

Our Mission is our *why*.

Helping people live healthier lives and helping make the health system work better for everyone.

Our Values unite us around *how we deliver Quality*.

Integrity

We do the right thing and follow through on our shared commitment to Quality.

Inclusion

We welcome, value, respect and hear all voices and diverse points of view.

Innovation

We invent a better future by learning from the past.



Compassion

We listen, advocate and act with urgency for those we serve and our colleagues.

Relationships

We work together to deepen connections and collaboration for better outcomes.

Performance

We strive for high Quality results in everything we do.

Integrity ● Compassion ● Inclusion ● Relationships ● Innovation ● Performance

Optum and you

Our relationship with you is foundational to the recovery and well-being of the individuals and families we serve. We are driven by a compassion that we know you share. Together, we can set the standard for industry innovation and performance.

Achieving our Mission:

- Starts with Providers
- Serves Members
- Applies global solutions to support sustainable local health care needs

From risk identification to integrated therapies, our mental health and substance abuse solutions help to ensure that people receive the right care at the right time from the right providers.

Specialty network services

Customers we serve:

- 50% of the Fortune 100 and 34% of the Fortune 500
- Largest provider of global Employee Assistance Programs (EAP), covering more than 19 million lives in over 140 countries
- Local, state and federal government contracts (Public Sector)

Serving almost 43 million members:

- 1 in 6 insured Americans
- The largest network in the nation, delivering best in class density, discounts and quality segmentation
- More than 140,000 practitioners; 4,200 facilities with 9,000 facility locations

Simultaneous NCQA and URAC accreditation

Staff expertise:

- Multi-disciplinary team of 50 staff Medical Directors, (e.g., child and adolescent, medical/psychiatric, Board-Certified Behavior Analysts, and addiction specialists) just to name a few



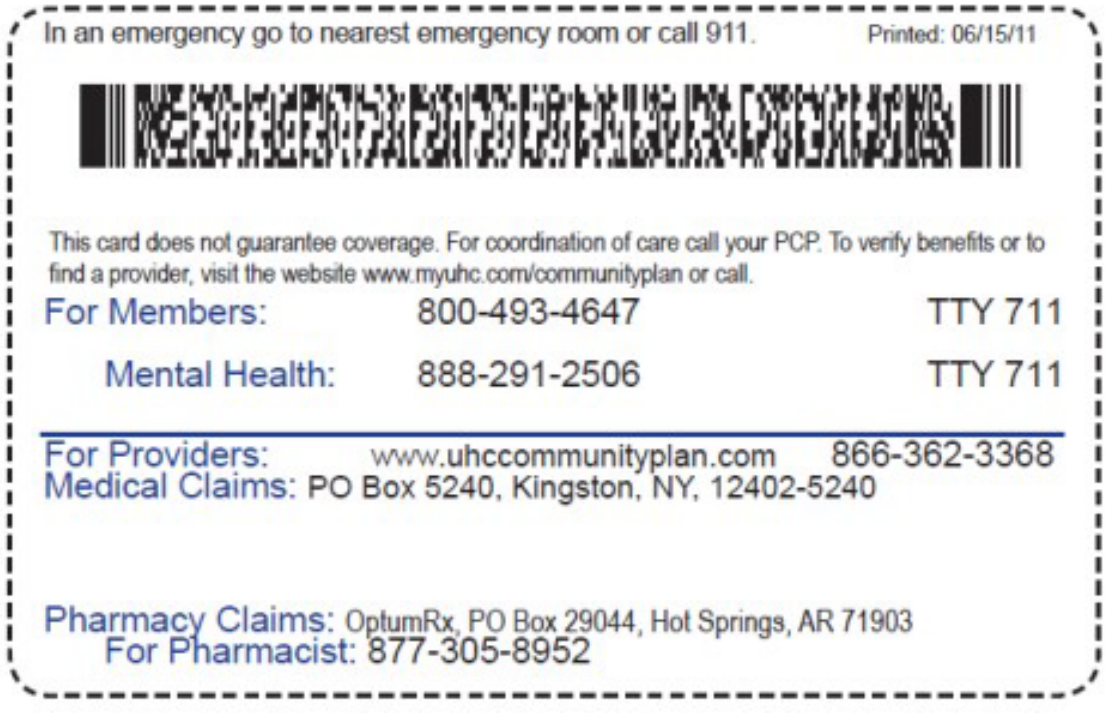
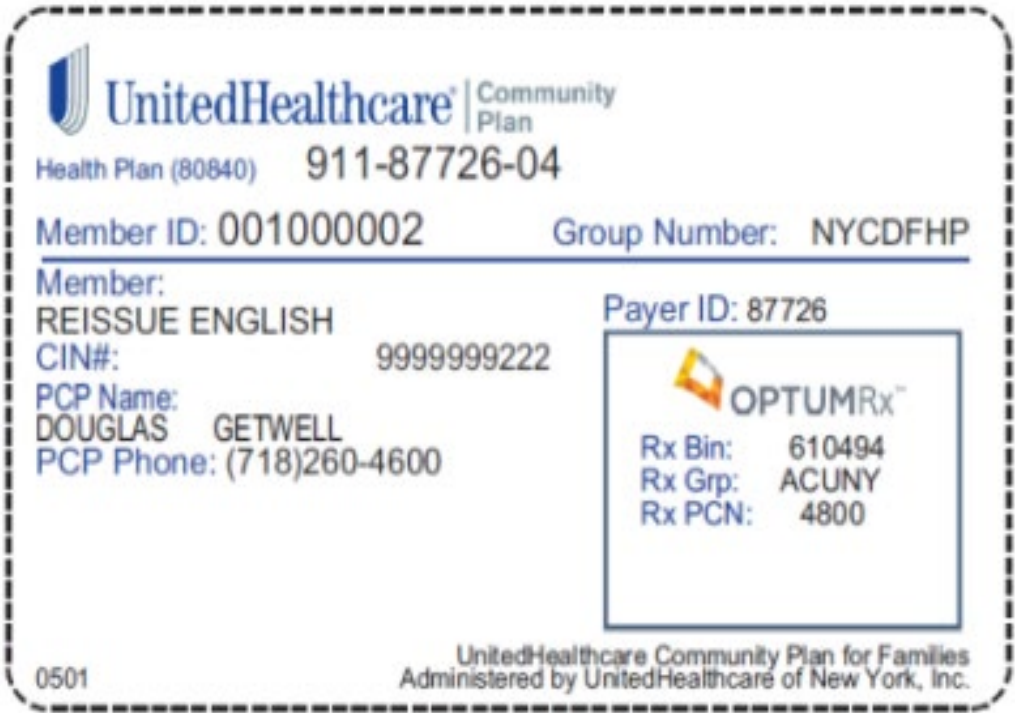
Optum ABA NY Medicaid Member Information

Optum



NY Medicaid member ID card

- Will be sent directly to the member
- All relevant contact information will be on the back of the card for both medical and behavioral customer service



Member rights and responsibilities

Members have the right to be treated with respect and recognition of his or her dignity, the right to personal privacy, and the right to receive care that is considerate and respectful of his or her personal values and belief system

Members have the right to disability related access per the Americans with Disabilities Act

You will find a complete copy of Member Rights and Responsibilities in the Provider Network Manual

These can also be found on the website: providerexpress.com

These rights and responsibilities are in keeping with industry standards. All members benefit from reviewing these standards in the treatment setting

We request that you display the Rights and Responsibilities in your waiting room, or have some other means of documenting that these standards have been communicated to the members



Member website

[Live and Work Well](#) makes it simple for members to:

- Identify network clinicians and facilities
- Locate community resources
- Find articles on a variety of wellness and work topics
- Take self-assessments

The search engine allows members and providers to locate in-network providers for behavioral health and substance use disorder services.

Providers can be located geographically, by specialty, license type and expertise.

The website has an area designed to help members manage and take control of life challenges.



Who is eligible?

To be eligible for ABA services, a client must meet the following criteria:

- ✏ NY Medicaid - Must be up to age 21
 - ❑ Must be covered under NY Medicaid
 - ❑ Must have ASD dx and/or Rhett's Syndrome; F84.0, F84.2, F84.5, F84.8 & F84.9

Diagnosis of ASD and/or Rhett's AND must be referred by a NYS licensed and NYS Medicaid enrolled physician (psychiatrist, developmental pediatrician, psychologist, psychiatric nurse practitioner, pediatric nurse practitioners or physician assistants);

- referrals for ABA services are valid for no more than 2 years AND Must include:
 - Age of the patient
 - ASD or Rhett's diagnosis
 - Date of initial diagnosis
 - Co-morbid diagnosis (if applicable)
 - Symptom severity level/level of support (if referral is from an ASD-diagnosing provider)
 - Statement the patient needs ABA services
 - DSM-5 Diagnostic Checklist for ASD Services



Credentialing Criteria NY Medicaid Autism/ABA Network



Required: NPI and EIN/TIN

Licensed Behavior Analyst (LBA) Providers must be enrolled with New York Medicaid

National Provider Identifier (NPI):

- Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans
- The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information
- We require that all claims submitted have an NPI number and taxonomy codes for reimbursement

To obtain an NPI number, follow the instructions on the NPI web site:

- nppes.cms.hhs.gov

Tax Identification Number (TIN), Employee Identification Number (EIN), or Social Security Number (SSN) information:

- irs.gov
- [Apply for an Employer Identification Number \(EIN\) Online | Internal Revenue Service \(irs.gov\)](https://www.irs.gov/applyforanemployeridentificationnumber)

Professional Liability Insurance:

- [BACB - Behavior Analyst Certification Board](https://bacb.com) has coverage information; enter “liability in the site’s “Search” feature located in the right side of the menu



ABA provider criteria

Applied Behavior Analysis (ABA) services for NY Medicaid members can be provided by

- Licensed Behavior Analyst (LBA)
 - ☐ Board Certified Behavior Analyst (BCBA) with active certification from the national Behavior Analyst Certification Board, and
 - ☐ State licensure in good standing
 - ☐ Have a Medicaid ID from the state of New York
 - ☐ Compliance with all state/autism mandate requirements as applicable to behavior analysts
- Certified Behavior Analyst Assistant (CBAA) working under the supervision of LBA's
 - ☐ Have a Medicaid ID from the state of New York
- Other individuals specified under Article 167 of NYS education law



ABA Virtual Visits

Optum allows BCBAs/Licensed BH Clinicians within contracted ABA practices to conduct ABA supervision and/or caregiver training via telehealth.

In order to provide supervision and/or caregiver training services via telehealth, you must be an approved Optum virtual visits provider who has attested to meeting the requirements specific to providing these services:

- You can complete and submit a virtual visits attestation on our virtual visits page of Provider Express and will be notified of approval or denial
- Once approved as a virtual visits provider, please be sure to alert the Optum Care Advocate that the ABA supervision and caregiver training services will be provided virtually when completing the authorization process

After receiving authorizations, to bill for the virtual ABA Supervision of Behavior Technicians and Family Training and Guidance:

- Simply include the same procedure code you would use for an in-person service, 97151, 97152, 97153, 97154, 97155, 97156 or 97157 on your claim with the “02” place of service code to let us know the service was provided via telehealth.

Additional information and resources can be found on our ABA page at Provider Express.



Steps in Providing Treatment

Eligibility, Authorizations &
Concurrent Reviews



Clinical teams

Dedicated Autism Clinical Team

There is a dedicated autism clinical team that supports the New York Medicaid ABA program:

- Each team member is a licensed behavioral health clinician or BCBA with experience and training in Autism
- Supervised by a manager who is a licensed psychologist and BCBA-D



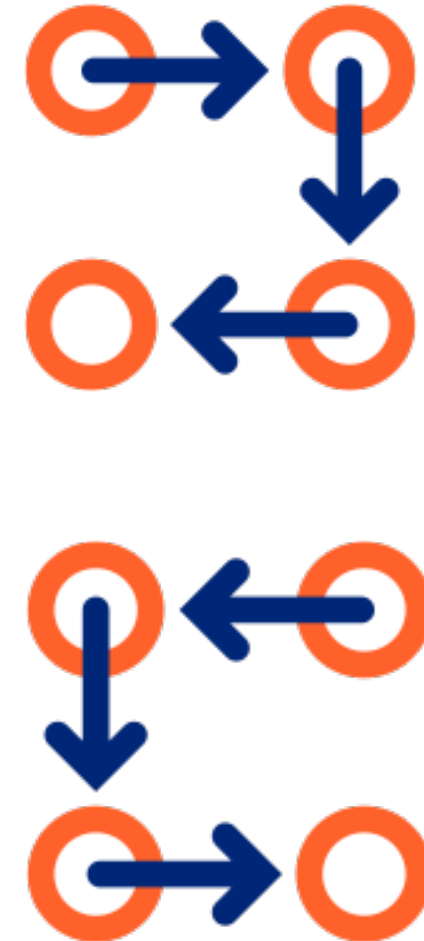
Intake

At intake

- Copy front and back of the member's insurance card
- Record subscriber's name and date of birth

Suggested information:

- Provide subscriber with your HIPAA policies
- Provide subscriber with consent for billing using protected health information including signature on file
- Always get a consent for services
- Informed Consent: services, to leave voicemail, email, etc.
- Billing policies and procedures
- Release of Information to communicate with other providers



Release of information

- We release information only to the individual, or to other parties designated in writing by the individual, unless otherwise required or allowed by law
- Members must sign and date a Release of Information for each party that the individual grants permission to access their PHI, specifying what information may be disclosed, to whom, and during what period of time
- The member may decline to sign a Release of Information which must be noted in the Treatment Record; the decline of the release of information should be honored to the extent allowable by law
- PHI may be exchanged with a network clinician, facility or other entity designated by HIPAA for the purposes of Treatment, Payment, or Health Care Operations



Eligibility and Prior Authorization

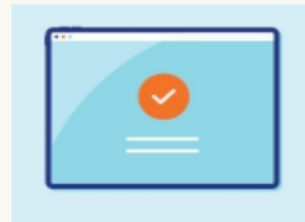
All ABA services require prior authorization:

- Verify benefits/eligibility online at providerexpress.com or call the Behavioral Health number located on the back of the member's ID card
- Check benefit coverage relating to both the service (e.g., Is Autism-based therapy covered?) and the diagnosis (e.g., Is autism covered?) on provider portal or by calling the number on the member's insurance card.
- Prior auth for online assessment request at: [ABA Assessment](#)
- Prior Authorization for treatment request obtained by:
 - Optum portal, providerexpress.com
- Authorization status can be viewed online at providerexpress.com

- When calling the Autism Care Advocate you must have:

- ☐ Member's name
- ☐ Member ID #
- ☐ Member date of birth
- ☐ Member address
- ☐ Agency TIN
- ☐ Agency name & servicing address
- ☐ Your call back number
- ☐ Description of care/treatment plan

Submit a digital ABA services request



In-network providers, [Log in](#) to the secure portal:

1. Select 'Auths' from the upper right menu
2. Click the 'Auth request' tab
3. Choose 'Request a new authorization'
4. Select ABA Assessment or Treatment from the drop down
5. Complete the required fields and submit

Treatment request requirements

Meet Medical Necessity

Goals are.

- Related to the core deficits
- Objective
- Measurable
- Individualized

Includes:

- Baseline and mastery criteria
- Transition Plan to lower level of care
- Discharge Criteria
- Behavior Reduction Plan/Crisis Plan
- Parent Goals
- Supervision and treatment planning hours
- Relevant psychological information
- Coordination of care with other providers

Not educational in nature

For more information, please see the [Treatment Plan Guidelines](#) on the Autism/Applied Behavior Analysis page of Provider Express.

Clinical information requirements for each review

- Confirmation member has an appropriate DSM-5 diagnosis that can benefit from ABA
 - Any medical or other mental health diagnoses
 - Any other mental health or medical services member is in
 - Any medications member is taking
 - How many hours per week is member in school?
 - Parent participation
 - Why IBT now?
- How long has member been in services?
 - Goals must not be educational or academic in nature; they must focus only on the core deficits such as imitation, social skills deficits and behavioral difficulties
 - Discharge criteria
 - Must meet medical necessity (see Provider Express for the Level of Care Guidelines and Coverage Determination Guidelines)

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

Concurrent reviews

The same information will be needed for each review:

- Any medical or other mental health diagnoses
 - Any other mental health or medical services member is in
 - Any medications member is taking
 - How many hours per week is member in school?
 - Parent participation
- Progress or lack thereof
 - Goals must not be educational or academic in nature – focusing only on the core deficits such as imitation, social skills deficits and behavioral difficulties
 - Discharge criteria
 - Must meet medical necessity (see Provider Express for the Optum Autism/ABA Clinical Policy)



Billing and Reimbursement



Diagnostic coding

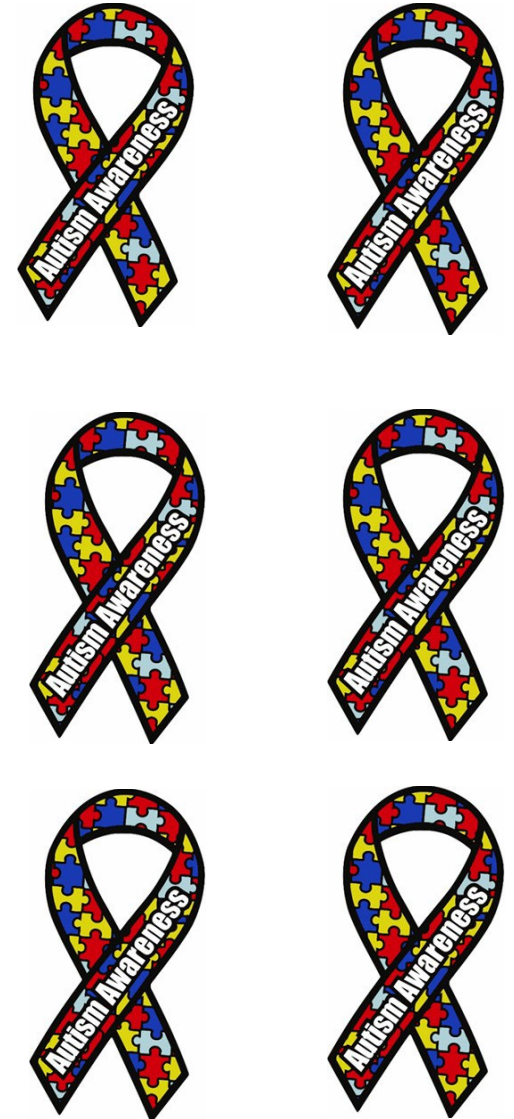
Guides for Coding:

- DSM-5 defined conditions:
 - Clinical criteria for ASD
 - Maps to the appropriate ICD billing code

ASD Coverage:

- Autism Spectrum Disorder, F84.0 (ICD-10)

A complete diagnosis with all 4 digits is required on all claims utilizing the ICD-10 coding.



NY ABA Medicaid

United Behavioral Health (OHBS)			
Billing Code	Modifier	Service Description	Units
97151		Behavior identification assessment, administered by a physician or other qualified health care professional, each one hour of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan (per 15 minutes)	15 min
97152		Behavior identification-supporting assessment, administered by one technician under the direction of a physician or other qualified health care professional, face-to-face with the patient (per 15 minutes)	15 min
97153		Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient (per 15 minutes)	15 min
97154		Group adaptive behavior treatment with protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with two or more patients (each 15 minutes)	15 min
97155		Adaptive behavior treatment with protocol modification, administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient (per 15 minutes)	15 min
97156		Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s) (each 15 minutes)	15 min
97157		Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present) face-to-face with multiple sets of guardians/caregivers (each 15 minutes)	15 min
97158		Group adaptive behavior treatment with protocol modification 15 minutes face-to-face with multiple patients, in a group setting of no more than 8 individuals.	15 min

Claims submission

All Autism/ABA Claims must be:

- Submitted on a Form 1500 (v.02/12) claim form
- Submit electronically via providerexpress.com or UHCprovider.com using the Claim Entry transaction feature
- Submit electronically using an EDI clearinghouse and payer ID # 87726
- Include appropriate taxonomy codes
- Submitted within 120 days of date of service

Please send paper claims to:

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



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

- Optum – 1-866-362-3368
- Logging into providerexpress.com or UHCprovider.com

Form 1500 - claim form

All billable services must be coded.

- Coding can be dependent on several factors:
 - ☐ Type of service (assessment, treatment, etc.)
 - ☐ Rate per unit
 - ☐ Place of service (home or clinic)
 - ☐ Duration of therapy (1 hr. vs. 15 min)
 - ☐ One DOS per line

You must select the code that most closely describes the service(s) provided.

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

HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

1. MEDICARE (Medicare) ☐ MEDICAID (Medicaid) ☐ TRICARE (Tricare) ☐ CHAMPVA (Champus) ☐ GROUP HEALTH PLAN (Group Health Plan) ☐ FECA (FECA) ☐ OTHER (Other) ☐

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE (MM/DD/YY) SEX

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No. Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED'S ADDRESS (No. Street)

8. RESERVED FOR NUCC USE

9. RESERVED FOR NUCC USE

10. RESERVED FOR NUCC USE

11. INSURED'S POLICY GROUP OR FECA NUMBER

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (MM/DD/YY)

15. DATE OF CURRENT OCCUPATION (MM/DD/YY)

16. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (MM/DD/YY)

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (MM/DD/YY)

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO ☐ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Reference to service line below (SLE)) (ICD-9-CM)

22. SUBSCRIPTION

23. PRIOR AUTHORIZATION NUMBER

24. A. DATES OF SERVICE (MM/DD/YY) B. PLACE OF SERVICE (FACILITY) C. PROCEDURES, SERVICES, OR SUPPLIES (Include Unusual Circumstances) D. MONITOR E. CHARGES

25. FEDERAL TAX ID NUMBER 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. HAVE FOR NUCC USE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address and phone number) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH #

34. SIGNATURE 35. DATE

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1107 FORM 1500 (02-12)

Claims tips

To ensure clean claims remember:

- An NPI number and taxonomy code is always required on all claims
- A complete diagnosis is also required on all claims

Claims filing deadline

- Timely filing for NY Medicaid is 120 days from date of service

Balance billing

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

Member eligibility

- Provider is responsible to verify member eligibility through DHS website

Coding issues

- Coding issues including incomplete or missing diagnosis invalid or missing HCPC/CPT examples:
 - ☐ Submitting claims with codes that are not covered services
 - ☐ Required data elements missing, (i.e., number of units)

Provider information missing/incorrect

- Example: provider information has not been completely entered on the claim form or place of service

Prior authorization required

- Prior authorization is required for all services or when additional units are being requested



Denials

Explanation of Benefits (EOB) / Provider Remittance Advice (PRA)

- Denial Codes:
 - ☐ Ineligible
 - ☐ Over limit
 - ☐ No out-of-network benefits
 - ☐ Prior approval required
- Non-Coverage Determination (NCD)
- Appeals



Claims tips

Rejections/Denials:

- Rejected claim – Claims that are rejected prior to hitting Optum claims system
 - ❑ Claims could be rejected for missing claims data (e.g., missing NPI, TIN or other required data element)
- Denied claim – Claims that are denied by Optum claims system
 - ❑ Claims could be denied automatically during auto adjudication (e.g., eligibility or timely filing issues)
 - ❑ Or claims could be denied during processing (e.g., no authorization on file, etc.)



Claims submission option 1- online

Log on to UHCprovider.com:

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

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

- To obtain a user ID, call toll-free 1-866-842-3278



Claims submission option 2 – EDI/electronically

Electronic Data Interchange (EDI) is an exchange of information

Performing claim submission electronically offers distinct benefits:

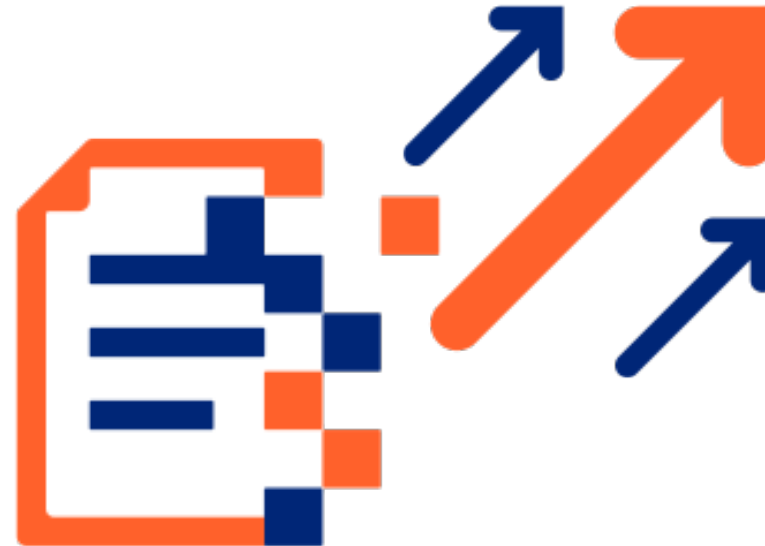
- Fast - eliminates mail and paper processing delays
- Convenient - easy set-up and intuitive process, even for those new to computers
- Secure - data security is higher than with paper-based claims
- Efficient - electronic processing helps catch and reduce pre-submission errors, so more claims auto-adjudicate
- Notification - you get feedback that your claim was received by the payer; provides claim error reports for claims that fail submission
- Cost-efficient - you eliminate mailing costs; the solutions are free or low-cost

Claims submission option 2 - EDI/electronically (cont.)

You may use any clearinghouse vendor to submit claims payer ID for submitting claims is 87726

Additional information regarding EDI is available on:

- [EDI Contacts | UHCprovider.com](#)
and
- [UHCprovider.com](#)



Optum Pay™

With Optum Pay, you receive electronic funds transfer (EFT) for claim payments, plus your EOBs are delivered online:

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

To receive direct deposit and electronic statements through Optum Pay you need to enroll at [Optum Health Payment Services](#)

Here's what you'll need:

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

If you're already signed up for Optum Pay with UnitedHealthcare Commercial or UnitedHealthcare Medicare Solutions, you will automatically receive direct deposit and electronic statements through Optum Pay for UnitedHealthcare Community Plan when the program is deployed.

*Note: For more information, please call **1-866-842-3278**, option 5 or go to [UHCprovider.com](#) > Claims, Billing and Payments > Optum Pay.*

Provider Express

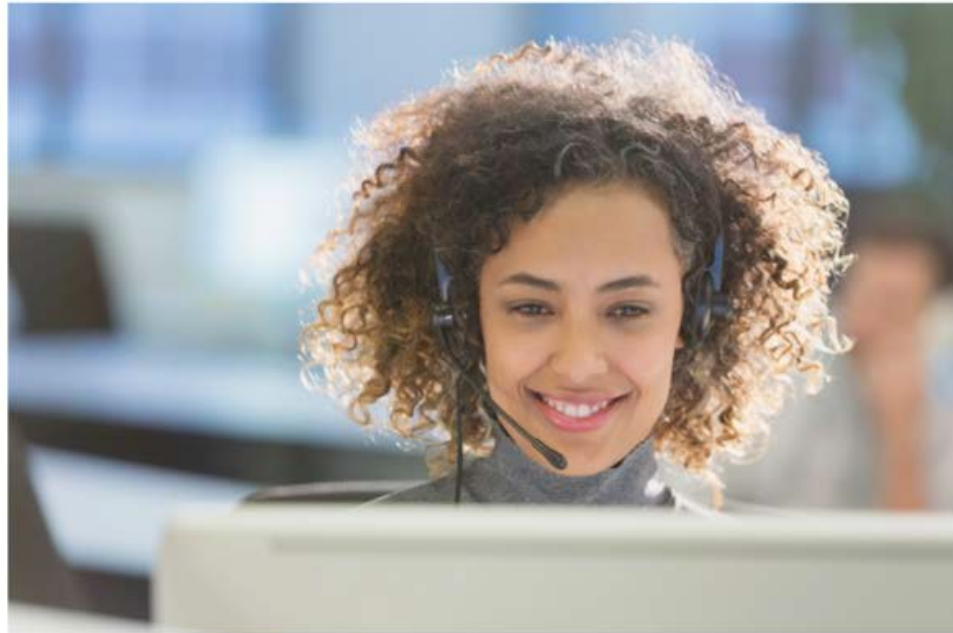
Optum



providerexpress.com

You can find:

- Clinical Criteria
- ABA Clinical Policy
- Best Practices
- Optum Network Manual
- Contact Information
- Common Forms
- Verify Benefits and Eligibility
- Claims Status
- Claim Submission
- Authorization Status



Please contact your assigned network manager for any practice updates (demographics, etc.)

providerexpress.com - First Time Users

- Register online for immediate access to secure Transactions
- No fees apply
- Provider Express Support Center available from 7 a.m. to 9 p.m. Central time – toll free at 1-866-209-9320
- Live chat feature also available

Create One Healthcare ID

One Healthcare ID securely manages your account so that you can use one One Healthcare ID and password to sign in to all integrated applications.



Already have One Healthcare ID? [Sign in now](#)

Profile Information

First name

Last name

Year of birth

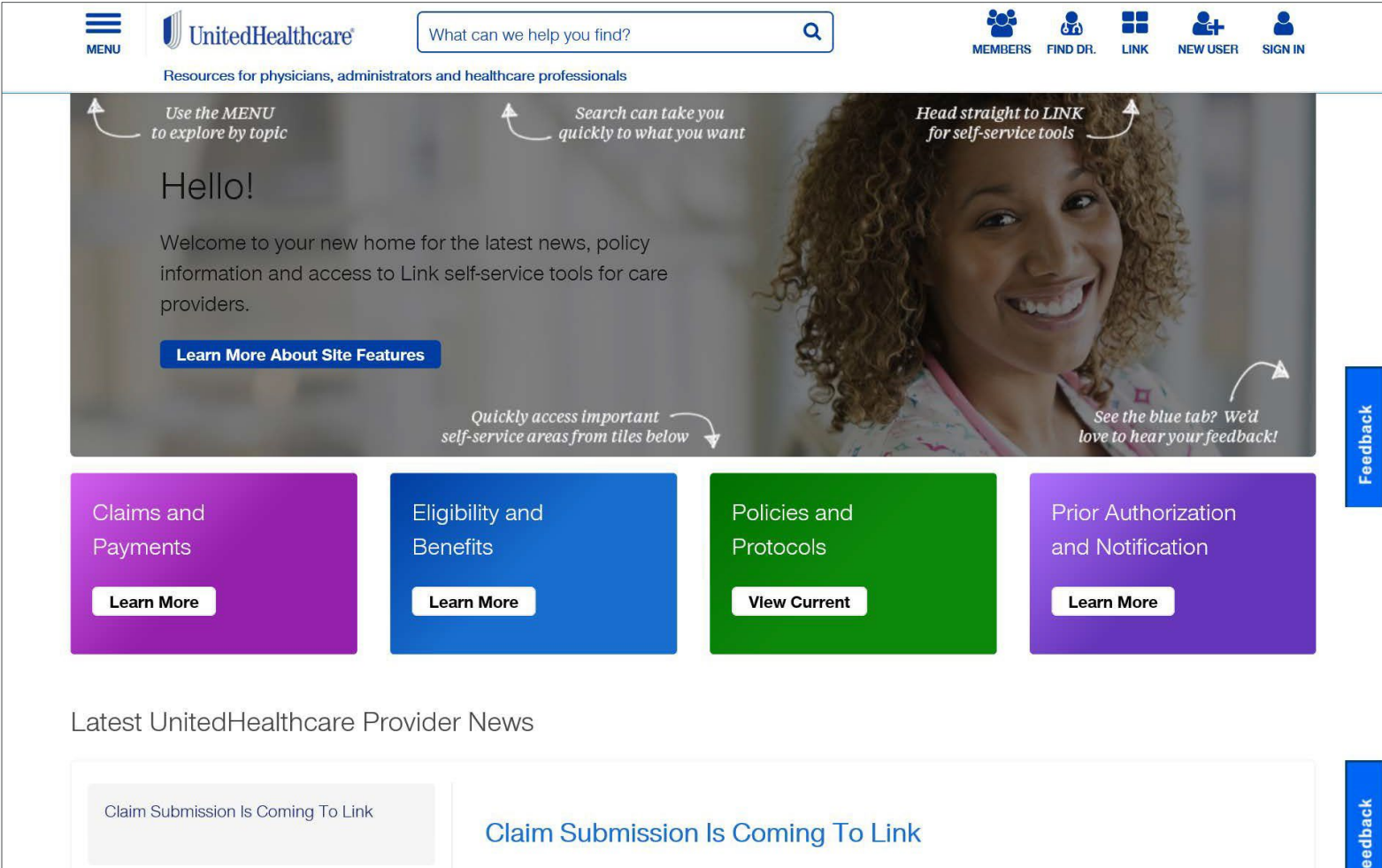


Sign In Information

Resources



UHCprovider.com provider website



Appendix



Helpful websites

To get an NPI number:

- [NPPES \(hhs.gov\)](https://nppes.hhs.gov)

To learn more about HIPAA:

- [HIPAA Home | HHS.gov](https://www.hhs.gov/hipaa)

To learn more about Tax IDs or Employee IDs:

- irs.gov

Optum provider website:

- providerexpress.com
- Claim Tips: Provider Express > Quick Links > Claim Tips
- Claim Forms: Provider Express > Quick Links > Forms > Optum Forms - Claims

Autism Votes website:

- [Advocate | Autism Speaks](https://www.autismvotes.com)

EMedNY

- [Provider Manual](#)
- [Enrollment Form](#)



Key terms: General

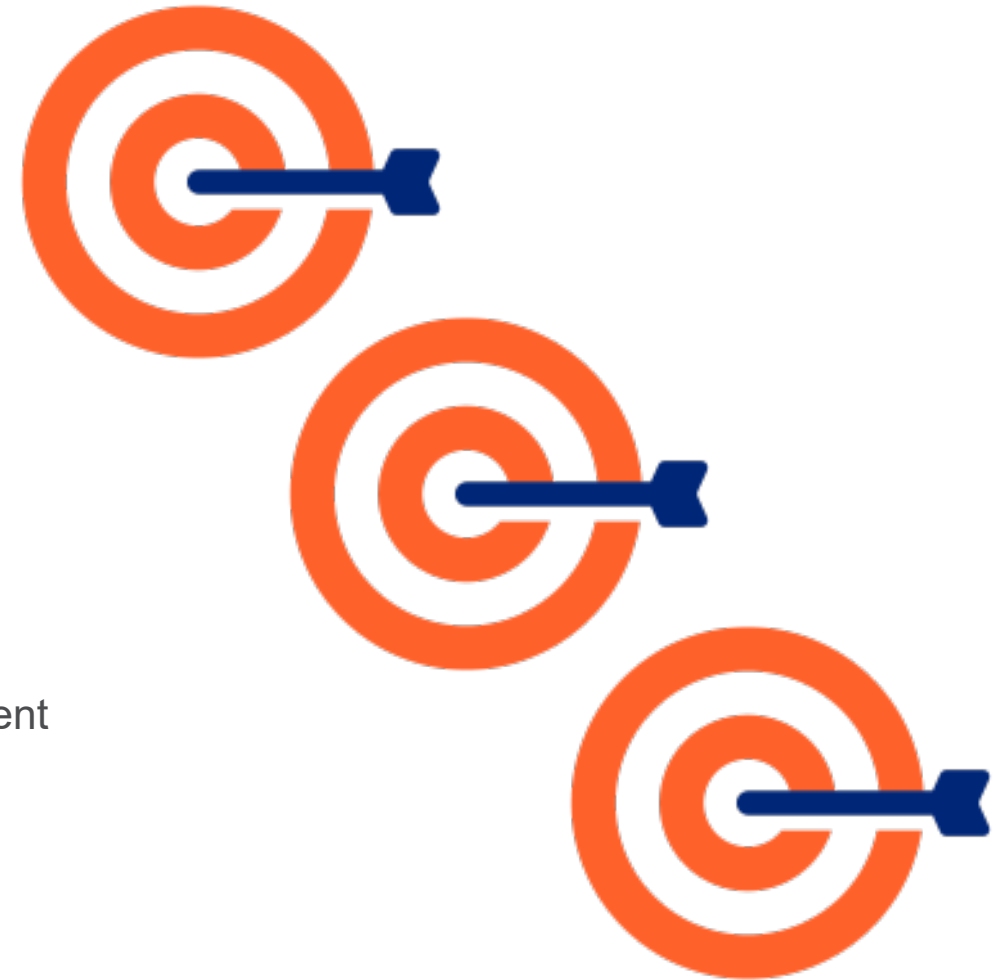
- NPI
- CPT
- HCPCS
- HIPAA
- Form 1500
- HCFA 1500
- CMS 1500
- Modifiers
- Units
- Prior authorization
- Signature on file



- DSM-5 diagnosis
- ICD-10 diagnosis code
- Subscriber ID or Member ID
- Dependent
- Policy or Group Number
- TIN or EIN
- Place of Service
- Diagnosis Pointer
- Fee schedule
- Par/Non-Par
- SPD/COC

Key terms: completing claim forms

- Type of plan box
- Patient name
- Dependent
- Subscriber ID or Member ID
- Signature on File
- Patient address
- Policy or Group Number
- Prior authorization
- DSM-5 diagnosis
- ICD-10 diagnosis code
- ICD indicator
- Dates of Service
- Place of Service
- Procedure Code
- Modifiers
- Diagnosis Pointer
- Charges (total)
- Units
- NPI and Provider ID
- TIN or EIN
- Accept assignment
- Total charge
- Amount paid by patient
- Balance due



Optum

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