Optum

MN Medicaid EIDBI Provider Orientation

Optum with UnitedHealthcare Community Plan of Minnesota

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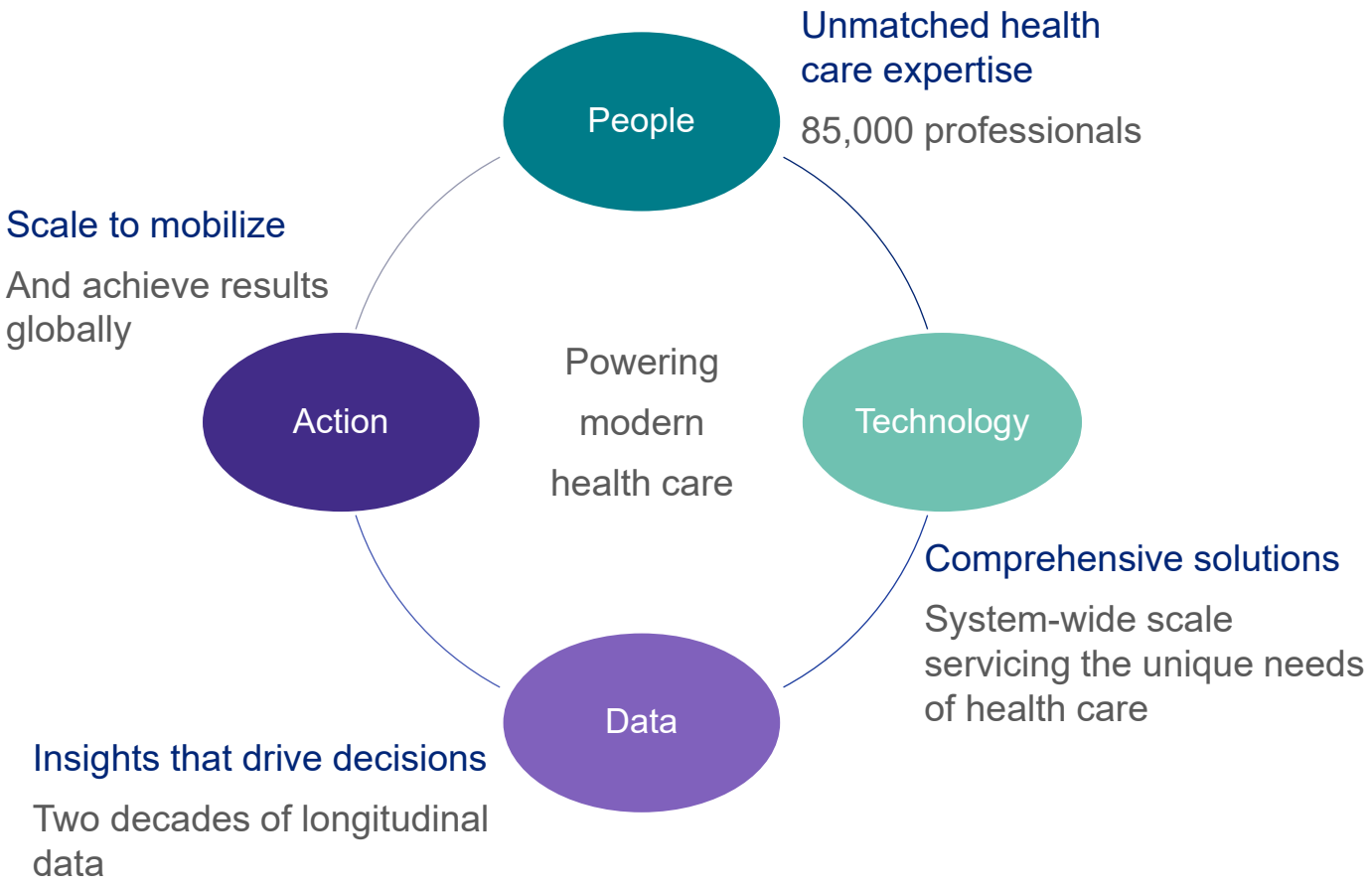
Who is Optum?

- Optum is a collection of people, capabilities, competencies, technologies, perspectives and partners sharing the same simple goal: **to make the health care 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



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Who is Optum?

Making care simpler and more effective for everyone

Whole person health - physical, mental and social

Simpler, smarter care coordination

Health intelligence and innovation

Proven clinical expertise and informed decision support

Connecting every aspect of health
Designing care around the person
Making health care smarter
Ensuring equitable health for all

Seamless administrative transactions

Health equity ingrained into every aspect of our company culture

Innovative community care models

Information when you need it

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UnitedHealth Group Structure

UNITEDHEALTH GROUP®

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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

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Our United culture

Our mission is to help people live healthier lives

Our role is to make health care work for everyone

Integrity.

Honor commitments

Never compromise

Compassion.

Walk in the shoes of the people we serve

And those with whom we work

Relationships.

Build trust through collaboration

Innovation.

Invent the future, learn from the past

Performance.

Demonstrate excellence

in everything we do

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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.

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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

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Member Information

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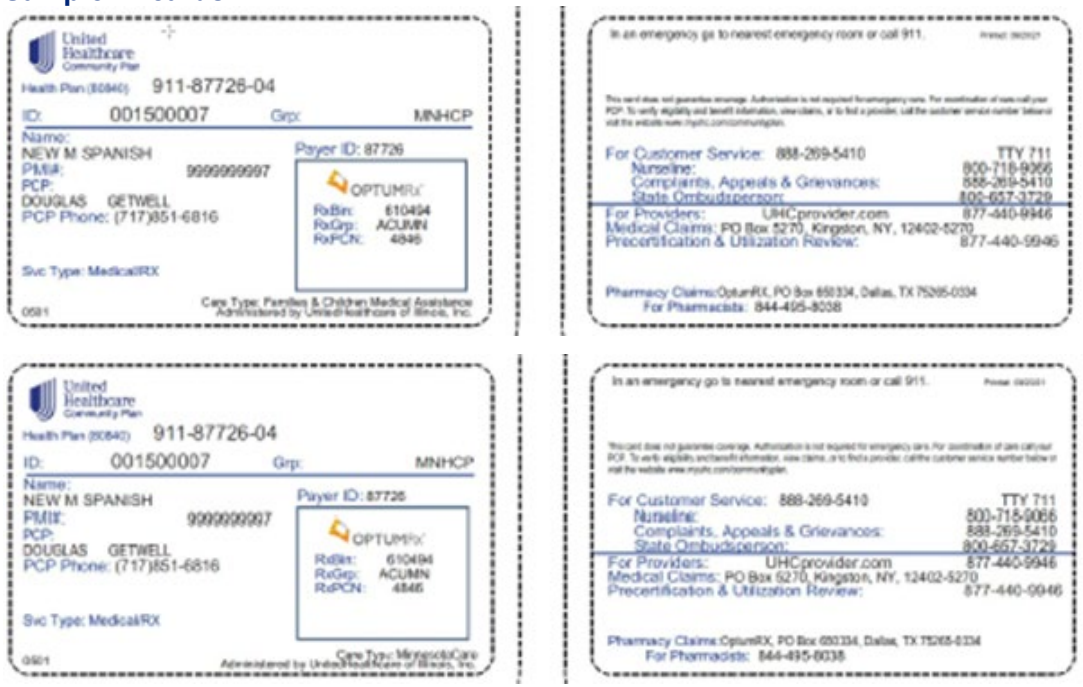
Member ID card

- 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

Sample ID cards



Sample member ID cards for illustration only; actual information varies depending on payer, plan and other requirements

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Member Rights and Responsibilities

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

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Locating a Participating Provider

UHCprovider.com

- Click on Members
- Click Find a Provider
- Click on Behavioral Health Directory
- Click on Medicaid Plans
- Pick Minnesota from the list
- Choose the plan listed on your ID Card: UnitedHealthcare Community Plan of Minnesota (Families and Children) or UnitedHealthcare Community Plan of Minnesota (MinnesotaCare)

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.

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Who is eligible?

To be eligible for Early Intensive Developmental and Behavioral Intervention (EIDBI) services, the member must meet the following criteria:

- Be under the age of 21
- Be covered under UnitedHealthcare Community Plan of Minnesota
- Have an Autism Diagnosis or related condition

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Credentialing/ Provider Criteria for EIDBI Program Network

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Required: NPI and EIN/TIN

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

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EIDBI provider types

Five EIDBI provider types:

- Comprehensive Multi-Disciplinary Evaluation (CMDE)
- Qualified Supervising Professional (QSP)
- Level I Provider
- Level II Provider
- Level III Provider

EIDBI - Overview of EIDBI Providers (state.mn.us)

Each provider type has different qualifications, roles and responsibilities during EIDBI service delivery.

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Credentialing Providers

- Provider Credentialing timeline is 30 days after receiving a clean application.
- A clean application would include all required documents, disclosures, dates, signatures etc. needed to proceed with the credentialing process.
- This applies only to providers that require credentialing.
- This timeframe may be extended if a quality or safety concern is identified during the credentialing review that requires further investigation.

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Steps in Providing Treatment

Eligibility, Authorizations & Concurrent Reviews

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Clinical Team

Dedicated Clinical Team

There is a dedicated clinical team that supports the Minnesota Medicaid EIDBI program:

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

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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

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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

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Eligibility and Prior Authorization

EIDBI 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.
- Treatment Authorization Request Form can be submitted on-line at providerexpress.com/content/ope-provexpr/us/en/clinicalresources/autismABA/txABA.html
- Meet Medical Necessity – this applies to initial and concurrent reviews
- Provider must submit the results of the assessment and the treatment request for any treatment requests
- 97151, T1024, H0046, and H0032, do not require prior authorization
- Authorization status can be viewed online at providerexpress.com
- When calling the Autism Care Advocate, you must have:
  - ❑ Member's name
  - ❑ Medicaid ID #
  - ❑ Date of birth
  - ❑ Provider Tax ID
  - ❑ Agency Address

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Treatment Request requirements

Meet Medical Necessity

Goals are:

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

Includes:

- When completing the treatment plan, the following items must be included:
- **Treatment Modality including techniques to support the enrollee**
- **Frequency and intensity of services**
- **Baseline and mastery criteria**
- Transition Plan to lower level of care
- **Environmental changes including personal / family circumstances**
- **Discharge Criteria**
- Behavior Reduction Plan/Crisis Plan
- **Family caregiver goals including amount of family caregiver training**
- Supervision and treatment planning hours
- Relevant psychological information
- Coordination of care with other providers
- **QSP signature and the parent/caregiver signature**

Note: Items **bolded** above indicate they are an absolute requirement of the initial & continued treatment plan

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

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Treatment Request requirements (cont.)

The following items must be included

- Treatment modality
- Baseline data, frequency and intensity of services
- Amount of family caregiver training
- Environmental changes
- Personal and family circumstances
- Techniques to support the Enrollee
- The QSP signature and the parent/guardian signature
- Goal mastery and progress, and discharge criteria

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

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Clinical information requirements for each review

- Confirmation member has an appropriate DSM-5 diagnosis that can benefit from EIDBI
- 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?
- Previous history with EIDBI services with your agency or another provider/agency

- 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

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

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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

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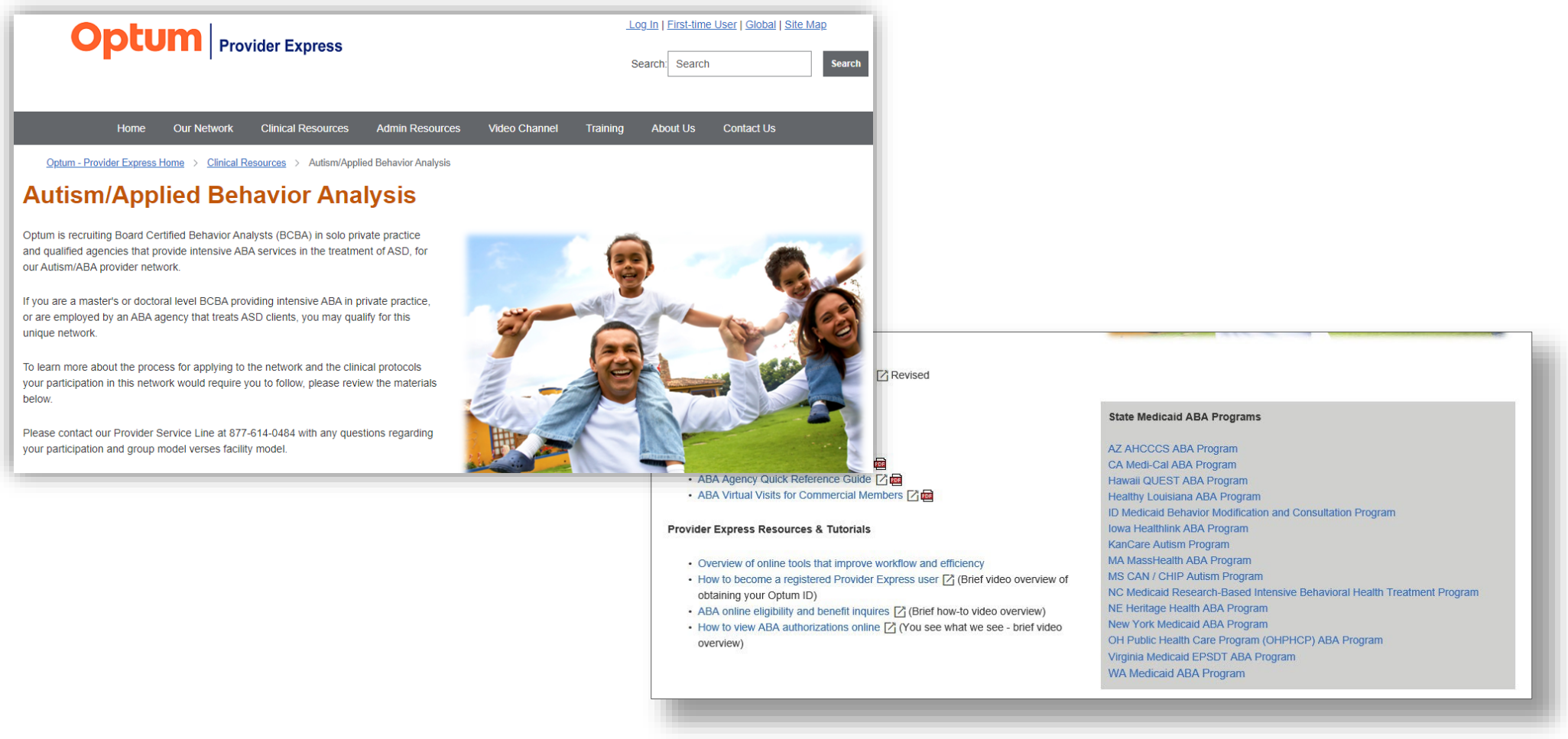
Prior Assessment Authorization – online portal submission



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Prior Assessment Authorization – online portal submission

Prior authorization request form can be found online at providerexpress.com

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Billing and Reimbursement

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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.

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Minnesota ABA Medicaid fee schedule

Contractual rates for Early Intensive Developmental and Behavioral Intervention (EIDBI) billing are published at Early Intensive Developmental and Behavioral Intervention (EIDBI) billing grid (state.mn.us) and are subject to change based on state direction.

UNITED BEHAVIORAL HEALTH			
Billing Code	Modifier	Service Description	Units
97151	UB	Comprehensive Multi-Disciplinary Evaluation (CMDE): Behavior identification assessment	15 min
97153	UB	Individual: Adaptive behavior treatment by protocol	15 min
97154	UB	Group: Group adaptive behavior treatment by protocol	15 min
97155	UB	Intervention -Individual: Observation and Direction: Adaptive behavior treatment with protocol modification	15 min
97156	UB	Family or Caregiver Training and Counseling: Individual: Family adaptive behavior treatment guidance	15 min
97157	UB	Family or Caregiver Training and Counseling –Group: Multiple family group adaptive behavior treatment guidance	15 min
H0032	UB	Development and Monitoring	15 min
H0046	UB	Travel Time	minute
T1024	UB	Evaluation and treatment by an integrated, specialty team contracted to provide coordinated care to multiple or severely handicapped children	15 min
0373T	UB	Adaptive behavior treatment with protocol modification, each 15 minutes	15 min

1	The listing of a service or CPT code above does not guarantee that it will be covered under every account-specific plan. To be reimbursable, a service provided to a beneficiary must be a covered benefit under the beneficiary's benefit plan. All reimbursements are less patient responsibility and represent the total allowable reimbursement, including patient responsibility, for all pre-authorized services only. Patient responsibility represents the applicable co-payment, coinsurance, and/or deductible, and is determined by type of insurance and/or benefit plan.
2	Modifier Descriptions UB EIDBI Modifier

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Claims submission

All EIDBI Claims must be:

- Submitted on a Form 1500 (v.02/12) claim form
- Submit electronically via UHCprovider.com using the Claims tool on the Provider Portal
- Submit electronically using an EDI clearinghouse and Payer ID 87726

Electronic Remittance Advice (ERA)

- Payer ID # 86047
- Include appropriate taxonomy codes
- Claims must be received within 6 months from the service date, unless otherwise allowed by law. Claims submitted late may be denied.

Please send paper claims to:

- Optum Behavioral Health
  P.O. Box 5270
  Kingston, New York 12402-5270

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

- Optum – 1-877-440-9946
- Logging into UHCprovider.com

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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

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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

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Claims Submission Option 2 - EDI/electronically (cont.)

- You may use any clearinghouse vendor to submit claims Payer ID for submitting claims is 87726
- Electronic Remittance Advice (ERA) Payer ID is 86047
- EDI Support: 1-800-210-8315 or email ac_edi_ops@uhc.com

Additional information regarding EDI is available on:

- EDI Contacts | UHCprovider.com

  and
- UHCprovider.com

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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 (BCBA vs Paraprofessional)
  - ❑ 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.

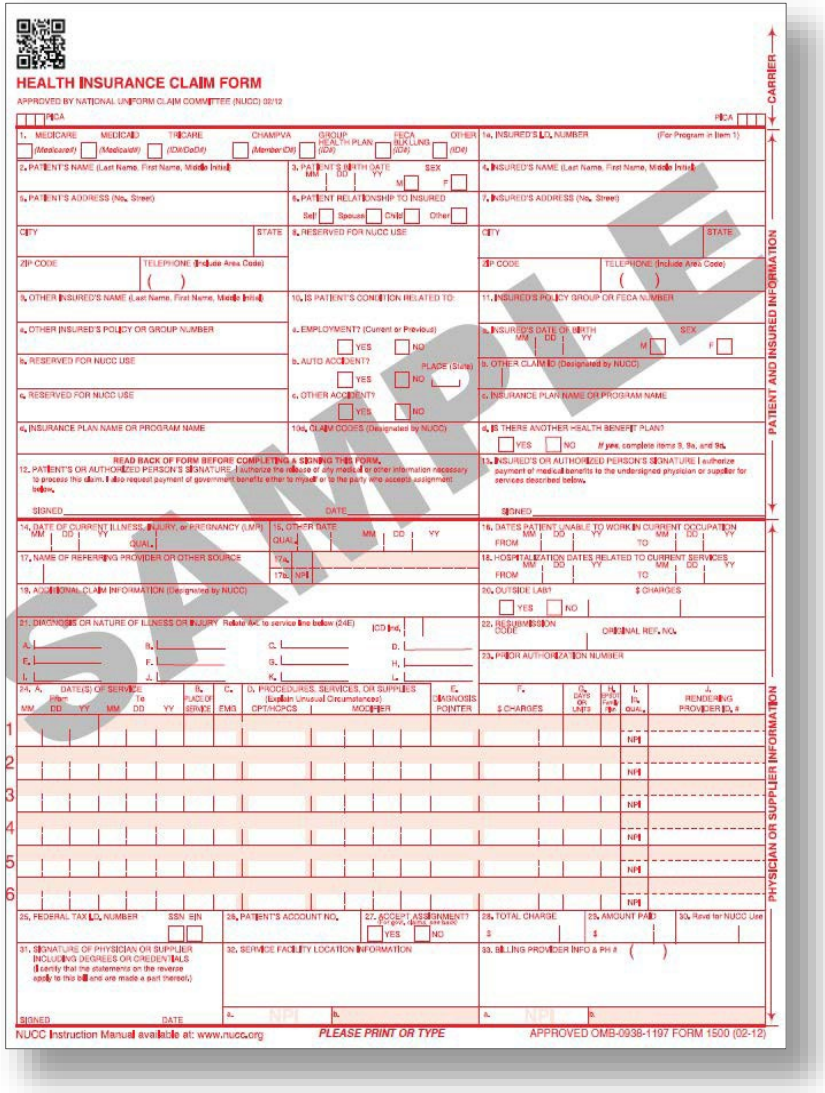
Please follow billing instructions provided by your Network Manager based on your contract and system set-up.

Claims status can be obtained by calling the Claims Customer Service Center In the event you experience claim problems, please contact the following:

By Phone: 1-877-440-9946

OR

Online by logging in to: UHCprovider.com



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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
  - ❑ Must be requested as soon as possible and no later than 60 days from denial receipt
  - ❑ Resolution of appeal within 30 calendar days of request.
  - ❑ Appeals can be requested:
    - Via telephone: 1-877-440-9946
    - Via mail:

      UnitedHealthCare Community Plan
      Attn: Appeals and Grievances Unit
      P.O. Box 31364

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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.)

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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

- Claims must be received within 6 months from the service date, unless otherwise allowed by law. Claims submitted late may be denied.

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
- Exception - 97151, T1024, H0046, and H0032, do not require prior authorization

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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 myservices.optumhealthpaymentservices.com/registrationSignIn.do

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.*

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Provider Express

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You can find:

- Autism ABA Corner with specific EIDBI resources
- New Provider Orientation “Navigating Optum” viewable on demand
- Network Manual
- Demographic Updates
- Guidelines / Policies & Manuals
- Clinical Resources
- Administrative Resources
- Recovery & Resiliency Toolkit
- Video Channel
- Webinars/Training Resources

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

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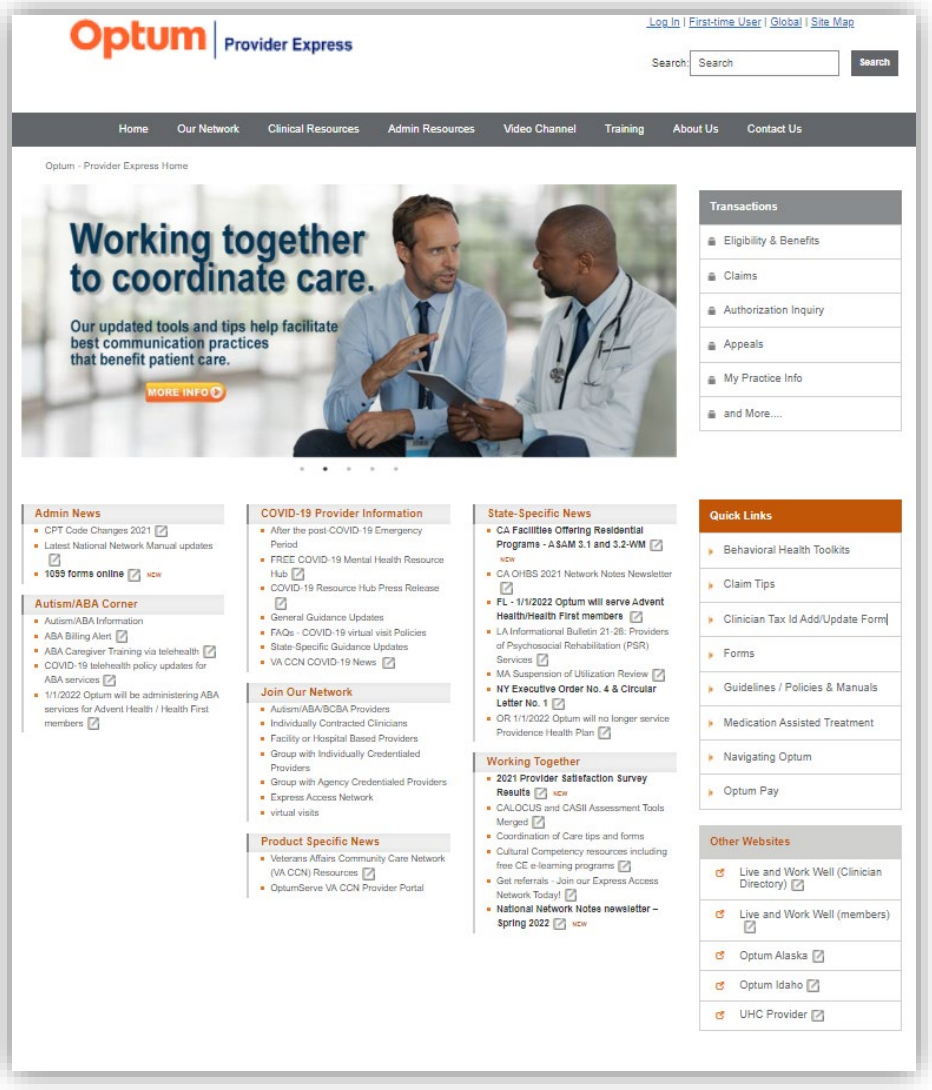

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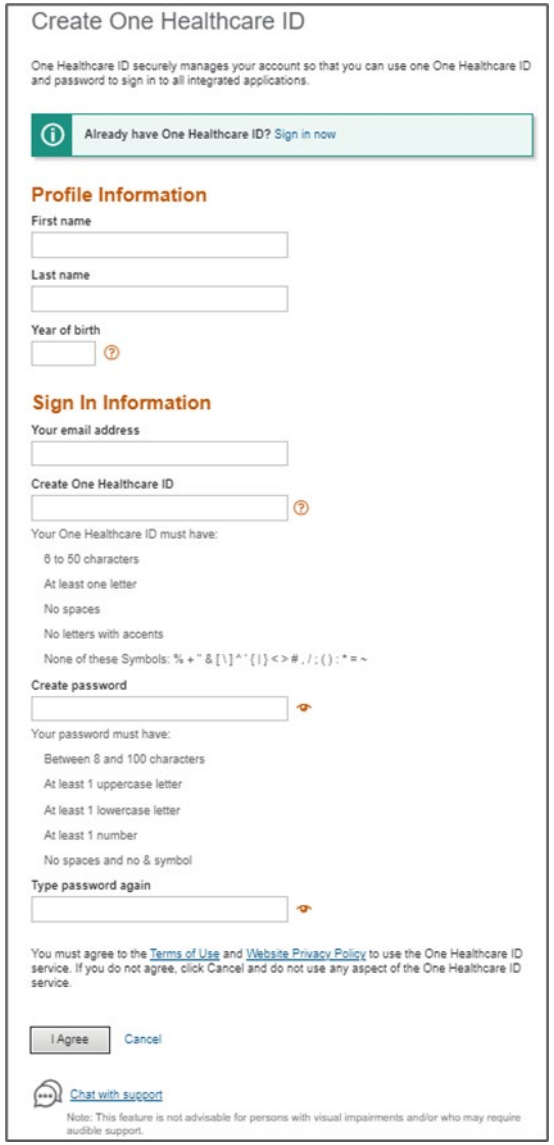
providerexpress.com - First Time users

- 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 on “Contact Us” page



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Resources

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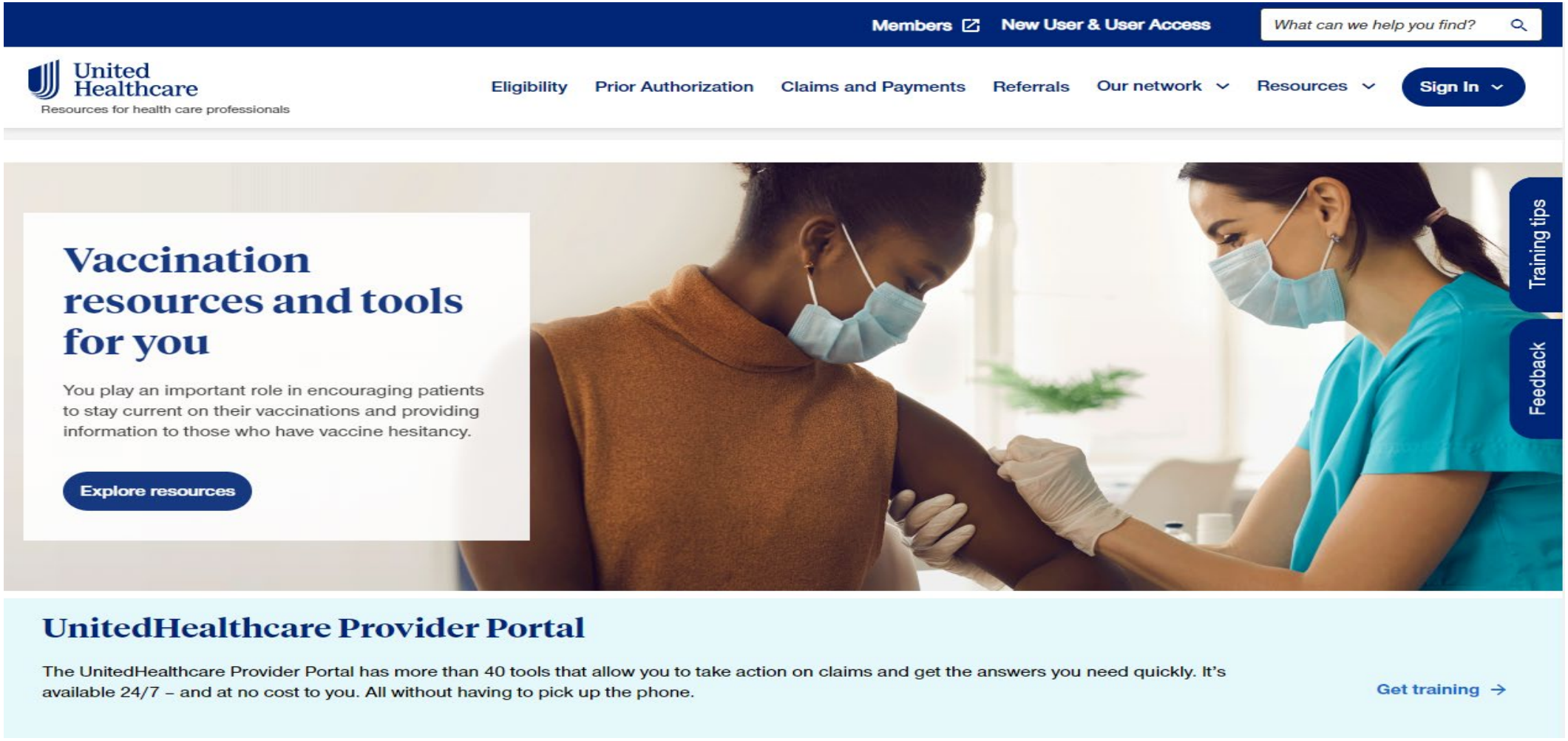
UHCprovider.com Website



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New User registration

UHCprovider.com

Provides clinicians with access to the latest news, policy information and to Link self-service tools for care providers

Create a One Healthcare ID

In order to access secure content on UHCprovider.com or to access Link self-service tools to submit claims, verify eligibility or to check for prior authorization requirements, you first need to have a One Healthcare ID that has been connected to the Tax ID of your practice, facility or organization.

Video: Accessing Link via UHCprovider.com

Need a One Healthcare ID?

Please register to create your One Healthcare ID.

Have a One Healthcare ID, but need to connect a Tax ID?

To start the process, sign in with your One Healthcare ID on UHCprovider.com and click "No" when asked if you received a registration letter that included a security code. From that point, complete the required fields for the form as prompted. For help see the Accessing Link - Quick Reference Guide.

Need help accessing certain applications on UnitedHealthcare Provider Portal?

If you are unable to access specific UnitedHealthcare Provider Portal Self-Service applications using your Tax ID connected One Healthcare ID login, please contact your organization's practice administrator – they are the only ones able to manage and make changes to account access.

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Minnesota Medicaid EIDBI Program Provider Quick Reference Guide

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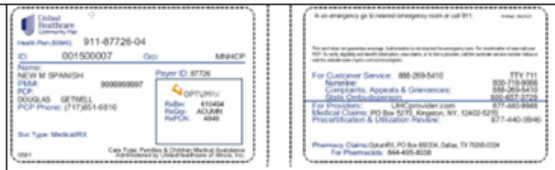
Minnesota EIDBI Program

Quick Reference Guide

ID Card	
Clinician is Responsible for:	Verifying benefits/eligibility online at providerexpress.com or call the Behavioral Health number located on the back of the Member's ID card • Obtaining authorization as necessary • Being familiar with the Network Manual located on our web site: providerexpress.com >Guidelines / Policies & Manuals> Network Manual • Being familiar with EIDBI specific guidelines on our website: providerexpress.com > Autism/ABA Corner
ABA Clinical Policy	EIDBI Clinical Policy can be found at providerexpress.com > Autism/ABA Corner > State Medicaid ABA Programs > MN Medicaid EIDBI Program, along with other resource materials.
Prior Authorization	All autism 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 • Prior Authorization can be obtained via Treatment Authorization Request Form and submitted either o Online at https://optumpeeraccess.secure.force.com/ABAtreatment/ o Or via fax at 1-888-541-6691
Claims Paper Submission	Mail paper claims to: • Optum, P.O. Box 5270 Kingston, NY 12402-5270 • All autism provider services must be billed on a Form 1500 • Submission should occur within 6 months of date of service.
Electronic Submission	Submit claims online through: • uhcprovider.com • Payer ID for submitting claims is 87726 • Electronic Remittance Advice (ERA) Payer ID 86047 • EDI Support 1-800-210-8315 or email ac_edi_ops@uhc.com
Claim Status	Claims status can be obtained by calling Customer Service Center: • Web portal at providerexpress.com or uhcprovider.com • 1-877-440-9946
Claim Appeals	Claim appeals process: • Process for appeal will be detailed in the Member's Rights Enclosure which accompanies the Explanation of Benefit (EOB) denial notice sent to the provider and the member • Mailed to Optum, Appeals & Grievances P.O Box 31364 Salt Lake City, UT 84131-0364
Update Practice Info	You can update your practice information by contacting your designated Autism Network Manager.

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Disclaimer	Information contained herein is subject to change. Please contact your Network Manager with any questions.
Network Management	Jeffrey Muench, Specialty Network Manager Email: Jeffrey.muench@optum.com

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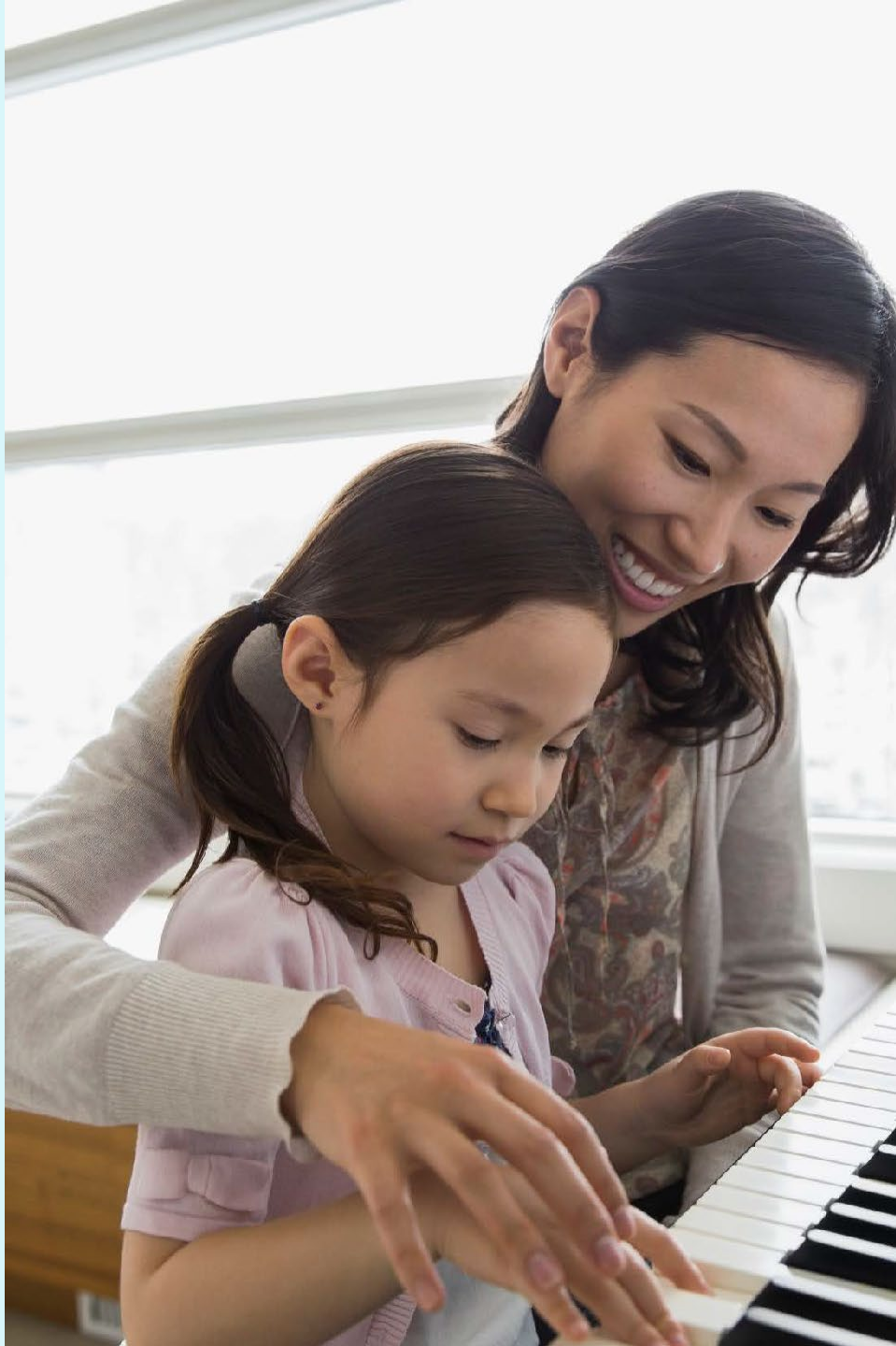
Appendix



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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

Minnesota Department of Human Services

- mn.gov/dhs/

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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

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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

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