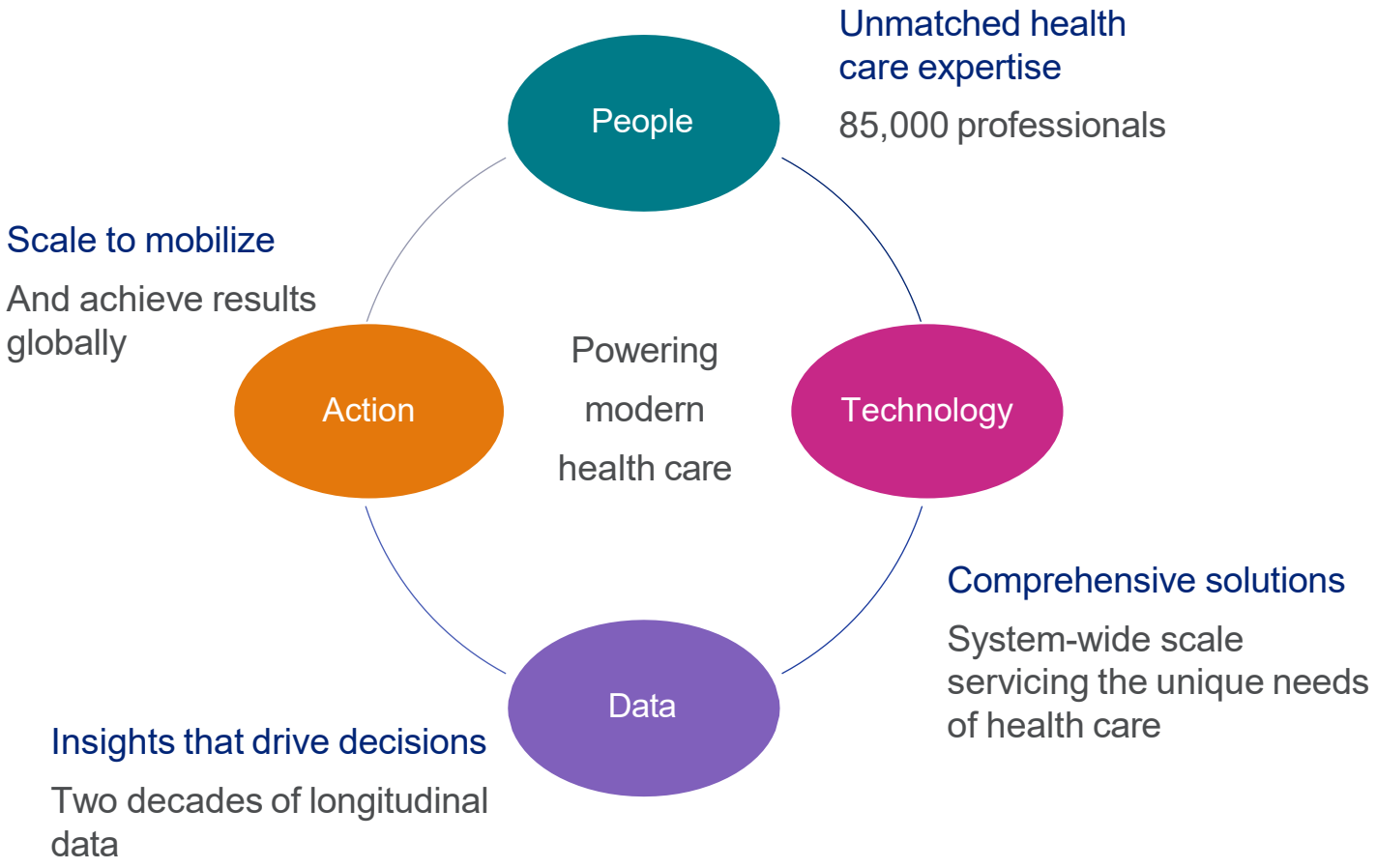
Optum

Ohio Medicaid ABA

ABA Provider Orientation
Optum with UnitedHealthcare Community Plan Ohio

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

UNITEDHEALTH GROUP®

Optum

Helping make the health system work better for everyone

Information and technology- enabled health services:

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

UnitedHealthcare®

Helping people live healthier lives

Health care coverage and benefits:

- Employer & Individual
- Medicare & Retirement
- Community & State
- Global

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.

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

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

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

Innovation
We invent a better future by learning from the past.

Performance
We strive for high Quality results in everything we do.

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

URAC
ACCREDITED
HEALTH UTILIZATION
MANAGEMENT

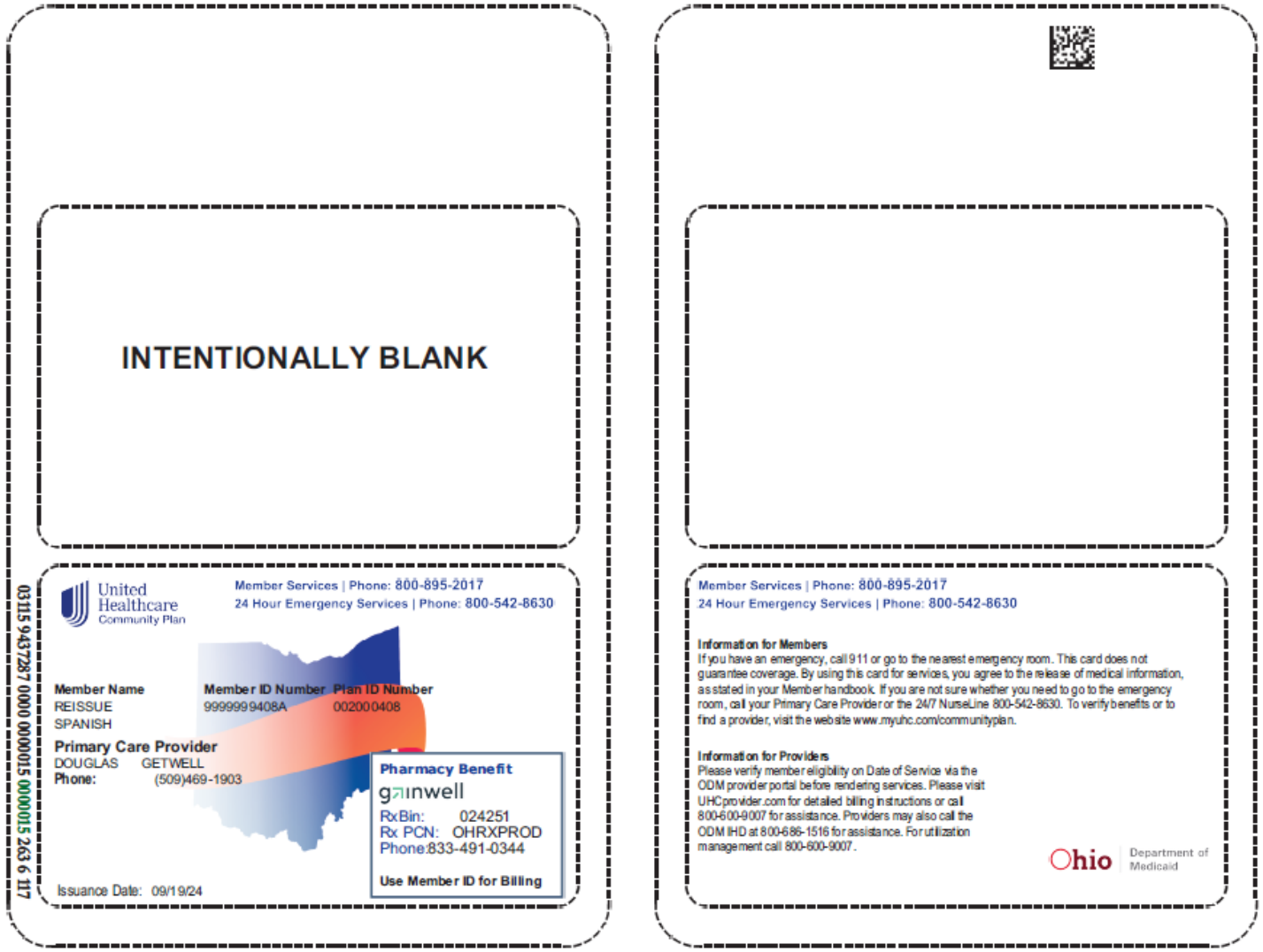
MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION
NCQA
ACCREDITATION
FULL

Optum ABA OH Medicaid Member Information

Optum

OH 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

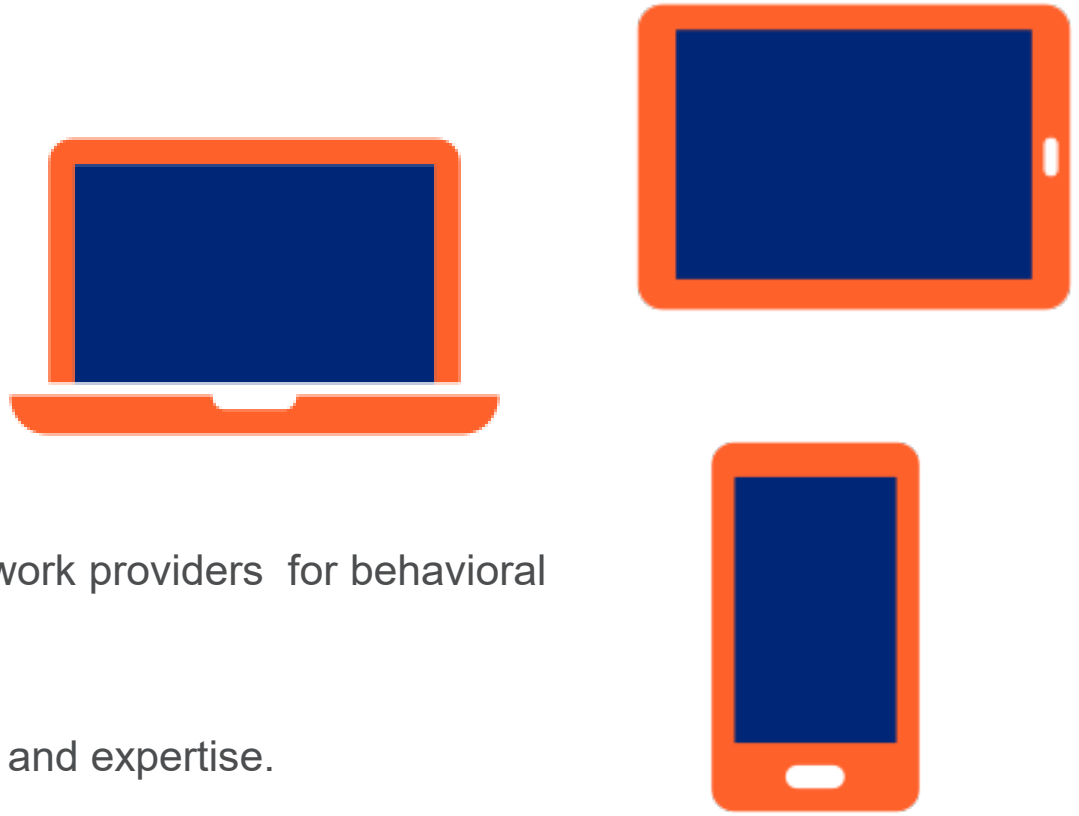
These rights and responsibilities are in keeping with industry standards. All members benefit from reviewing these standards in the treatment setting

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:

- Must be up to age 21
- Covered under UnitedHealthcare Community Plan of Ohio
- Have an Autism Diagnosis

Credentialing Criteria OH Medicaid Autism/ABA Network

Optum

Required: NPI and EIN/TIN

Certified Behavior Analyst (CBA) Providers must be enrolled with Ohio 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)

Professional Liability Insurance:

- BACB - Behavior Analyst Certification Board 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 OH Medicaid members can be provided by

- Certified Behavior Analyst (CBA)
  - ❑ 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 Ohio
  - ❑ Compliance with all state/autism mandate requirements as applicable to behavior analysts

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 visit's 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 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

Optum

Clinical teams

Dedicated Autism Clinical Team

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

- Each team member is a licensed behavioral health clinician, BCBA or CBA with experience and training in Autism Spectrum Disorders and ABA

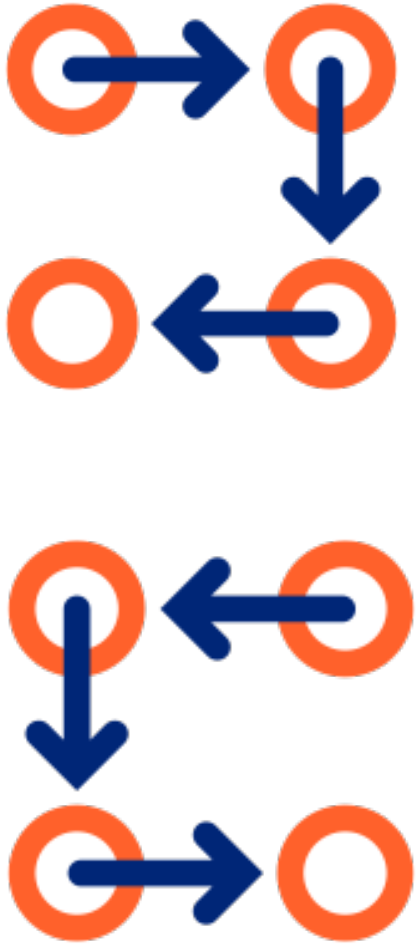
Intake

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



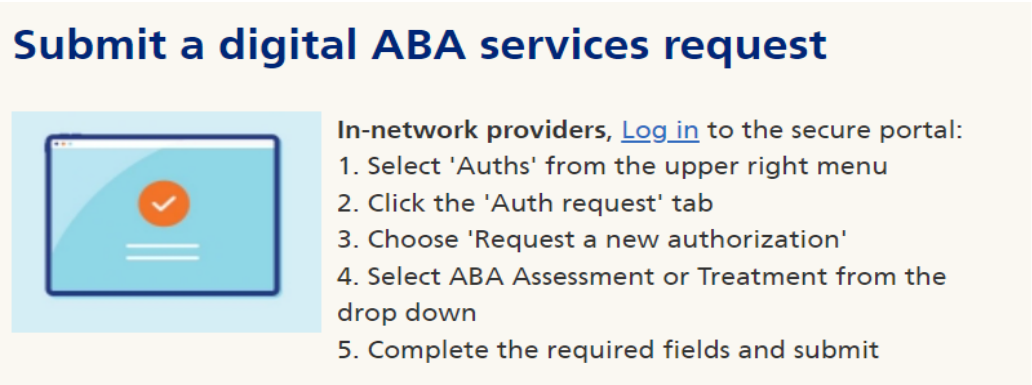
Release of information

- 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 Authorization for assessment & treatment request obtained via secure provider portal:
  - Locate by visiting the ABA Information Page on Provider Express
- Authorization status can be viewed online at providerexpress.com
- When calling the Autism Care Advocate you must have: * see note for all info needed
  - ❑ Member's name
  - ❑ ID #
  - ❑ Date of birth
  - ❑ Address



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 Ohio Medicaid Supplemental Clinical Criteria 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 was received within the past 3 years 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 – 85% involvement is required based on the requested amount
- Attendance/Care giver participation log is required for each review
- 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 Ohio Medicaid Supplemental Clinical Criteria 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 (updated diagnostic evaluation if not received within the past 3 years)
- 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– 85% involvement is required based on the request amount
- Attendance/Care giver participation log is required for each review

- 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

Optum

Diagnostic coding

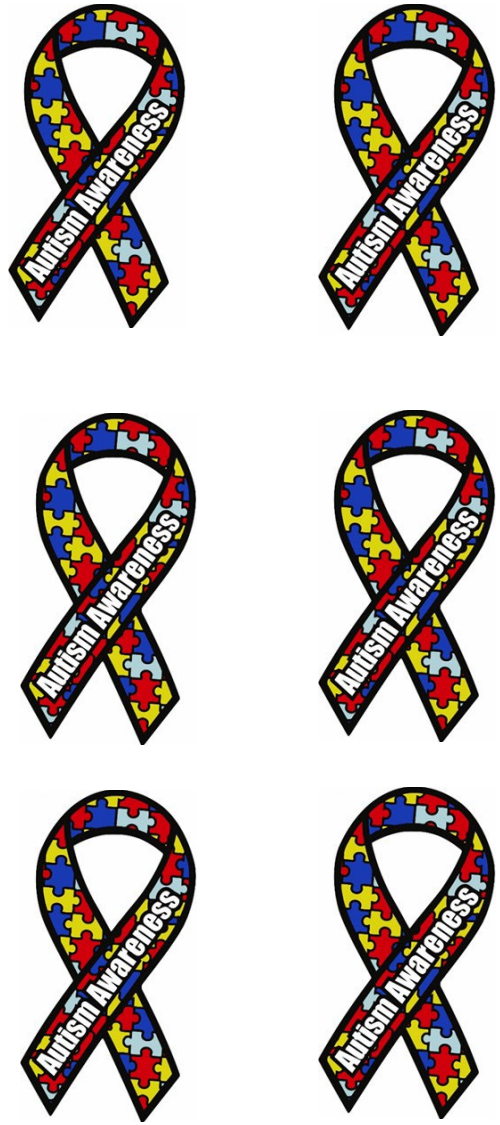
Guides for Coding:

- 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.



OH ABA Medicaid

United Behavioral Health (OHBS) OH ABA Medicaid		
Billing Code	**Service Description**	**Units**
97151	Behavior identification assessment by qualified health care professional	15 min
97152	Behavior identification assessment by technician under direction of qualified health care professional	15 min
97153	Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to one patient	15 min
97154	Adaptive behavior treatment by protocol, administered by technician under direction of qualified health care professional to multiple patients	15 min
97155	Adaptive behavior treatment with protocol modification administered by qualified health care professional to one patient	15 min
97156	Family adaptive behavior treatment guidance by qualified health care professional (with or without patient present)	15 min
97157	Family adaptive behavior treatment guidance by qualified health care professional without patient present	15 min
97158	Group adaptive behavior treatment with protocol modification administered by qualified health care professional to multiple patients	15 min

1)	Per Hour or Unit Payment: The Reimbursement Rate made to Provider for each unit of service provided to a Member as defined by the definition of the Billing Code. Such payment shall be considered payment in full for all MH Services provided to the Member, included but not limited to nursing care, diagnostic and therapeutic services, and supplies. Such payment is exclusive of physician fees. If physician services are rendered, such services are included in the rate of
2)	Per 15 Minute Payment: The Reimbursement Rate made to Provider for each unit of service provided to a Member as defined by the definition of the Billing Code. Such payment shall be considered payment in full for all MH Services provided to the Member, included but not limited to nursing care, diagnostic and therapeutic services, and supplies. Such payment is exclusive of physician fees. If physician services are rendered, such services are included in the rate of reimbursement.
3)	The MH Services authorized by UBH and provided to a Member on an outpatient basis of the diagnosis, testing, and/or treatment of a mental health condition, other than Emergency MH Services or as part of a partial hospitalization or day treatment program, Provider shall be paid by Payor the lesser of (a) Provider's Customary Charge for such MH Services, less any applicable Member Expenses; or (b) the Method of Payment set forth above, less any applicable Member Expense(s).
4)	Proper billing form: CMS 1500

Claims submission

All Autism/ABA Claims must be:

- Submitted on a Form 1500 (v.02/12) claim form
- Submit electronically via UHCprovider.com using the Claim Entry transaction feature
- Submit electronically using an EDI clearinghouse and payer ID # 88337
- Include appropriate taxonomy codes
- Submitted within 365 days of date of service

Please send paper claims to:

- UnitedHealthcare Community Plan
  P.O. Box 8207
  Kingston, NY 12402

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

- Optum – 800-600-9007
- Logging into UHCprovider.com

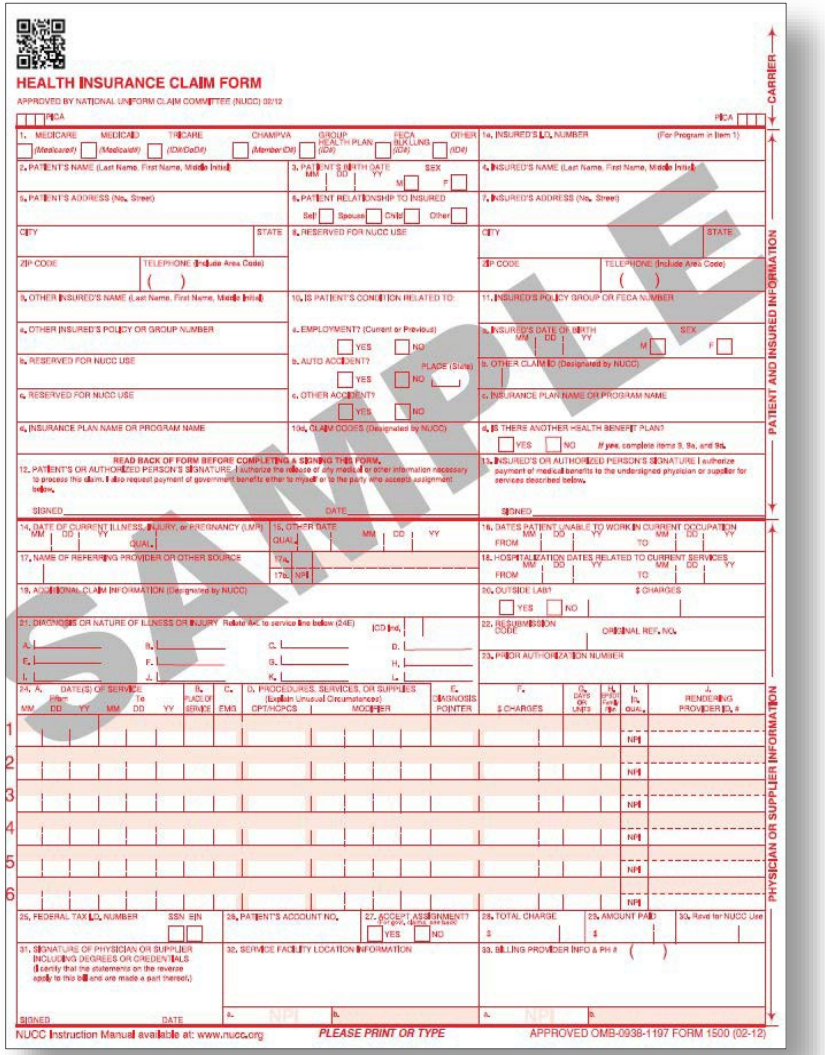
Form 1500 - claim form

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.



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 OH Medicaid is 365 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 UHCprovider.com

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 88337

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

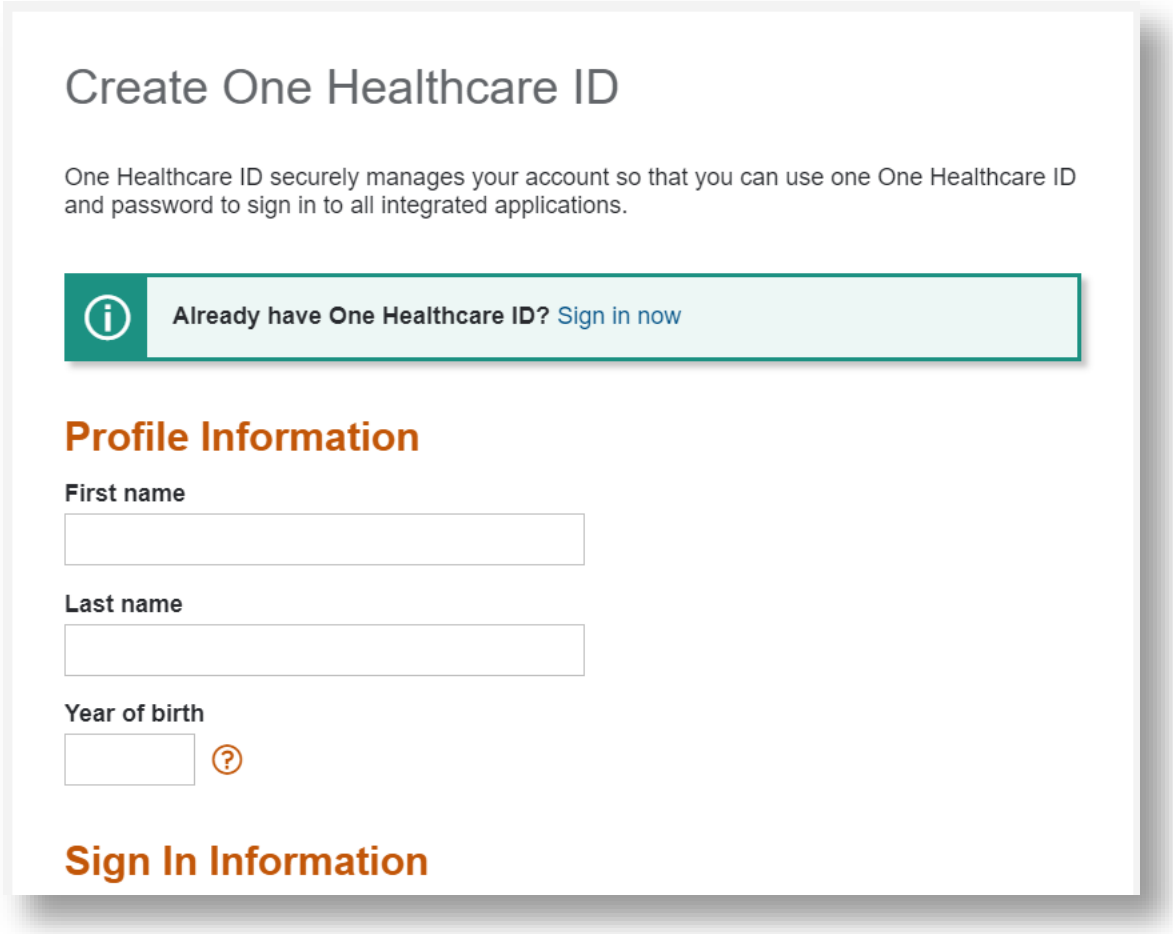
You can find:

- 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

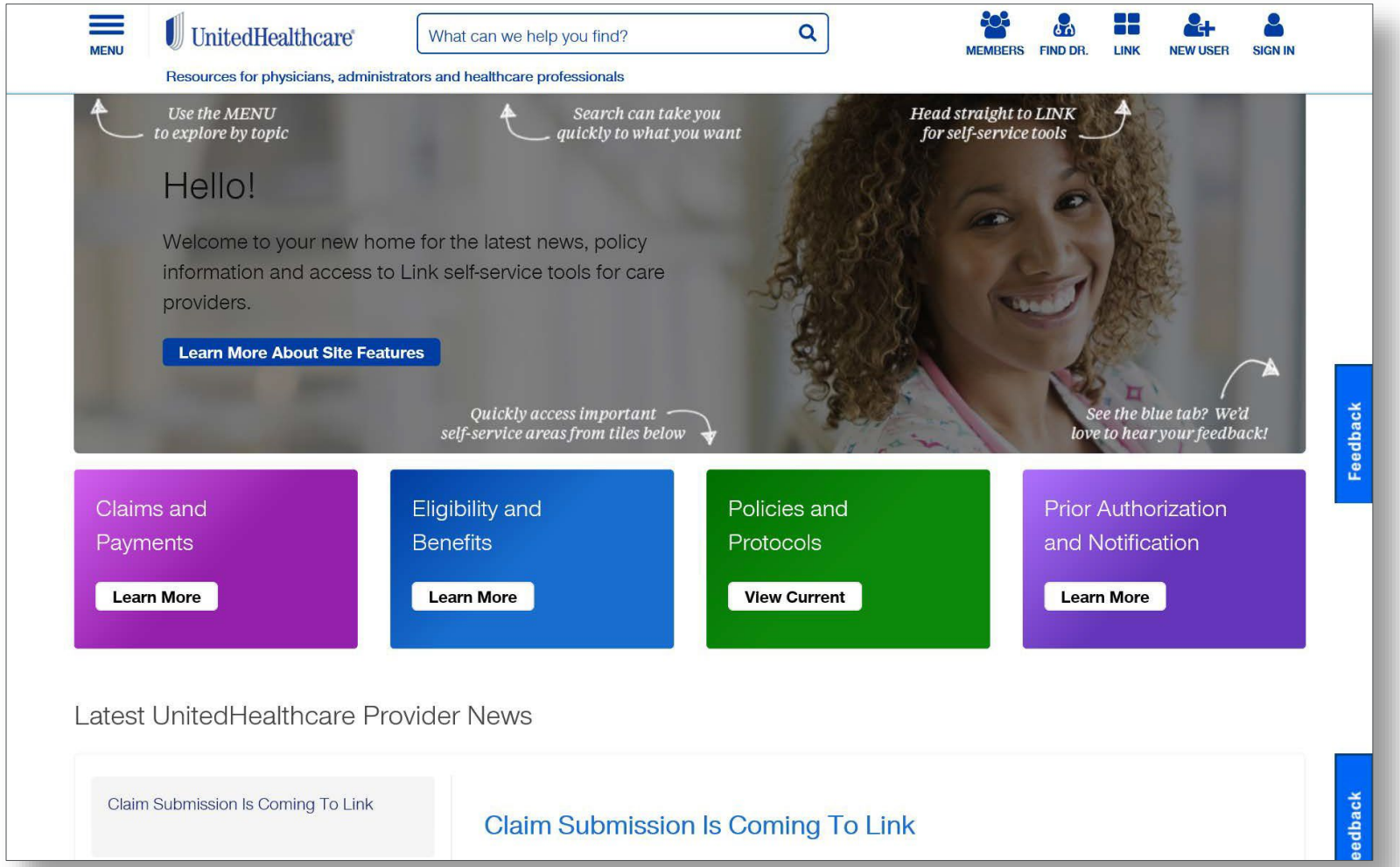
- Register online for immediate access to secure Transactions
- No fees apply
- Provider Express Support Center available from 7 a.m. to 9 p.m. Central time – toll free at 1-866-209-9320
- Live chat feature also available



Resources

Optum

UHCprovider.com provider website



Appendix

Optum

Helpful websites

To get an NPI number:

- NPPES (hhs.gov)

To learn more about HIPAA:

- HIPAA Home | HHS.gov

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

OH Provider Enrollment

- Provider Enrollment

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