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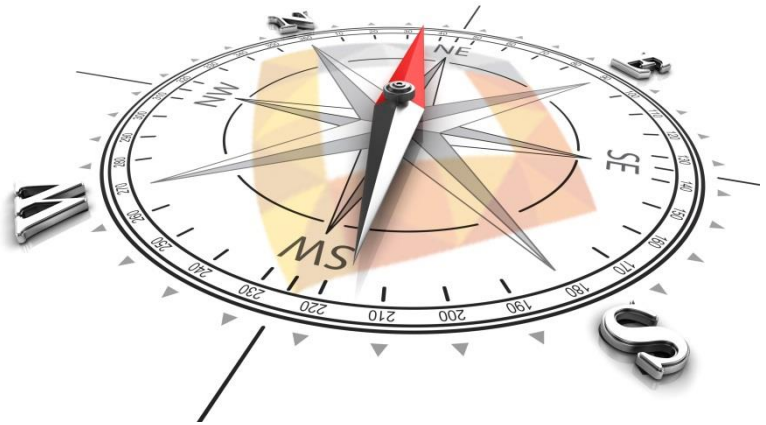
Optum Behavioral Health Providers

Refresher

2024

Welcome to Optum – refresher training



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Coordination of Care

Importance of Coordination of Care (COC)

Coordination of care among behavioral health clinicians and medical care providers improves the quality of patients' care

Individuals with mental health and substance abuse disorders frequently rely on multiple organizations and treatment professionals to provide their health care. Additionally, a significant number of people with serious medical conditions also have behavioral health conditions.

Effectively coordinating care between these treatment professionals can lead to improved health outcomes, result in reduced healthcare costs, and benefit practitioners by enhancing networking with other professionals.

Please be sure to have the member sign a release of information form. You may use your own form or access the CONFIDENTIAL EXCHANGE OF INFORMATION FORM on Provider Express.

Coordination of Care tips

- At the initial session, discuss what coordination of care is and invite your patient to ask any questions they may have about the process
- Engage and inform your patient about the importance and benefits of coordinating their care with other health care professionals
- Complete a COC form with the member within a **week** of your initial assessment and **annually** thereafter
- Provide the appropriate assessment information to other treatment professionals, with the appropriate permissions and releases on file
- Request that the other treating professional provide you with relevant clinical information including medical, mental health or substance use treatment they are providing
- Document all actions in the patient progress notes, including if the patient declined to allow coordination of care

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Performance Specifications, Quality measures and other Resources

Performance Specifications, Quality Measures and other Resources

Medicaid Performance Specifications - Performance Specifications are a component of the Optum Provider Manual, which is an extension of your Provider Agreement with Optum. The general performance specifications apply to all Optum network providers at all levels of care. Additionally, providers are held accountable to the service-specific performance specifications for each level of care for which they are contracted.

Clinical and Quality Measures Toolkit for Behavioral Providers – Our Quality Program supports the efforts of practitioners and providers through information analysis, education, administrative support, and behavioral health clinical quality management expertise. You will find useful information and tools on this page that will help you manage your practice and improve the quality of care you provide to our members.

Behavioral Health Clinical Practice Guidelines – Links to industry Practice Guidelines such as AACAP Practice Parameters and ASAM Clinical Guides.

Screening Tools for Adults

- Generalized Anxiety Disorder 7-item scale
- Edinburgh postnatal Depression Scale
- Patient Health Questionaire-9
- PHQ-9 Scoring Guide
- Patient Health Questionnaire-(PHQ-4)
- Columbia Suicide Severity Rating Scale
- Suicide Behaviors Questionnaire - Revised
- SAFE-T
- Quick Reference Guide for Substance Use Screening Tools
- AUDIT
- AUDIT-C
- Cage-AID Substance Use Screening Tool
- Level 2 - Substance Use
- Opioid Risk Tool
- DSM-5 Opioid Use Disorder Checklist
- Single Item Alcohol and Drug Screeners
- Drug Abuse Screening Test (DAST -10)
- Cannabis Use Disorder Identification Test (CUDIT-R)

Screening Tools for Adolescents/Children

- Vanderbilt Scale
- Generalized Anxiety Disorder 7-item scale
- CSBS DPTM Infant-Toddler Checklist
- ABA Assessment Form
- Childhood Autism Spectrum Test
- Child Mania Rating Scale – Parent Version
- PHQ-9: Modified for Teens
- Bipolar Spectrum Diagnostic Scale for an Adult Assessment
- Quick Reference Guide for Substance Use Screening Tools
- CRAFFT 2.1
- Level 2 - Substance Use 11-17
- Level 2 - Substance Use - Parent/Guardian of Child Age 6-17
- AUDIT
- AUDIT-C
- Cannabis Use Disorder Identification Test (CUDIT-R)
- Columbia Suicide Severity Rating Scale
- Suicide Behaviors Questionnaire - Revised

Screening Tools for Older Adults

- Short Portable Mental Status Questionnaire
- Behavioral Health Disparities in Older Adults
- Depression and Anxiety: Screening and Intervention
- Mood Disorder Questionnaire
- Bipolar Spectrum Diagnostic Scale for an Adult Assessment
- Geriatric Depression Scale
- UCLA Loneliness Scale Version 3
- Depression and Anxiety: Screening and Intervention
- Quick Reference Guide for Substance Use Screening Tools
- Alcohol and Psychoactive Medication Misuse/Abuse
- Prescription Medication Misuse and Abuse Among Older Adult
- Cannabis Use Disorder Identification Test (CUDIT-R)
- Suicide Behaviors Questionnaire - Revised

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Optum Health Education - CEU Credits

Health Equity and Cultural Competency Training: Our mission is to help people live healthier lives and make the system work better for everyone. Promoting and instilling the values of culture, inclusion and diversity are critical to achieving this mission and truly making a difference. As part of this commitment, we offer free, on-demand, CEU eligible training for in-network behavioral health professionals.

- Gender Diversity in Mental Health and Substance Use (available for CEU credits until 08/01/2024)
- Providing Quality Care for Adults With Intellectual and Developmental Disabilities (available for CEU credits until 12/15/2024)
- Healing Racial Trauma Through Somatic Anti-Racism Practices (available for CEU credits until 04/18/2025)
- Kitchen Sink of Common Issues in a Joint Visit with Medical and Behavioral Health Providers (available for CEU credits until 11/06/2026)
- Basics of an Effective Integrated Behavioral Health Clinician as a Partner in the Medical Home Model
- The Impact of Trauma on Children and Youth: A Paradigm Shift (available for CEU credits until 01/22/2027)

Additional trainings available on Optum Health Education

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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 (ASAM Level 4)
- Observation/Holding Beds
- Administratively Necessary Day (AND) Services
  - Available to Medicaid 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)
- Intensive Community-Based Acute Treatment for Children and Adolescents (ICBAT)
- 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 3.1), MassHealth members only
- Residential Rehab Services (RRS), Low Intensity (Level 3.1), MassHealth members only
- Transitional Care Unit (TCU) for DCF Youth, MassHealth members only

Covered Services, Diversionary Services

Non-24-hour diversionary services:

- Community Support Program (CSP, CSP for Chronically Homeless Individuals, and CSP for Justice Involved), MassHealth members only
- Partial Hospitalization Program(PHP)
- Psychiatric Day Treatment
- Structured Outpatient Addiction Program (SOAP and eSOAP)
- Program of Assertive Community Treatment (PACT)
- Intensive Outpatient Program (IOP)
- Recovery Support Navigators, MassHealth members only
- Recovery Coaches

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
- Applied Behavioral Analysis for members Under 21 Years of Age (ABA Services)
- Family Support and Training
- Intensive Care Coordination
- Specialing – therapeutic services provided to a member in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual's safety.
- Preventive Behavioral Health Services for members Younger than 21
- Assessment for Safe and Appropriate Placement (ASAP)
- Collateral Contact
- Opioid Treatment Services
- Ambulatory Detoxification (Level II.d or 2WM)
- Psychological Testing
- Neuropsychological Testing
- Special Education Psychological Testing for (MassHealth) members
- ECT
- Repetitive Transcranial Magnetic Stimulation (TMS)
- In-Home Behavioral Services
- In-Home Therapy Services
- Therapeutic Mentoring Services
- Inpatient-Outpatient Bridge Visit
- BH Emergency Service/Crisis Evaluations
- Youth Mobile Crisis Intervention
- Behavioral Health Urgent Care

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Authorization and Notification Definitions

- Mass General Brigham Health Plan has designated services which require providers to contact Optum Behavioral Health when a member accesses those services.
- Notification: when required, notification should occur prior to the delivery of certain non-routine outpatient services or within a specific timeframe for specific 24-hour levels of care. Notification requirements include clinical information to determine benefit coverage.
- Authorization (a.k.a.: prior authorization): occurs prior to a service being delivered to a member and is a result of the clinical and benefit determinations made per the provider notification.

Services Requiring Authorization and/or Notification

Services Requiring Authorization	Services Requiring Notification
Partial Hospitalization, Intensive Outpatient (IOP), and Day Treatment	Acute Inpatient Psychiatric Hospitalization (within 72 hours of admission)
Psych testing greater than 5 hours	Community Based Acute Treatment (CBAT)/Intensive Community Based Acute Treatment (ICBAT) (within 72 hours of admission)
Electroconvulsive Treatment (authorization obtained by phone only)	Substance Use Disorder Acute and Residential (ASAM 4.0, 3.7, 3.5) (within 48 hours of admission)
Program for Assertive Community Treatment (PACT) Services	Residential Rehabilitation Services (RRS) (ASAM 3.1) (within 7 days of admission)
Administratively Necessary Days, Specialing, and Transitional Care Unit	Psych Testing 5 hours or less
Applied Behavioral Analysis (ABA) Services for members with Autism Spectrum Disorder	
Transcranial Magnetic Stimulation	

Please reference the Authorization and Notification section of the Mass General Brigham Health Plan Manual Addendum located on provider express for detailed information regarding services requiring authorization and notification.

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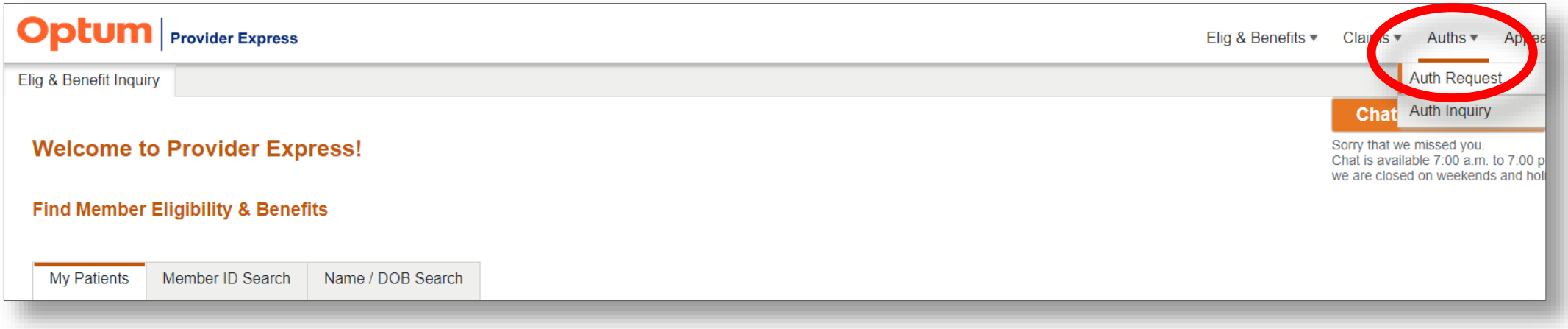
Authorization process

Authorizations can be requested in two ways:

1. 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.
   - View authorization details



2. Calling Optum via the number on the member's card

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

Discharge Planning – Experiencing or at Risk of Homelessness

MassHealth has outlined additional discharge planning requirements for enrollees experiencing or at risk of homelessness

- Hospitals must assess each admitted member's current housing situation within 24 hours of admission
- Hospitals must invite and encourage participation from the member, member's family, primary care providers, BH providers, key specialists, community partners, case managers and any other supports identified by the member. And, if applicable, Dept of MH (DMH), Dept of Developmental Svcs (DSS) or MA Rehabilitation Commission (MRC)
  - Determine whether any non-DMH, non-DSS or non-MRC involved member may be eligible to receive services from those agencies. Within 2 business days, offer to assist application to receive services
- If a member is expected to remain in hospital less than 14 days, the hospital must contact:
  - Emergency shelter last resided in, if known, or contact local emergency shelter to discuss housing options
- Make reasonable efforts to prevent discharges to emergency shelters for members with skilled care needs or BH conditions that would impact the health and safety of individuals residing in the shelter
- Follow procedures for unavoidable discharges to emergency shelters or the streets
- Follow procedures for tracking and reporting

Additional detail related to MassHealth requirements can be found in the Mass General Brigham Health Plan Provider Manual Addendum located on Provider Express.

Medical necessity

Medically necessary services 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.

Medically necessary services are appropriate when 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:

- CASII, LOCUS, ESCII Clinical Guidelines Optum Psychological and Neuropsychological Testing Guidelines
- Behavioral Health Clinical Policies
- American Society of Addiction Medicine (ASAM) Criteria

LOCUS/CASII/ECSII Guidelines can be found at providerexpress.com:

- Path: Provider Express > Clinical Resources > Guidelines/Policies

Massachusetts Medicaid Supplemental Clinical Criteria can be found at providerexpress.com:

- Path: Provider Express > Clinical Resources > Guidelines/Policies > State/Contract Specific Criteria > Massachusetts

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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 (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
- Intensive Hospitalization Diversion
  - Intensive Hospital Diversion (IHD) program will provide intensive short-term (on average, 4 to 6 weeks) in-home crisis stabilization and treatment to youth and their families to support diversion from psychiatric hospitalization and other out-of-home placements. The clinical goal of this program is to provide youth under 21 and their parents/caregivers with the intensive short-term treatment and support needed to maintain the youth at home safely and to (re)connect them to ongoing outpatient and/or community-based services. IHD is a specialized service of In-Home Therapy (IHT). As such, IHD providers are expected to adhere to IHT performance specifications in addition to those contained within. Where there are differences between the IHT and IHD performance specifications, IHD specifications take precedence

    For more information on IHD please visit: Optum - Provider Express Home > Our Network > State-Specific Provider Information > Welcome Massachusetts > Medicaid Performance Specifications

Child and Adolescent Needs and Strengths (CANS) for MassHealth/ACO Members

All behavioral health providers treating children and adolescents who are enrolled in MassHealth and under the age of 21 must use the CANS tool as part of the Early and Periodic Screening Diagnosis and Treatment (EPSDT) clinical assessment process. The CANS must be updated every 180 days to ensure that treatment plans address strengths and needs as they evolve.

Services that Require Use of the CANS:

- Outpatient Therapy (diagnostic evaluations and individual, family and group therapy)
- In-Home Therapy Services
- Intensive Care Coordination
- The CANS must also be completed as part of the discharge planning process for the following 24-hour level of care services:
  - Psychiatric inpatient hospitalization at acute inpatient hospitals, psychiatric inpatient hospitals and chronic and rehabilitation inpatient hospitals
  - Community-Based Acute Treatment (CBAT) and Intensive Community-Based Acute Treatment (ICBAT)
  - Transitional Care Units (TCU)

Please see the Provider Manual Addendum on Provider Express for more details around the CANS requirements:
Mass General Brigham Health Plan Manual Addendum (providerexpress.com)

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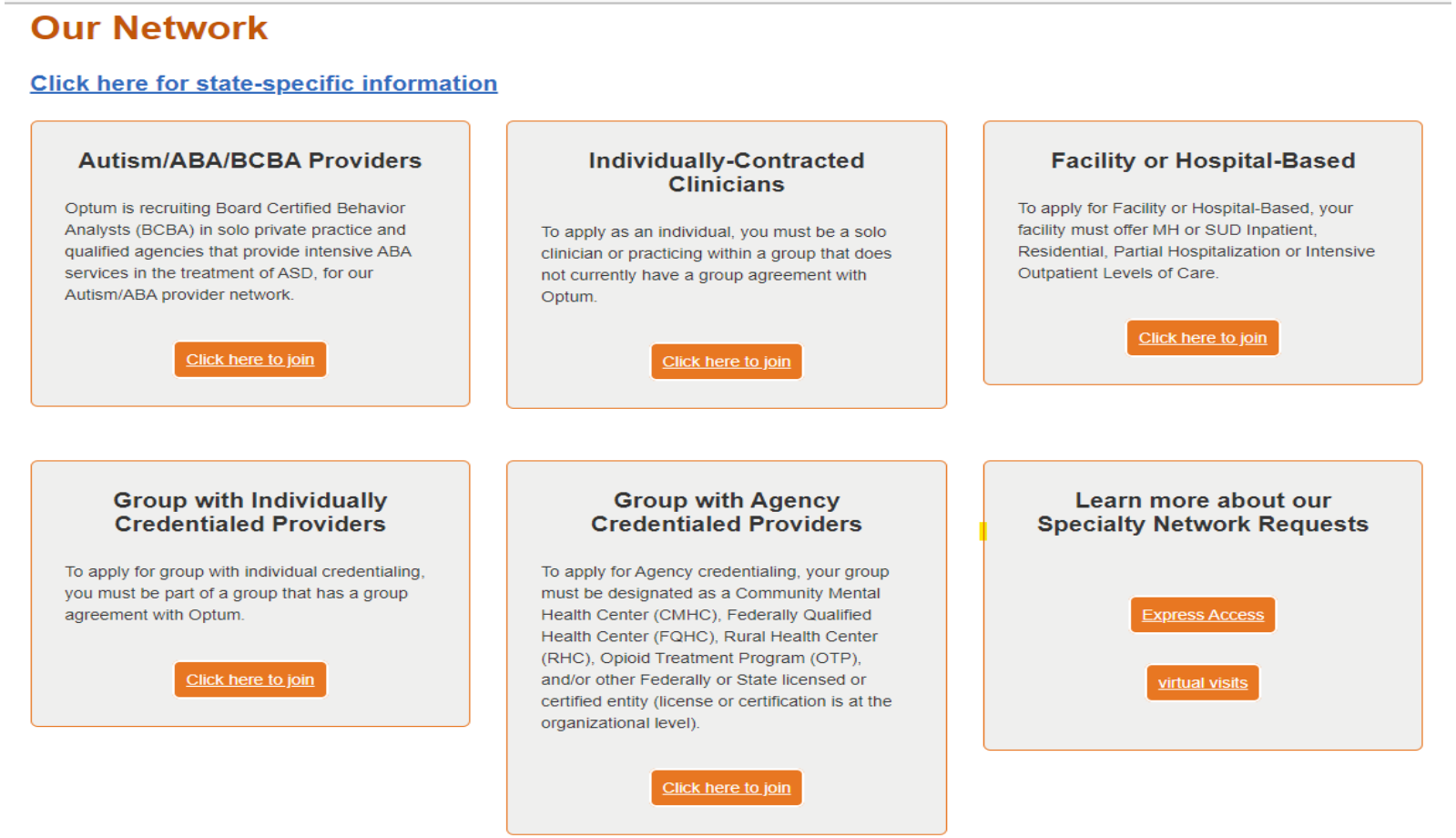
Network

Enrolling Providers

If you would like to become a contracted provider, please visit our website Our Network



Enrolling Providers

MA Licensing Information

CAQH Participation is required in the majority of the states to join our network. If your state requires it, you will be required to enter your CAQH ID # on the credentialing application. To participate in CAQH, please contact: www.CAQH.org

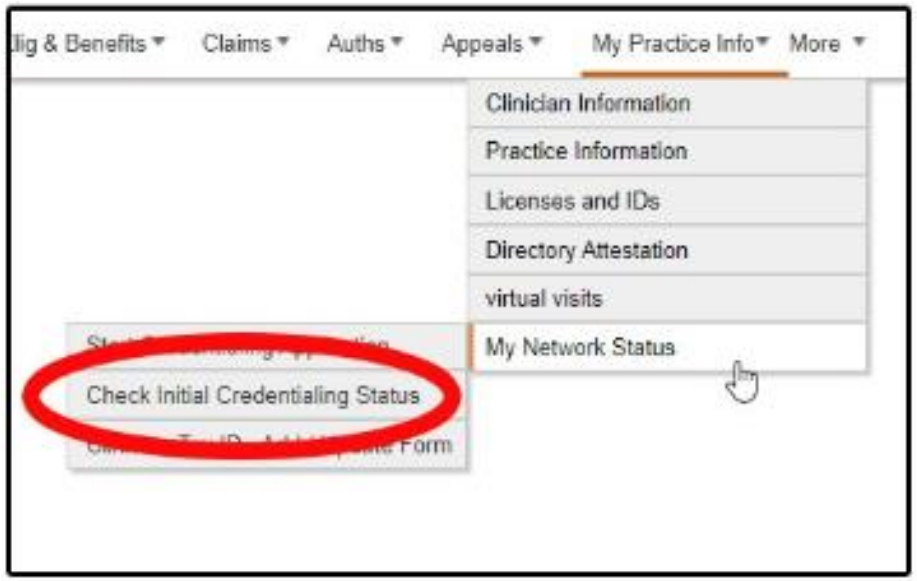
Improve the Speed of Processing - Tips for Applying to the Network

We recently conducted an audit of credentialing application issues. Here's an at-a-glance view of the most common issues that will slow down or lead to the cancellation of the credentialing of your application to join our network.

Category	Issues	Requirement
CAQH	• Your CAQH profile status is incomplete or expired • Your group information including but not limited to primary and practice locations listed on your UBH Network Participation form does not match what you have listed on your CAQH profile • We do not have authorization to access your CAQH application (log into the CAQH ProView Provider portal, go to the user account setting menu and review the Authorization section to update your preferences to authorize United Behavioral Health/US Behavioral Health Plan) • Information in your completed CAQH profile needs to be updated (Examples include Practice Information, Credentialing Contact information, License and Professional Liability Insurance effective and expiration dates)	The information on CAQH must match the information you provide on the Optum NPRF form.
Attached Documents	• Attaching the wrong document • Not signing the W-9 form or providing an incorrect Tax ID number or EIN • Current Professional Liability Insurance Certificate	Providing all the correct and completed documents is required.
Document Return	Slow response time to requested information. • Individual Contracts • Disclosure of Ownership documents	Missing documents are sent out via DocuSign. Sign and return as quickly as possible.

Enrolling Providers

Individual providers – Using the **Initial Credentialing Status Toolbar** you can easily track the status of your online submission as it moves along the approval process. Log into the secure transactions area of Provider Express, hover over *My Practice Info* >> *My Network Status* >> click on *Check Initial Credentialing Status*.



Agency or Group Practice – contact Network Management at (877) 614-0484

Facility – contact Network Management at (877) 614-0484

Autism/ABA - contact Network Management at 877-614-0484

Enrolling Providers

To link an existing provider to your TIN:

Clinician Tax ID - Add / Update Form

This form is used by credentialed providers to add a new Tax ID to their record, change an existing Tax ID or inactivate a Tax ID from their record. Add/Update Form

The combination of the Provider Name and Individual NPI (Type 1) uniquely identifies you and your requests in the system. Please use the same information each time so you can view all of your requests together.

REMINDER: If you are only making DEMOGRAPHIC CHANGES to an existing practice, you can add, modify and/or delete a practice, remit, mailing, credentialing or 1099 address on providerexpress.com under Transactions --> My Practice Info.

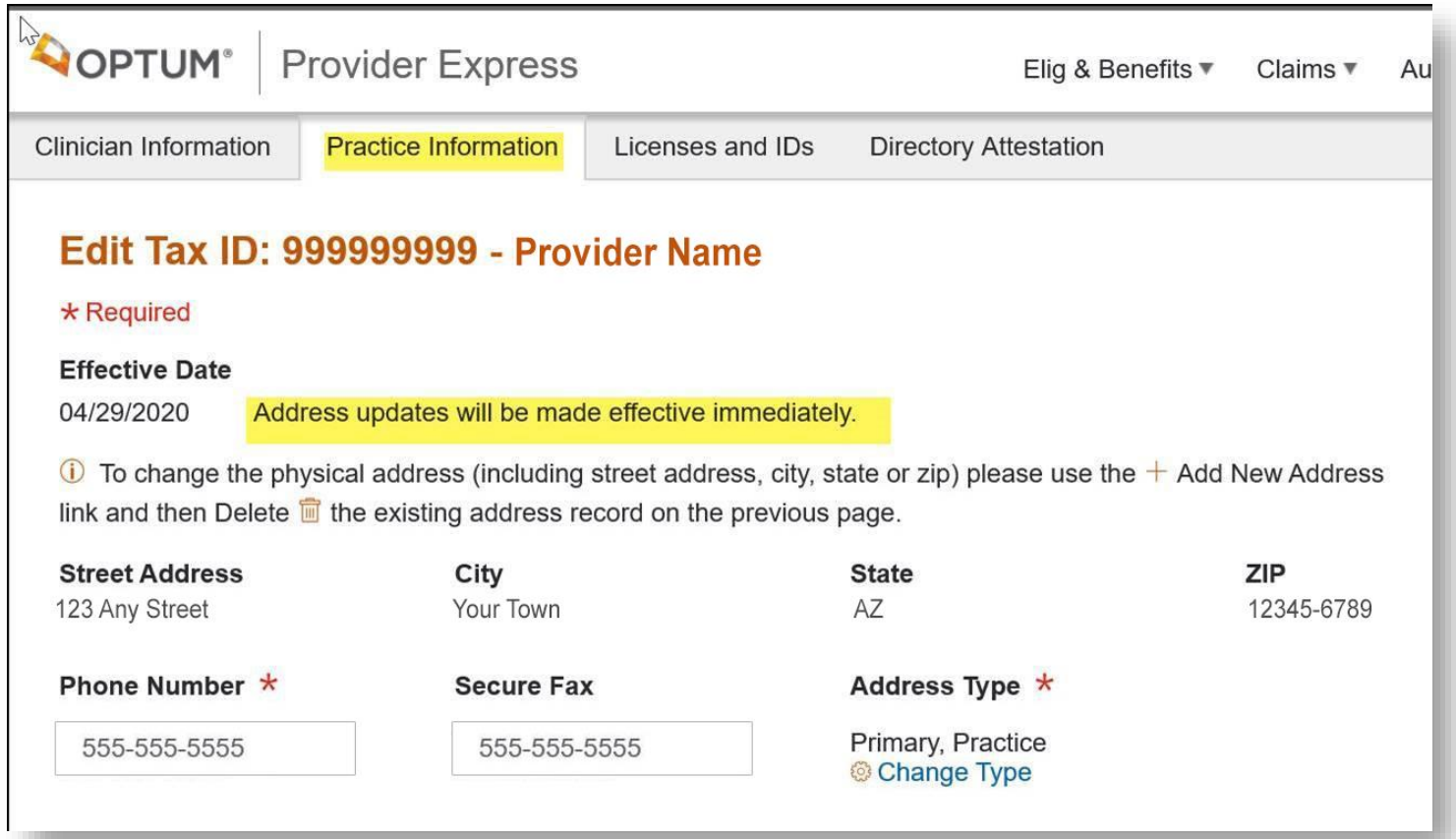
Staying current with "*My Practice Info*"

Having the most up-to-date information at Optum ensures that referrals can find you and that you get reimbursed promptly and accurately.

Change, add or modify your address and other demographic information

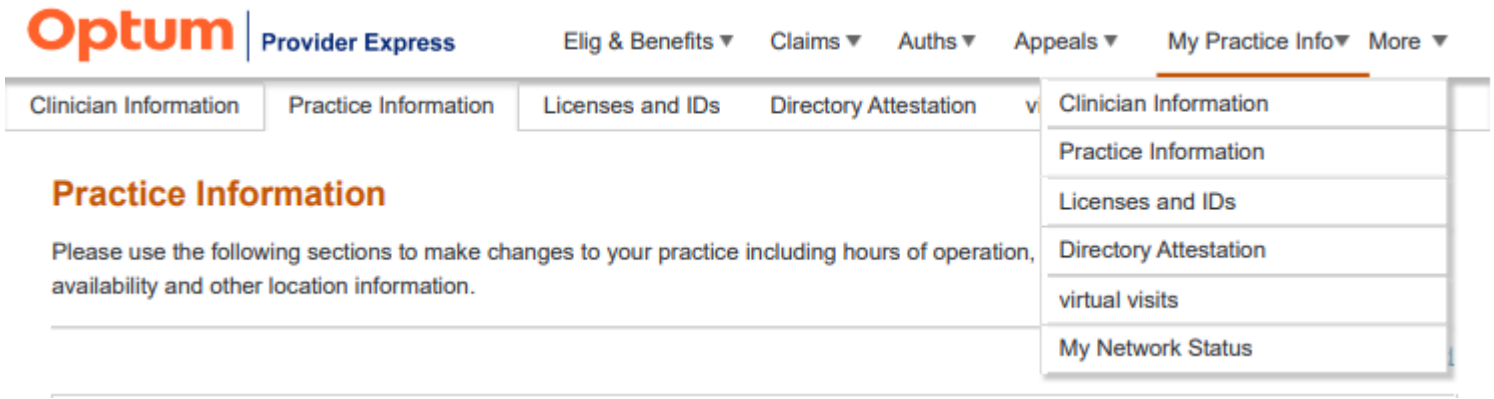
Indicate your availability to accept new patients into your practice

Let us know if you are going to be away for an extended period of time



Staying current with "*My Practice Info*"

Under the Consolidated Appropriations Act (CAA), Providers are required to attest to their data every 90 days, including **updating your area of expertise (AOE)**. Individually contracted providers can add or delete expertise as well as submit the required documentation for attested area of expertise.



Updating Your Practice Information

To learn more about maintaining your practice information on Provider Express, please view our 3-minuted video, "My Practice Info."

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Roster and Group Address Maintenance

Roster Maintenance

Groups/Agencies whose Agreement requires submission and maintenance of a provider roster are responsible to ensure their roster data is up to date and on file with Optum. Roster updates may be submitted through *providerexpress.com* secure “Transactions”.

For Groups/Agencies that are required to submit and maintain a roster, it is essential that providers who are independently licensed and may be acting in a supervisory role be promptly added to the roster for claims to process correctly.

Groups/Agencies that do not use Provider Express may maintain their rosters by submitting them to their Provider Relations Advocates.

Note: Non-independently licensed providers and paraprofessionals are not added to Optum rosters.

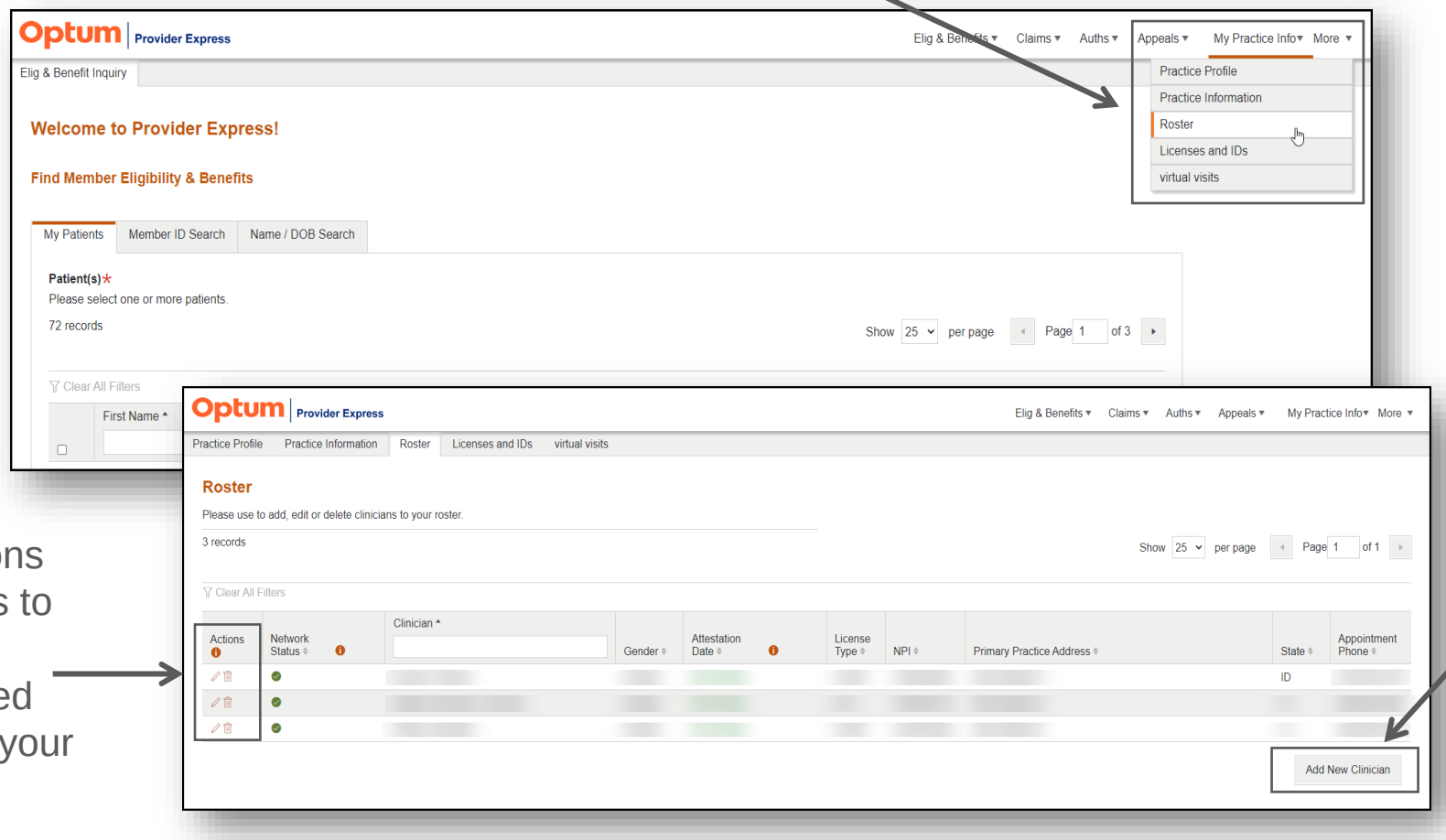
Notify us at providerexpress.com within ten (10) calendar days whenever there are changes to your provider roster.

Roster management is critical to timely and accurate claim processing. Failure to maintain your group roster creates risks for:

- **Timely claims adjudication**
- **Potential HIPAA violations**

Roster Maintenance

After logging in to secure transactions, select *My Practice Info* from the menu bar and then click on *Roster* from the drop-down menu.

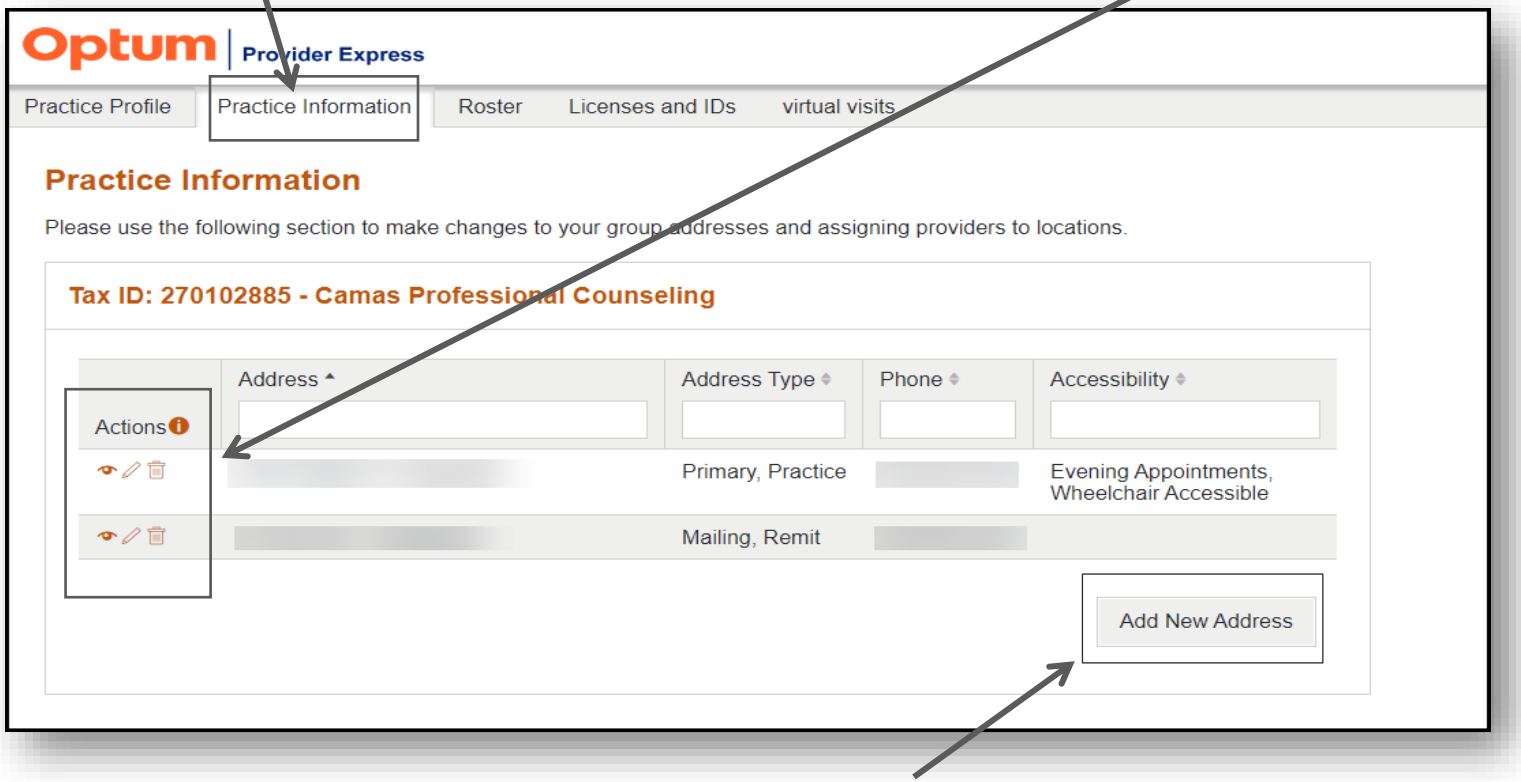


Use the options under Actions to view, edit or delete licensed providers on your roster.

Click on “Add New provider” to add a new licensed provider to your Roster.

Group Address Maintenance

To View or make updates to the Groups Addresses, click on the Practice Information tab and choose an option under Actions.



To add a new practice location or a new mailing or remit address, click on the “Add New Address” button.

Recredentialing

- Recredentialing is completed every 36 months (3 years):
  - Timeline 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

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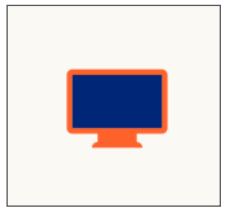
Benefits and Eligibility

Understanding covered benefits



Optum uses Clinical Criteria based on sound clinical evidence to make coverage determinations, including externally adopted clinical criteria such as American Society of Addiction Medicine (ASAM) Criteria to inform discussions about evidence-based practices and discharge planning. In using its Clinical Criteria, Optum takes individual circumstances and the local delivery system into account when determining coverage of behavioral health services.

Optum Members have a variety of benefits available to them

Check a Member’s benefits and eligibility on *Provider Express* through secure Transactions or call the number on the back of the members ID card

***Always check benefits before providing services to a member served by Optum**

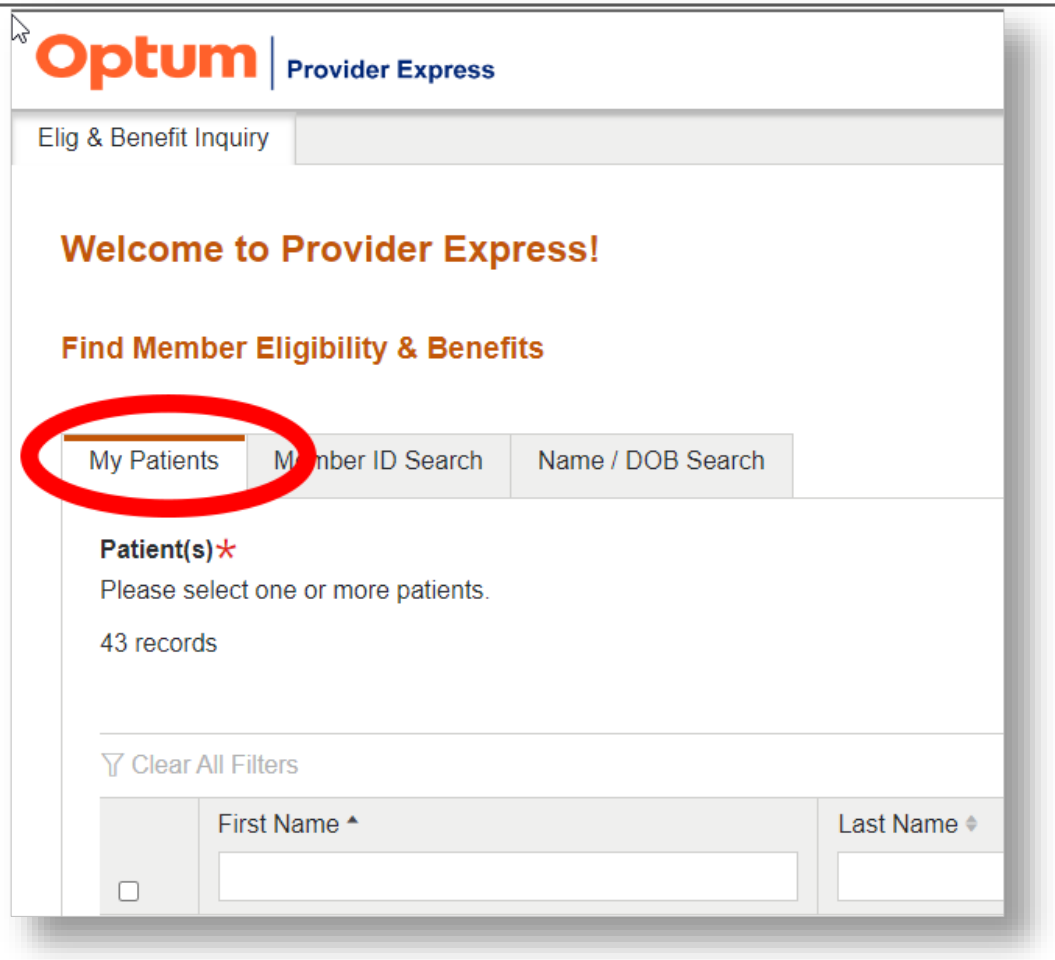
Eligibility and benefits verification using Provider Express

Provider Express - *providerexpress.com*

Our industry-leading provider website includes both public and secure pages for behavioral health providers.

“Eligibility & Benefits” allows 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.

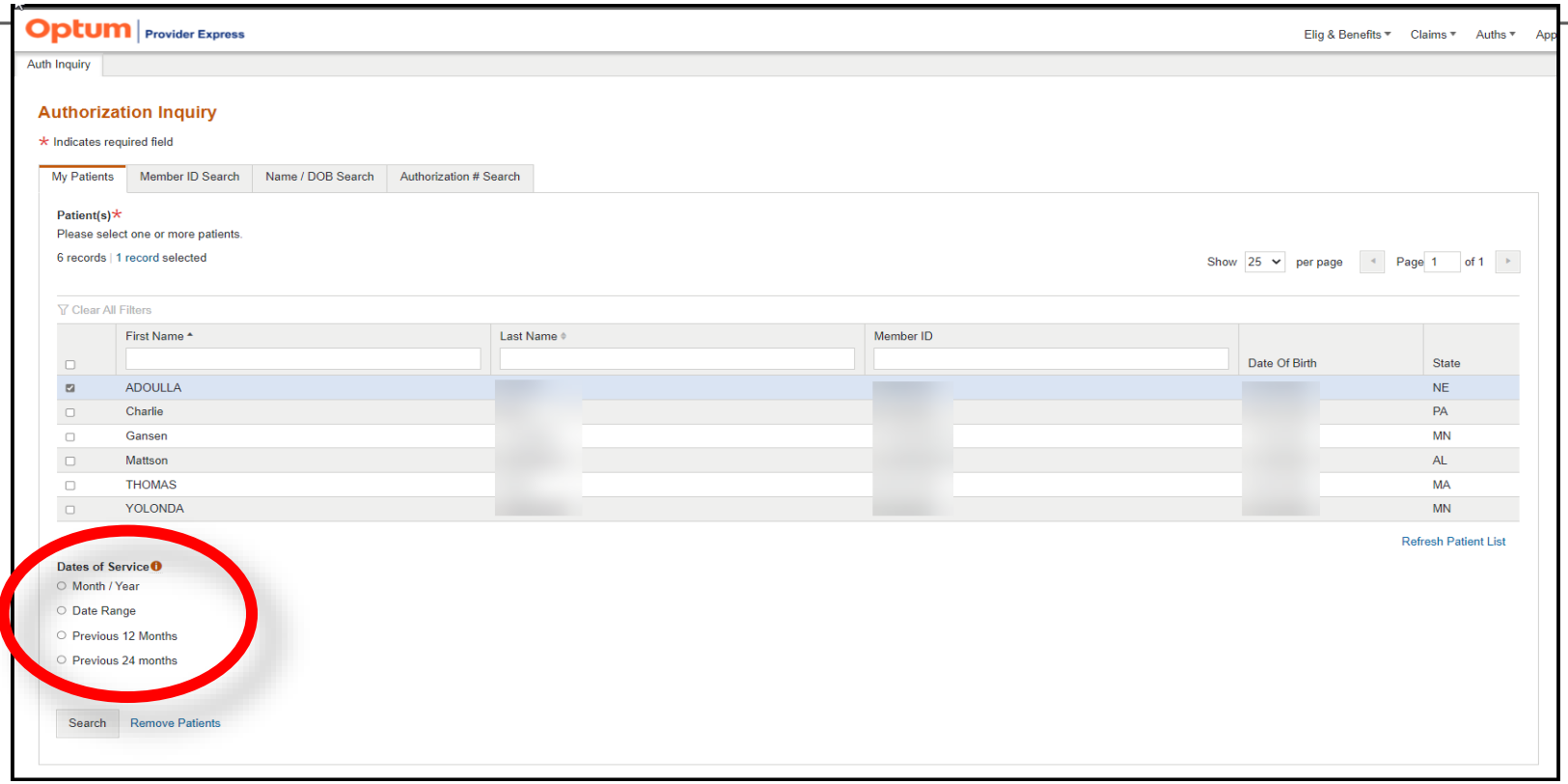
“My Patients” is a list of patients that can be stored on Provider Express and used for various online transactions without an additional search. The My Patients list is customizable at a User level.



Check authorization status online

There are several search options available for this feature:

- My Patients
- Member ID
- Name & Date of Birth
- Authorization #



The Authorization Inquiry searches for active authorizations within the past 180 days, but you can choose a more specific date range to search, as well.

Note: All of these search options will render the same viewable authorization detail information

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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.
- Record review audits are completed of providers who render services to Mass General Brigham Health Plan members of any age.
- A sample of providers are randomly selected for review on an annual basis.

Documentation standards

Documentation requirements for Mass General Brigham Health Plan providers are described in the Mass General Brigham Health Plan Addendum to the Optum National Manual. From the home page, select Our Network > Welcome to the Network > Massachusetts > Mass General Brigham Health Plan > Provider Manual Addendum.

- 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)

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Adverse Incident Reporting

Behavioral health adverse incident reporting

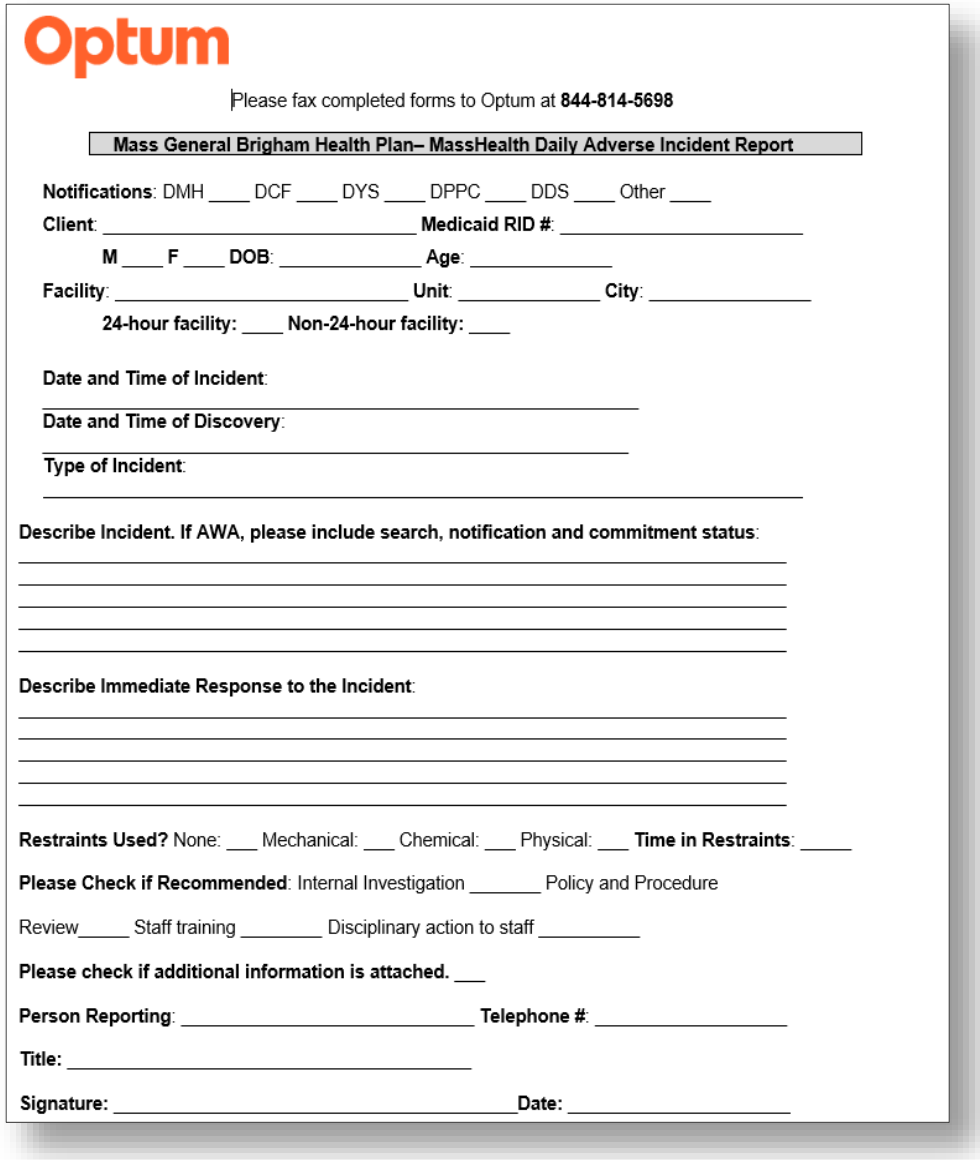
Behavioral Health reportable adverse incidents include, but are not limited to, the following:

- 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

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 posted to Provider Express: from the Home page, select Our Network > Welcome to the Network > Massachusetts > Mass General Brigham Health Plan > Adverse Incident Report Forms

Adverse incident report form, MassHealth



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Please fax completed forms to Optum at **844-814-5698**

Mass General Brigham Health Plan– 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:** _____

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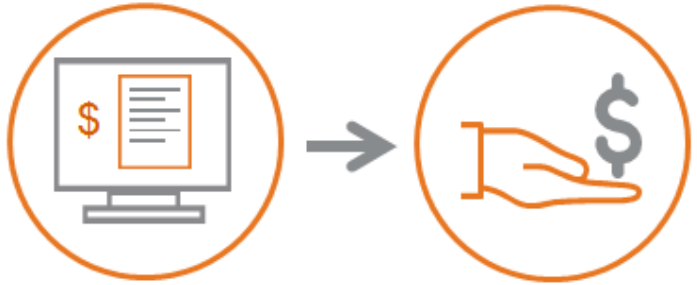
Claim Billing Reference Guide

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

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Claims submission option 1, Online: Provider Express

Our network providers 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 providers and groups
- Outpatient behavioral claims

Get started today with your One Healthcare ID:

- Register for a One Healthcare ID today by clicking First-time User
- Need help registering for a One Healthcare ID? Watch this quick video

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Tips for timely and accurate payments, Provider Express

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

Missing or incomplete information	Member demographic info has errors	Unclear or illegible information
Provider Express "Claim Entry" prevents the submission of claim if required fields are blank *Examples*: NPI number, ICD-10 derived diagnosis code	Member information is auto-populated when you use *"Claim Entry"* on *Provider Express* *Examples:* Name, DOB, ID number	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 of 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)
    - Please Note: BH preventive pediatric services only requires a symptom code to be billed (z code)
- 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:

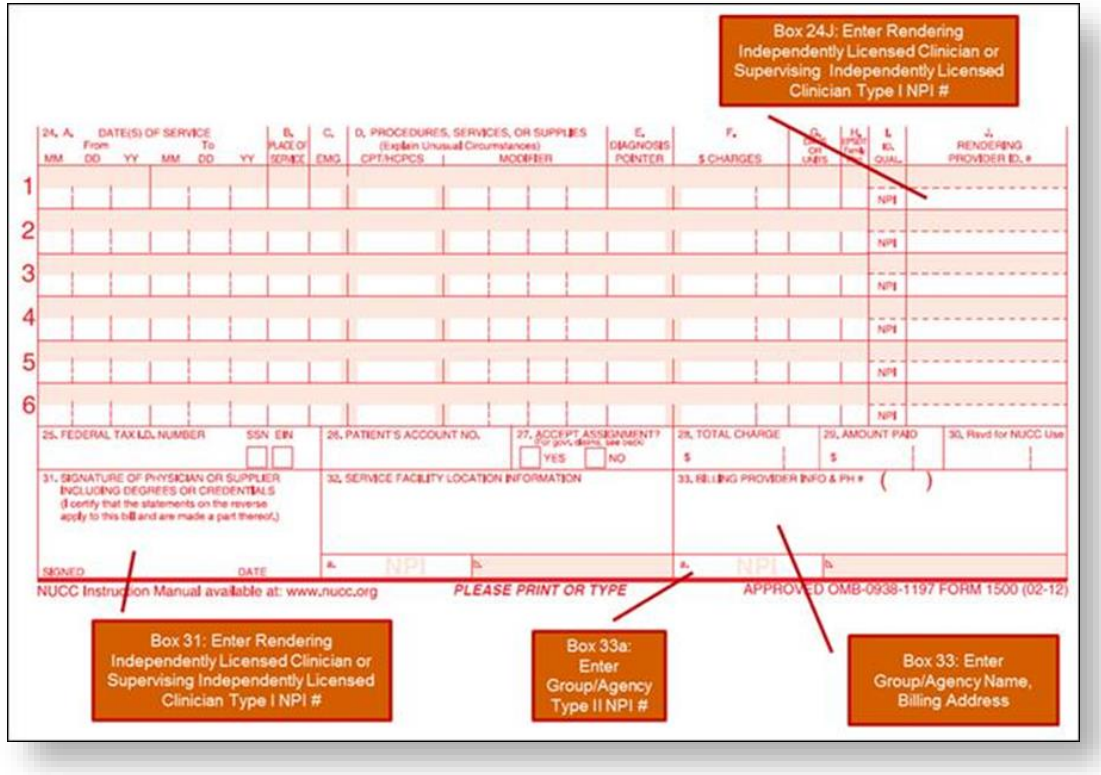
Medicaid
Optum P.O. Box 30760 Salt Lake City, UT 084130-0760

Claim billing reference guide

Independently licensed providers employed by a licensed agency/CMHC

When billing Optum for services rendered by an independently licensed provider for Mass General Brigham Health Plan Health members, the following guidelines apply for Medicaid plans:

- Claims must be billed listing the licensed provider in field 24J and field 31 on the 1500 form
- Independently licensed providers must be credentialed or rostered accordingly if they are affiliated with Groups/Agencies whose Agreement requires submission and maintenance of a provider roster
- When billing for an independently licensed provider employed by a group, payment is issued to the group

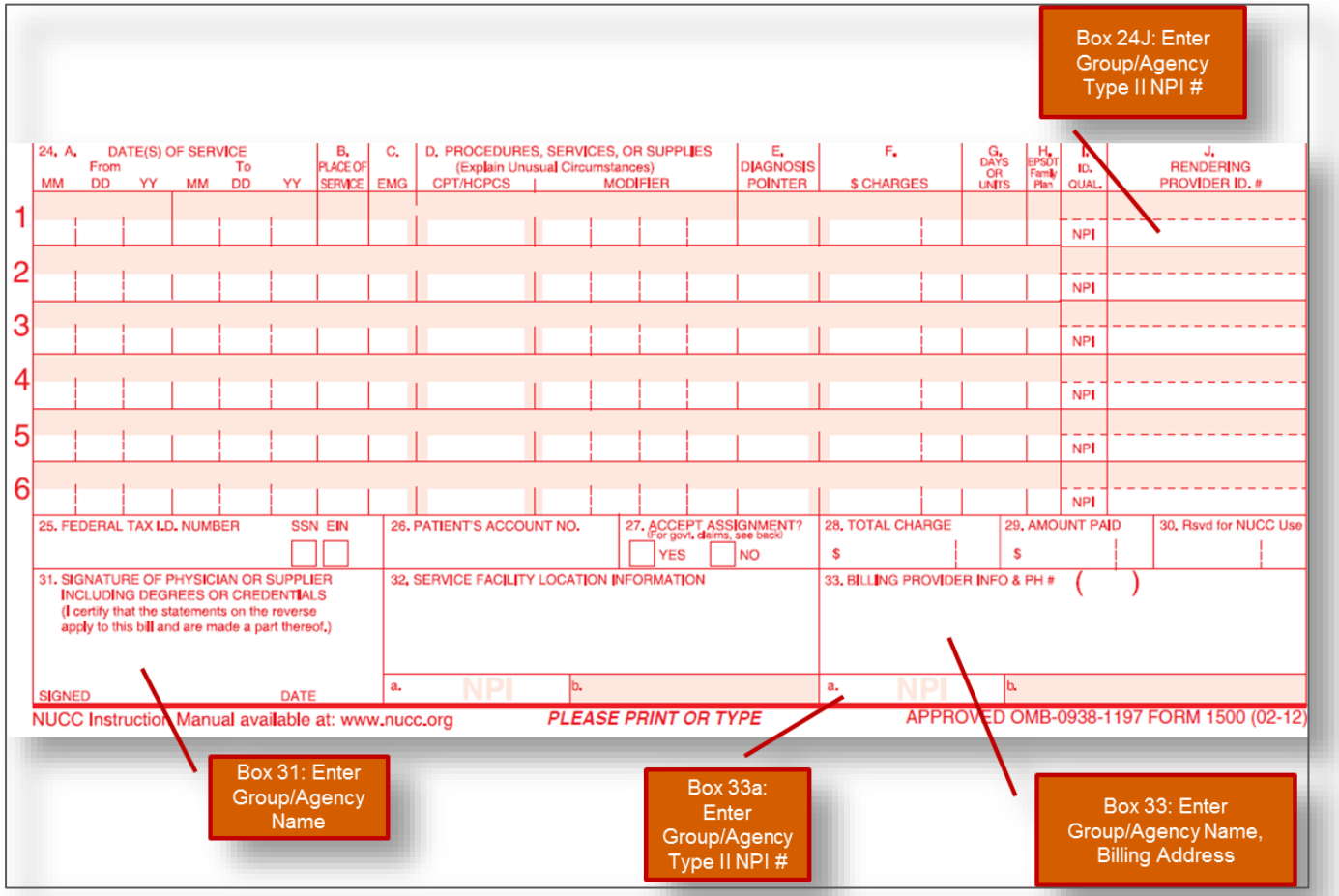


Claim billing reference guide

Group/Agency/Facility Agreements

Group/Agency/Facility – applies to groups/agencies/facilities who do not use provider rosters and do not credential providers individually.

- Providers who have group or facility Agreements for any line of business should bill according to your Agreement, that is, bill using your group/facility information not under specific individual providers.

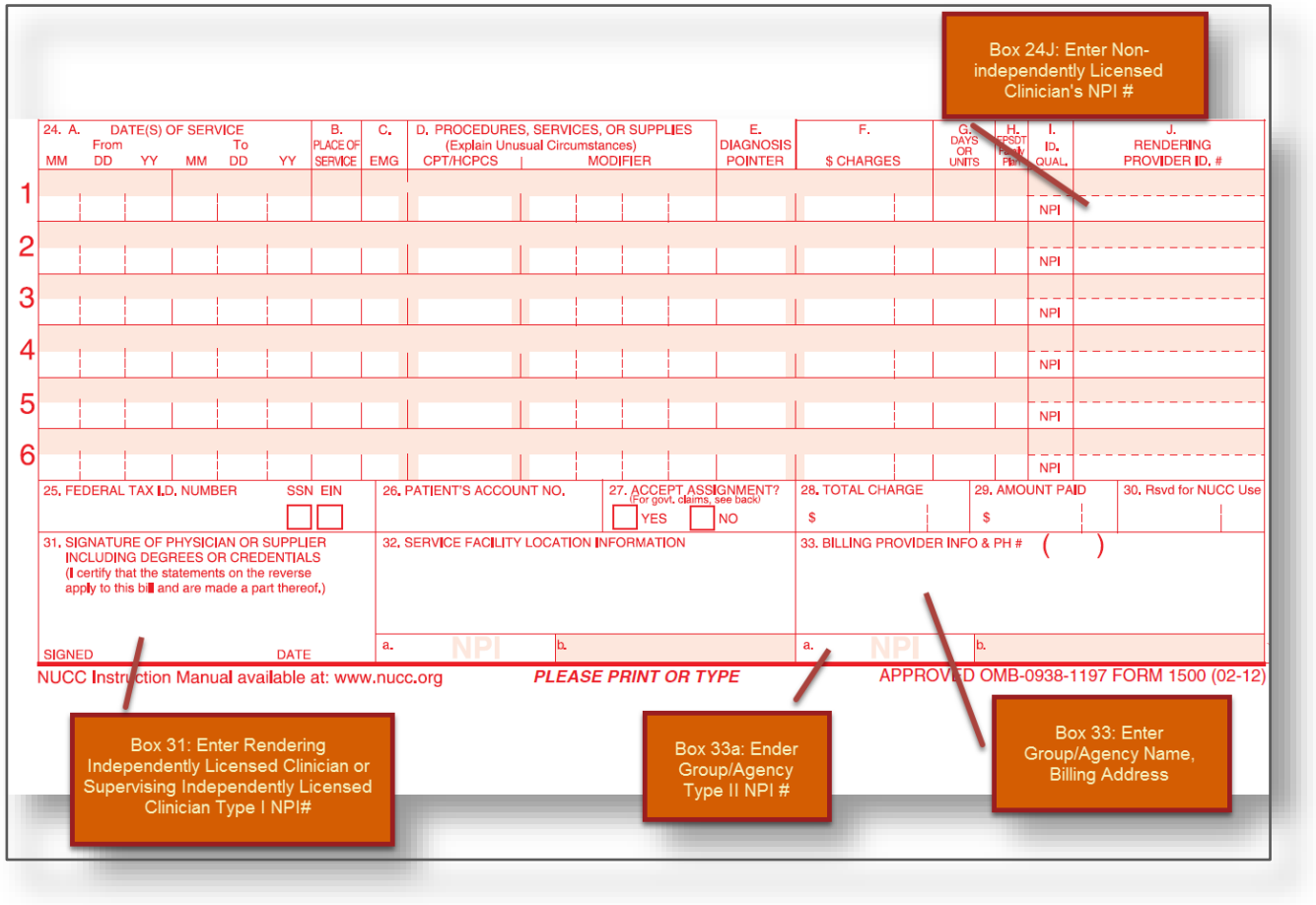


Claim billing reference guide

Non-independently licensed providers employed by a licensed agency/CMHC

When billing Optum for services rendered by a non-independently licensed provider for Mass General Brigham Health Plan Health Medicaid members, the following guidelines apply:

- Non-independently licensed providers are required to have a Type I (individual) NPI number
- Record the non-independently licensed provider's Type I NPI number in Box 24J
- Record the licensed supervising provider's NPI in Box 31
- When billing for a non-independently licensed provider, payment is issued to the group



Billing Supervision for Group Practices and Clinicians

Billing supervision allows non-licensed providers, working towards their license or licensed providers working towards a higher level of licensure to be reimbursed for services provided while under the supervision of an independently licensed provider.

- Providers rendering services must have a minimum of a master's degree
- All services that are rendered must be within the scope of the provider's training
- Optum may periodically conduct chart audits to ensure compliance with Optum policies and procedures
- Claims are submitted to Optum under the name of the licensed, contracted provider

Eligible Supervising Providers: Providers are required to practice within the scope of their license when providing supervision. Optum does not dictate these requirements. Requirements for providing supervision are detailed by the state licensing boards.

Optum

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)	Urgent (Expedited)
• 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.	• 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 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

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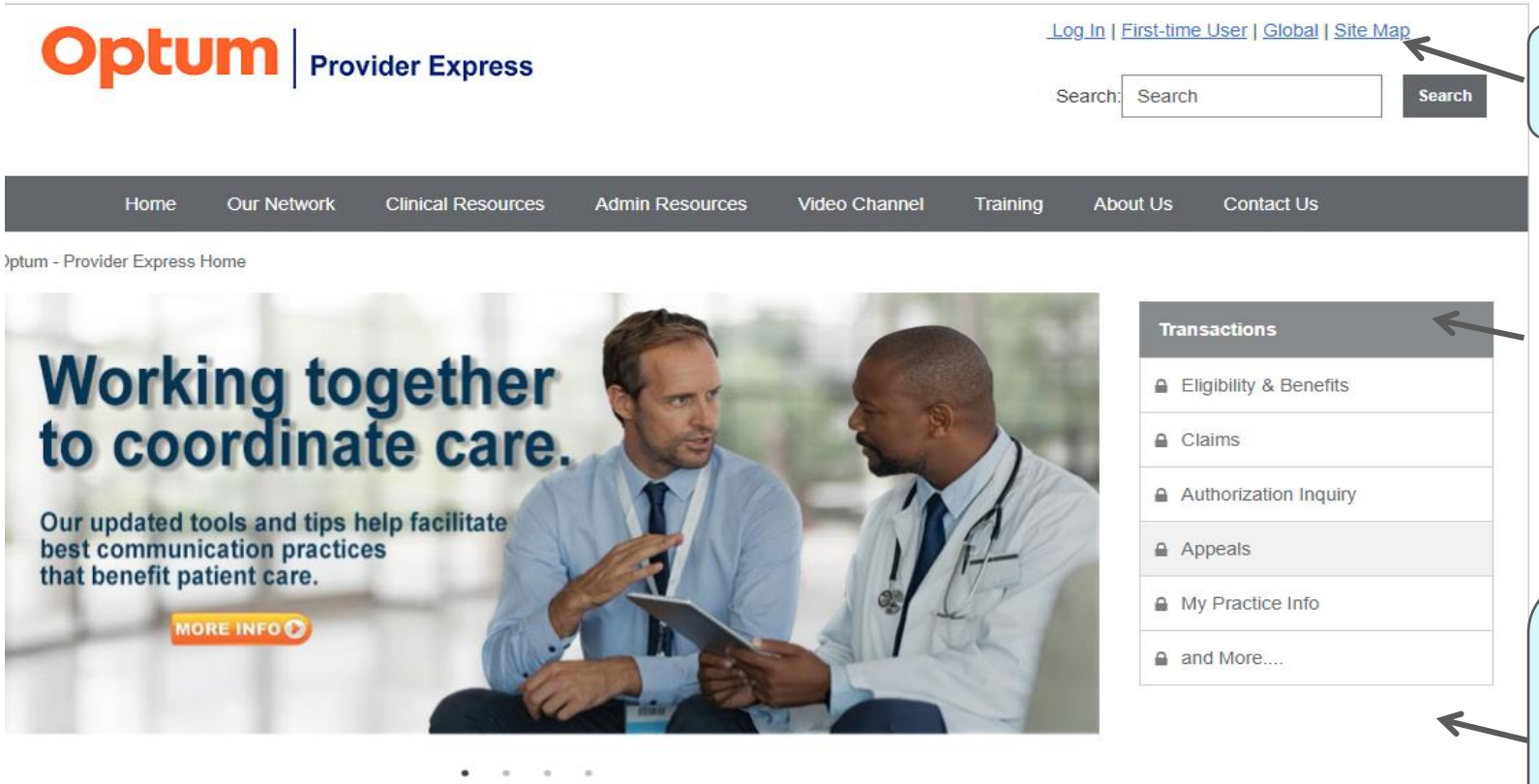
Secure Provider Portal

Provider Express: Secure Provider Portal



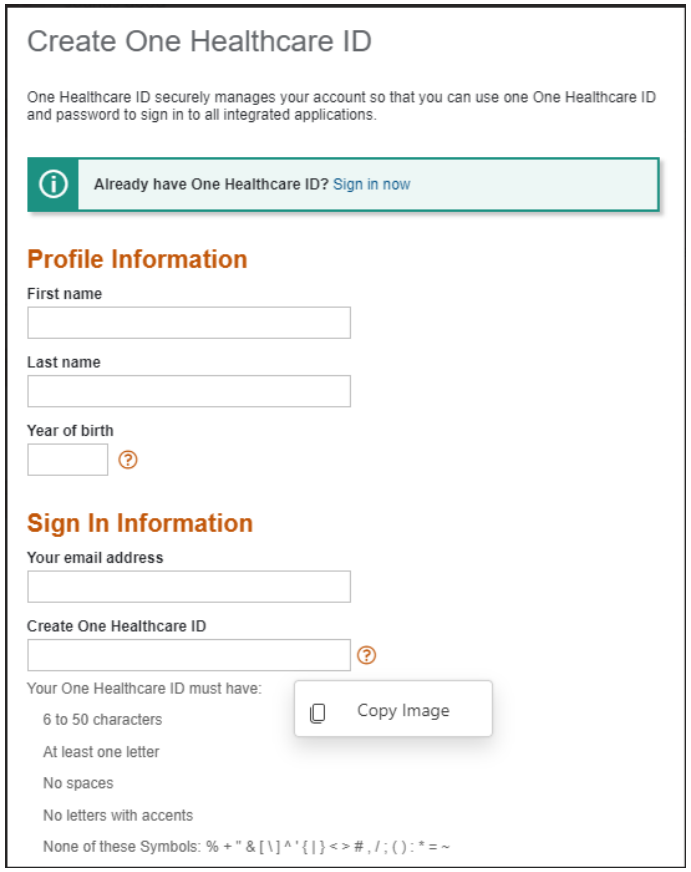
Secure pages require registration

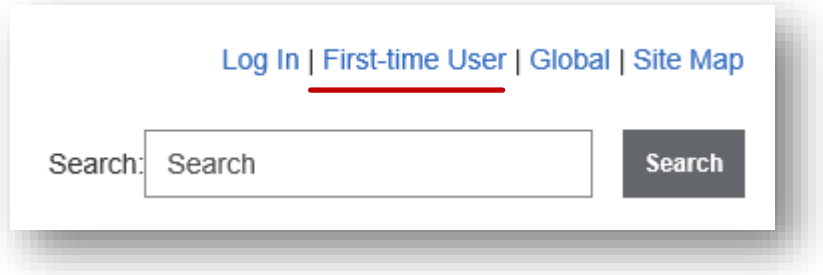
Secure "Transactions" gives you access to Member- and Provider-specific information

Quick Links give easy access to items providers commonly use

Provider Express: Secure Provider Portal

To register, select the “First-time User” link in the upper right-hand corner of the home page





You will be prompted to create a One Healthcare ID

Provider Express: Secure Provider Portal

Provider Express offers a range of secure transactions

- ✓ Check eligibility and authorization or notification of benefits requirements
- ✓ Obtain authorization or complete notification for higher levels of care
- ✓ Create and maintain My Patients list
- ✓ Submit professional claims and view claim status
- ✓ Make claim adjustment requests
- ✓ Register for Optum Pay including Electronic Funds Transfer (EFT)
- ✓ Update practice information
- ✓ Check Participation status

Training on many of these topics is available on the Video Channel or through the Guided Tours

Receive payments faster

Benefits of Optum Pay™

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

Registering for Optum Pay is easy!

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

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Provider Express Video Channel

Optum

Contacting Optum and Understanding the Service Model

Understanding the Service Model

Customer Service / Intake

Optum Behavioral Health has call centers and teams dedicated to supporting members and providers serve. For the best experience to resolve an inquiry related to one of your patients, **please call the Customer Service number on the back of the member's insurance card** for inquiries related to:

- Claims
- Patient Eligibility
- Benefit Information
- Authorizations
- ASO Funding Information

Provider Services Line

The Provider Services Line for behavioral health providers is **(877) 614-0484**.This department can best assist you with inquiries related to:

- Credentialing/Recredentialing
- Contracting/Fee Schedules
- Network Status

The Provider Relations Team is here to help with your escalated issues. Please reach out to us at ma-nh-me-networkmanagement@optum.com

Understanding the Service Model

ABA Network Contact

VACCN Contact: Region 1: 888-901-7407

UMR: Contact Us

UMR Provider Portal

Surest Health Plan (formerly Bind) Surest Health Plan

Student Resources Provider Page

Helpful links

Massachusetts - Provider Express

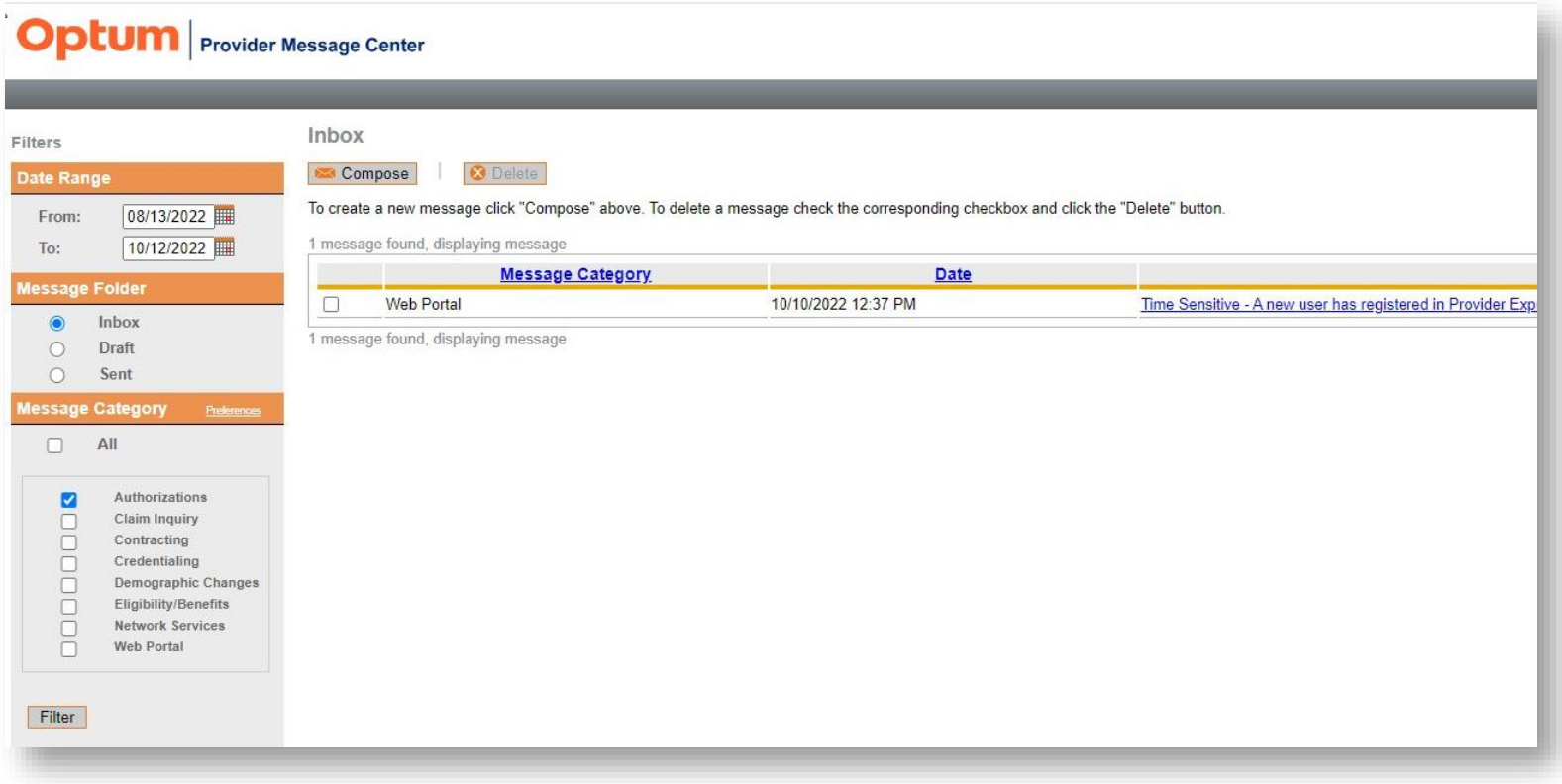
National - Provider Express

Provider Express Support - Contact Us

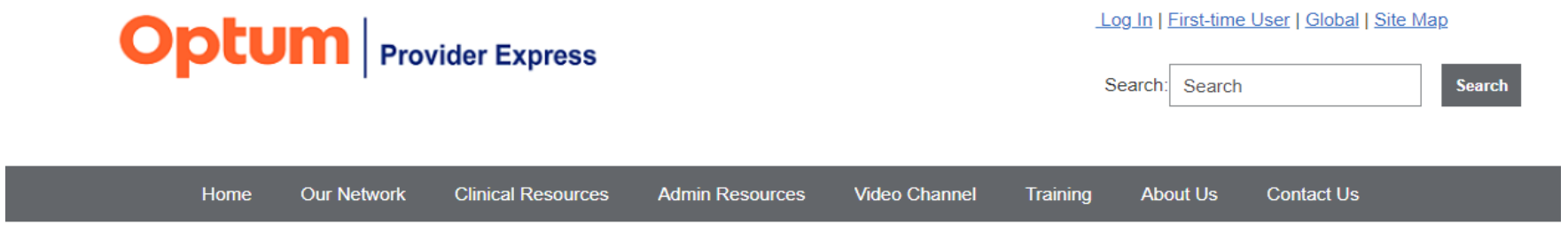
Optum Pay Support Team 877-620-6194

Send secure communications on *"Message Center"*

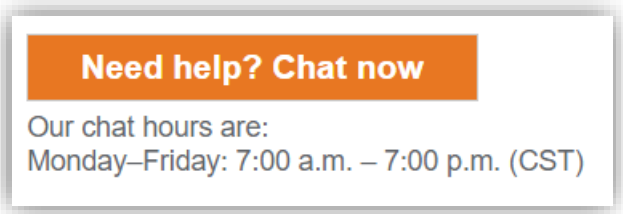
- "*Message Center*" is an online tool that enables you and Optum staff to communicate with one another within a secure channel
- The "*Message Center*" is located within the secure Transactions area



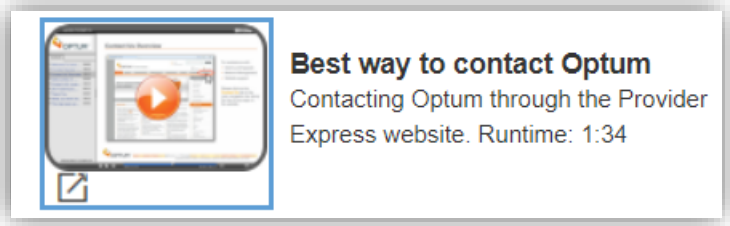
Best way to contact Optum



From the "*Contact Us*" page you can get help with claims, Network Management or website support



Live Chat is available for website technical support



Check out our brief *Contact Us* video

Mass General Brigham Health Plan Provider Express page

Welcome Massachusetts (providerexpress.com)

Thank You