Optum MMA Training (Medicaid)

October 2018

Agenda

- Introductions
- MMA Overview
- Overview of Agency Contracting
- Overview of ALERT Process
- Overview of Claim Submission Guidelines
- Optum Initiatives
- Resources
- Questions & Answers

Introductions

Presentation will be hosted by the following Optum Staff:

- Network
  - Amy Rice, Director Provider Services, SE Region
  - Jean Higgins, Senior Network Manager
  - Rebeca Oliva Arzola, Senior Network Manager
  - Desa Stevens, Network Manager
  - Vonisha Lambert, Network Manager
  - Jennifer Durgee-Hemminger, Network Manager (Part Time)

Overview

- United Behavioral Health (UBH) operating under the brand Optum will provide behavioral health services for MMA members in Regions: 3, 4, 6, & 11 with the new Medicaid roll out.

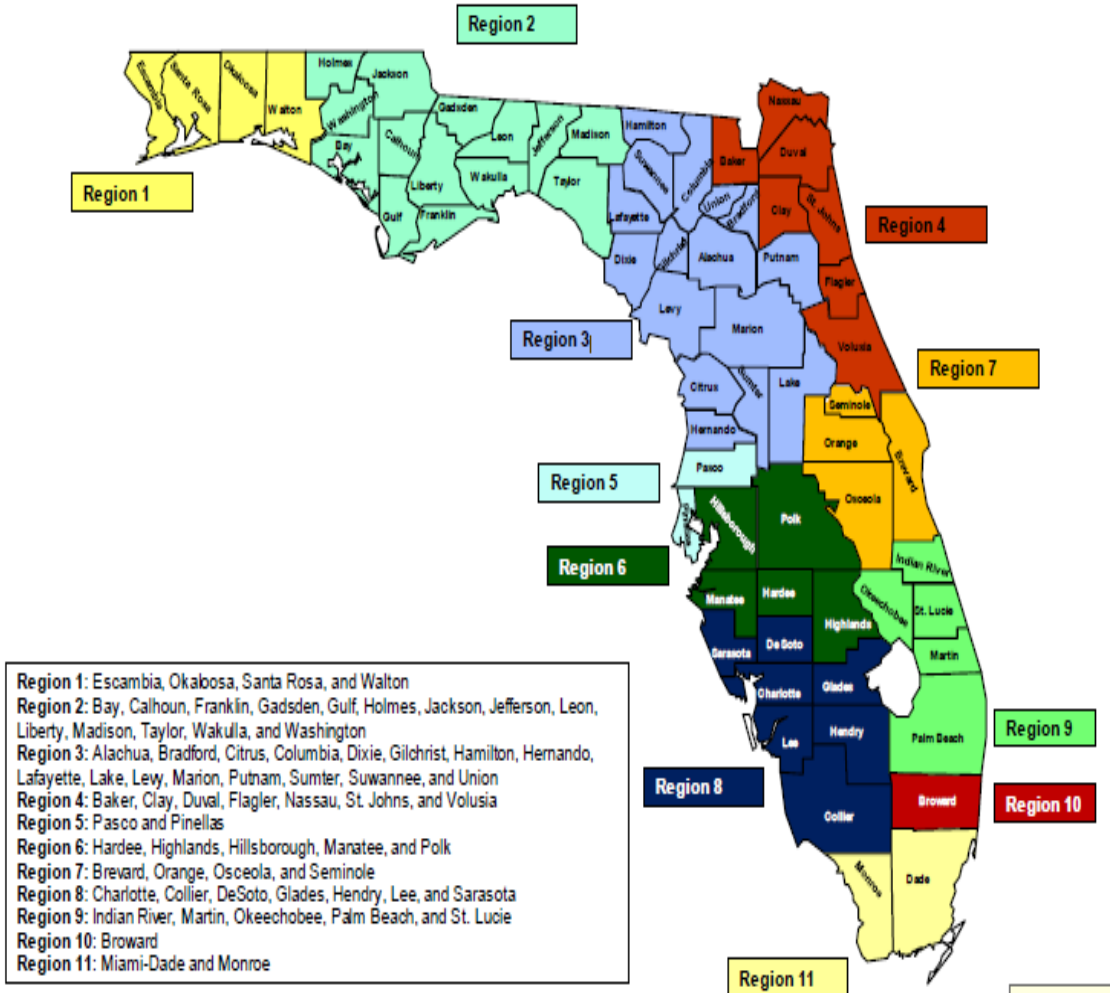
- Region 11 – effective date 12/1/2018
- Region 6 – effective date 1/1/2019
- Regions 3 & 4 – effective date 2/1/2019

Medicaid Regions Map

UnitedHealthcare Community Plan MMA is located

in Regions:

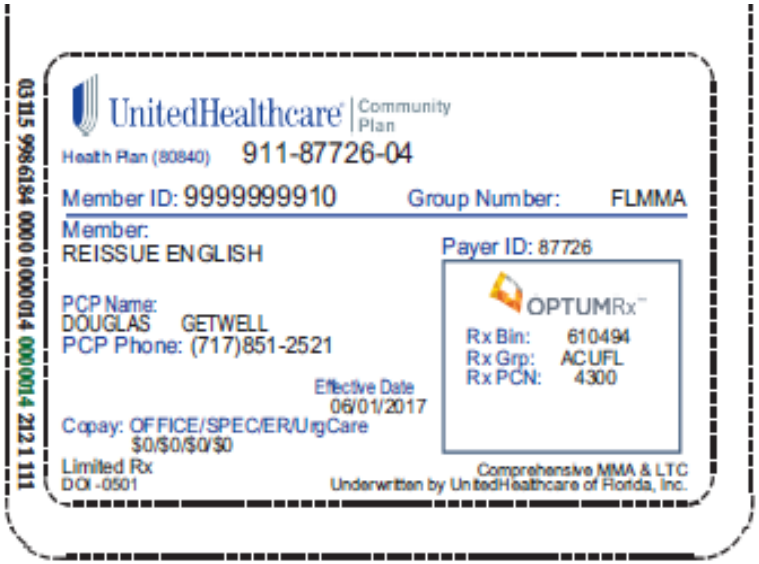
3, 4, 6, & 11

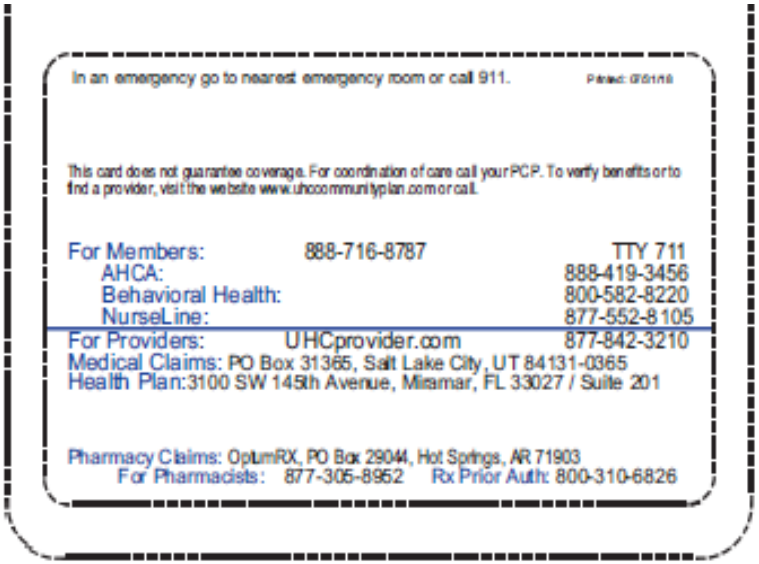


Region 1: Escambia, Okaloosa, Santa Rosa, and Walton
Region 2: Bay, Calhoun, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Taylor, Wakulla, and Washington
Region 3: Alachua, Bradford, Citrus, Columbia, Dixie, Gilchrist, Hamilton, Hernando, Lafayette, Lake, Levy, Marion, Putnam, Sumter, Suwannee, and Union
Region 4: Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia
Region 5: Pasco and Pinellas
Region 6: Hardee, Highlands, Hillsborough, Manatee, and Polk
Region 7: Brevard, Orange, Osceola, and Seminole
Region 8: Charlotte, Collier, DeSoto, Glades, Hendry, Lee, and Sarasota
Region 9: Indian River, Martin, Okeechobee, Palm Beach, and St. Lucie
Region 10: Broward
Region 11: Miami-Dade and Monroe

How to Identify Our MMA Members

Please accept these members
and provide services as you normally
do for Optum members





Overview of Agency Contracting (Group Contract)

- Group contracts are typically only available to:
  - Agencies classified as Community Mental Health Centers (CMHCs) by AHCA.

- Rostered Clinicians only applicable for Group Contracts
  - Each agency supplies a roster of independently licensed clinicians who render services to their clientele
  - Only independently licensed clinicians can be loaded in Optum's systems under the agency contract. Accepted roster provider types are: MD, DO, ARNP, Licensed Psychologist, LCSW, LMHC, LMFT and Certified Case Manager Supervisor (CCMS).
  - If claims are submitted with clinicians who are not licensed, the claims will be unable to be processed until submitted with a licensed supervising clinician who is rostered.
  - It is important to keep roster lists as updated as possible. All changes can be submitted through www.providerexpress.com , except CCMS add requests will need to be sent to Network Managers via the roster update form.

Overview of Agency Contracting (Group Contract)

- Supervisory Protocol only applicable for Group Contracts
  - Supervisory Protocol Contract Addendum and AHCA requirements apply.
  - Non-independently licensed clinicians are required to be supervised by an individually licensed clinician who is rostered under the agency contract.
  - Non-independently licensed clinicians cannot be loaded in Optum's systems and cannot bill for services under their own name.

OVERVIEW OF ALERT PROCESS

Overview of ALERT Process

Florida Medicaid MMA (Managed Medical Assistance)

Outpatient Prior Authorization Change for Contracted Providers

- Optum Prior authorization for many **HCPC Codes** for Outpatient and Telemental Health Services (see list below**) is no longer required** for Florida Medicaid (MMA) members

- Optum will apply algorithms to identify practice management patterns that appear to fall outside of typical patterns

- When a pattern of care is atypical or does not match guidelines for service level, a telephonic review for medical necessity may be initiated

- Use of the applicable code modifiers are required for billing of services

Overview of ALERT Process

*Authorization is no longer required for the below codes

Note:
The two tables below reflect Agency for Health Care Administration (AHCA) descriptions for the codes listed.

Telemental Health Services – Florida Medicaid (MMA)		
Code	**Modifier**	**Description**
H0001	GT	Limited functional assessment, substance abuse - telemedicine
	HN GT	Biopsychosocial Evaluation, substance abuse - telemedicine
	HO GT	In-depth assessment , new patient, substance abuse - telemedicine
	TS GT	In-depth assessment, established patient, substance abuse - telemedicine
H0031	GT	Limited functional assessment, mental health - telemedicine
	HN GT	Biopsychosocial Evaluation, mental health - telemedicine
	HO GT	In-depth assessment - new patient, mental health - telemedicine
	TS GT	In-depth assessment - established patient, mental health - telemedicine
H0046	GT	Behavioral Health related medical services: verbal interaction- MH - telemedicine
H0047	GT	Behavioral Health related medical services: verbal interaction- SA - telemedicine
H2000	HP GT	Psychiatric Evaluation by a physician - telemedicine
H2010	HE GT	Brief individual medical psychotherapy, mental health - telemedicine
	HF GT	Brief individual medical psychotherapy, substance abuse - telemedicine
	HO GT	Brief Behavioral Health Status Exam - telemedicine
T1015	GT	Medication Management - telemedicine

Overview of ALERT Process

*Authorization is no longer required for the below codes

Outpatient Services - Florida Medicaid (MMA)		
Code	**Modifier**	***Description***
H0001		Limited Functional Assessment, S/A
	HN	Biopsychosocial Evaluation S/A
	HO	In-depth Assessment New Patient S/A
	TS	In-depth Assessment Established Patient S/A
H0004		Individual or Group Therapy Provided by a Mental Health Practitioner (FQHC-based service)
H0020		Methadone or Buprenorphine administration (Medication Assisted Treatment Services) - (weekly)
H0031		Limited Functional Assessment, Mental Health
	HA	Comprehensive behavioral health assessment
	HN	Biopsychosocial Evaluation
	HO	In-depth assessment, new patient, mental health
	TS	In-depth assessment, established patient, mental health
H0032		Treatment Plan development, new and established patient, mental health
	TS	Treatment Plan review, mental health
H0046		Behavioral health - related medical services; verbal interaction, mental health
H0047		Behavioral health - related medical services; verbal interaction, substance abuse
H0048		Behavioral health- related medical services; alcohol and other drug screening specimen collection
H2000		Psychiatric Review of Records
	HO	Psych Evaluation by non-M.D.
	HP	Psych Evaluation by M.D.

Overview of ALERT Process

*Authorization is no longer required for the below codes

H2010	HE	Brief individual medical psychotherapy, mental health
	HF	Brief individual medical psychotherapy, substance abuse
	HO	Brief Behavioral Health Status Exam
	HQ	Brief Group Medical Therapy
H2012		Behavioral Health Day Services, Mental Health
	HF	Behavioral Health Day Services, Substance Abuse
H2017		Psychosocial Rehabilitation Services
H2019		Psychological Testing
	HM	Therapeutic Behavioral On Site Services, therapeutic support
	HN	Therapeutic Behavioral On Site Services, behavior management
	HO	Therapeutic Behavioral On Site Services, Therapy
	HQ	Group Therapy
	HR	Individual and Family Therapy
H2030		Clubhouse Services
T1007		Treatment plan development, new and established patient, substance abuse
	TS	Treatment plan review, substance abuse
T1015		Medication Management
	HE	Behavioral health related services; medical procedures, mental health
	HF	Behavioral health related services; medical procedures, substance abuse
T1017		Targeted Case Management
	HA	Targeted Case Management - child
	HK	Intensive Case Management
T1023	HE	Behavioral Health medical screening, mental health
	HF	Behavioral Health medical screening, substance abuse

Overview of ALERT Process

Reimbursement Policy

Alert: Florida Medicaid Edits

Reimbursement Policy – Claims Editing

This notice provides information about Florida Medicaid coverage guidelines and their associated claim edits. Reimbursement policies establish processes to ensure accurate and appropriate claim processing in accordance with industry standards. These processes serve to identify potentially inappropriate billing and/or utilization of services. Requests for medical records may be made for administrative review (not based or used for Medical Necessity). In those cases, record requests outline what is to be submitted; please provide requested records within defined time-frames. Optum provides education and support as a component of our process.

Coverage and Limitations

The Florida Agency for Health Care Administration (AHCA) has published policy that enrolled providers must comply with in order to obtain reimbursement. The claims edits for Florida Medicaid conform to the reimbursement policies as published in the applicable Coverage and Limitations Handbook(s) as published by ACHA. The edits identified from the applicable publication(s) will be updated in our systems as new publications and changes are made.

Overview of ALERT Process

Chapter 3 of the Handbook, “Reimbursement and Fee Schedule” including Appendix A “Procedure Codes and Fee Schedule” details the reimbursement and service limitations that pertain to the specific procedure codes, Healthcare Common Procedure Coding System (HCPCS) Level II codes.

The Handbook specifies reimbursement guidelines by HCPCS code and modifier code, which include, but are not limited to:

- Duplicate services billed that will not be reimbursed on the same Date of Service to the same recipient

- Services which will not be reimbursed when billed on the same Date of Service at the same time as other billed services for the same recipient

Even when a written authorization lists a range of CPT and/or HCPCS codes, payment for any specific code is subject to ongoing administrative review of benefit limits. For a full list of services that are separately reimbursable please see the applicable Coverage and Limitations Handbook(s). Claim submissions not in compliance with these rules will be denied.

Additional information can be obtained by reviewing the applicable Handbook(s) maintained by AHCA:
http://ahca.myflorida.com/medicaid/review/specific_policy.shtml

CPT Code Authorization Requirements

Authorization is required for the below CPT Codes for Outpatient and Telemental Health Services. Please always call to verify.

90837	Psychotherapy, 60 min	Yes
96101	Psych Testing: per hour, Interpreting and preparing report	Yes
96102	Psych Testing (includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psychopathology, eg, MMPI and WAIS), with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face to face.	Yes
96103	Psych Testing	Yes
96116	Neuro Behavioral Status Exam	Yes
96118	Neuropsychological Testing, per hour of Psychologist's or Physician time, both face to face time adminstering tests to the patient and time interpreting these test results and preparing the report.	Yes
96119	Neuropsychological Testing, with qualified health care professional interpretation and report, administered by technician, per hour of technician time, face-to-face.	Yes
96120	Neuropsychological testing administered by a computer, with qualified health care professional interpretation and report.	Yes
90870	Electroconvulsive therapy (includes necessary monitoring)	Yes

Services Requiring Authorization

Authorization Required

The following services require authorization. Additional facility based services may also require authorization. If the service you are requesting is not listed here, please call the number on the back of the member's ID card to verify benefits and authorization requirements.

Inpatient Hospital

Crisis Stabilization Unit

Statewide Inpatient Psychiatric Program (SIPP)

Substance Abuse Residential

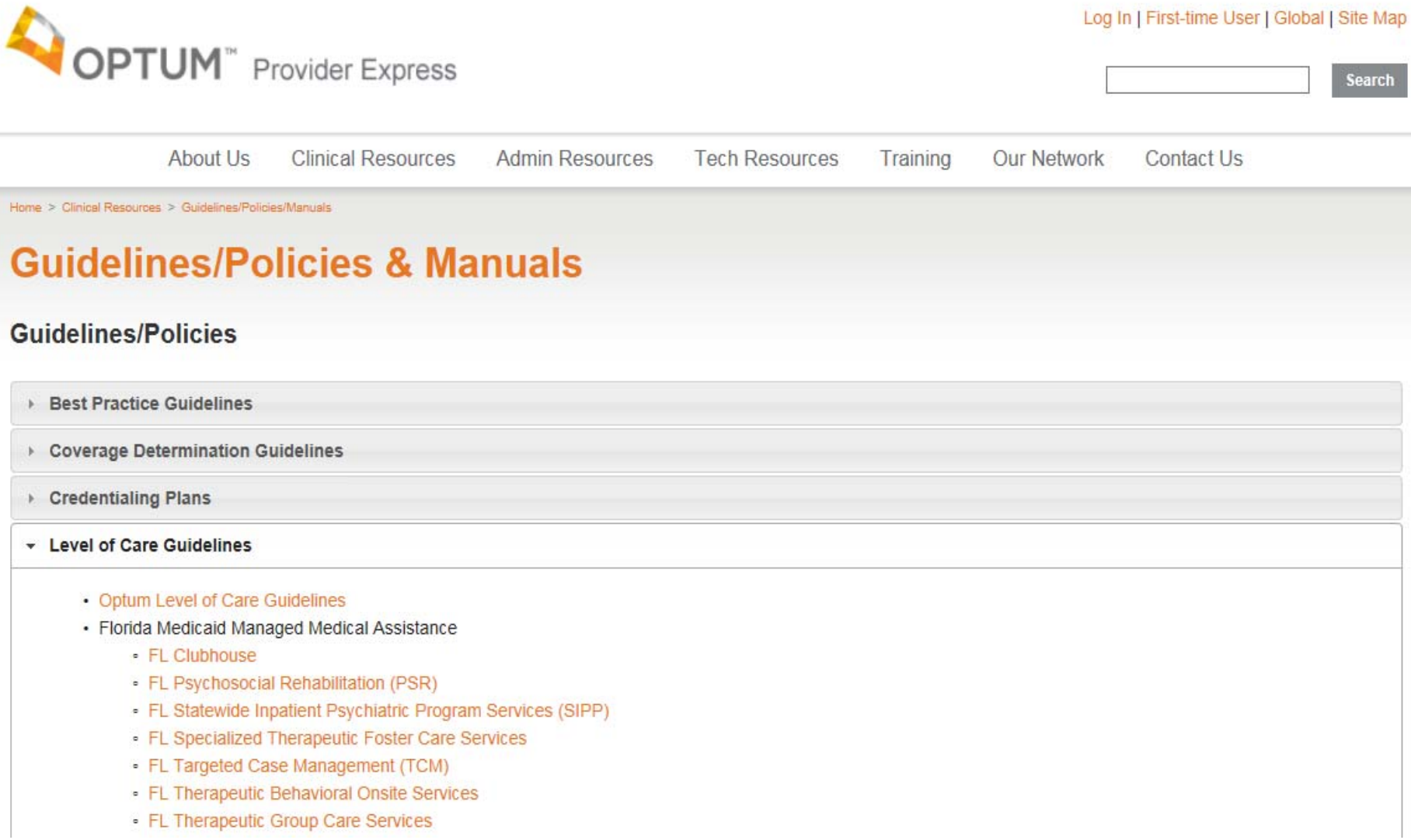
Psychological Testing using CPT Code

Specialized Therapeutic Foster Care – Level I, Level II, Crisis Intervention

Therapeutic Group Care Services

**Please be aware that Medicaid plans do not typically have out of network benefits (outside of any applicable continuity of care period) except for some emergency care.*

UBH Level of Care Guidelines



OVERVIEW OF CLAIM SUBMISSION GUIDELINES

Claim Submission Guidelines

- Optum follows claim submission guidelines as defined by the following organizations:
  - CMS (Centers for Medicare & Medicaid Services)
  - HIPAA (Health Insurance Portability and Accountability Act)
  - NUCC (National Uniform Claim Committee)

- Claims address: P.O. Box 30760, Salt Lake City, UT 84130
- UBH Electronic Payor ID is **87726**
- Providers may also submit their claims through www.providerexpress.com
- Claims must be submitted within 90 days of the date of service unless otherwise specified by contract.
- Clean claims are processed within contractual guidelines/requirements
- Clearinghouse Info: Provider can use vendor of choice
- **Claims Customer Service:** Please contact the number on the back of the member's ID card or on the Provider Remittance Advice

Claim Submission Guidelines

Provider hints to avoid denials:

- ✓Obtain authorization if needed
- ✓Make sure the provider on the claim form matches provider on the authorization and that services billed match authorization in system
- ✓Rendering licensed clinician must be listed on claim form
- ✓Rendering licensed clinician must be loaded in UBH claims payment system
- ✓If you have not submitted claims to Optum previously or your credentialing application is in process, you MUST submit a copy of your W9 with your claims to ensure claims will be procesed.

Claim Submission Guidelines

Provider hints to avoid denials:

AHCA State Table

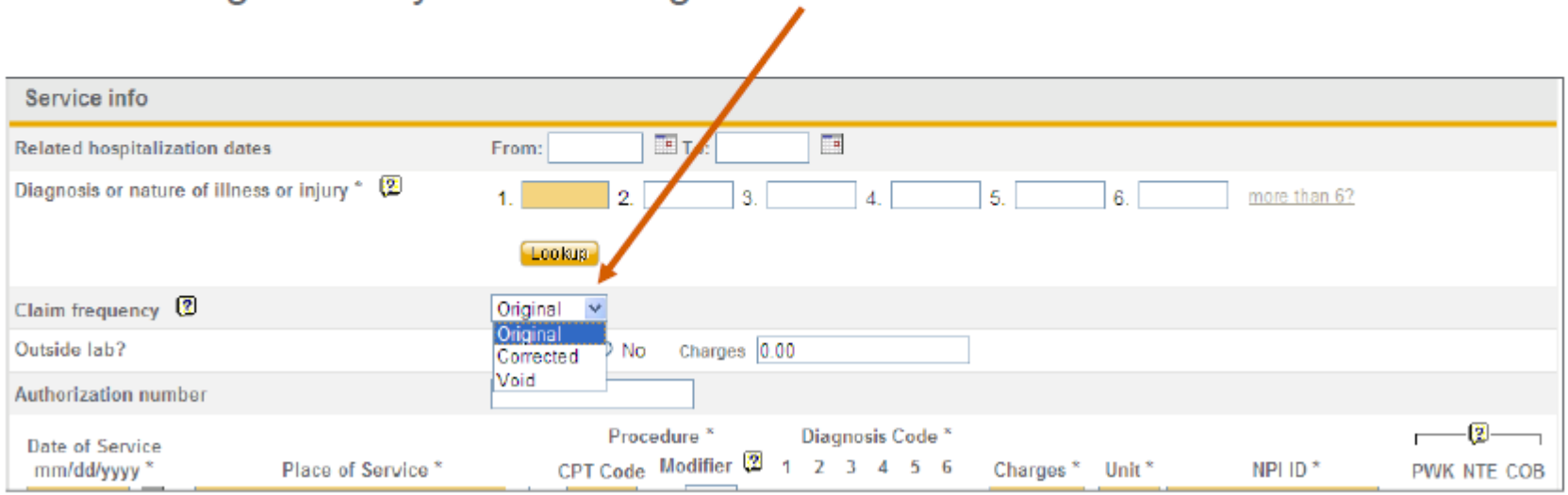
- ✓Make sure every NPI on the claim form matches an active Medicaid ID on the AHCA State Table

- ✓To review the AHCA State Table:
  - ➢Go to: http://portal.flmmis.com/flpublic/Provider_ManagedCare/Provider_ManagedCare_Registration/tabid/77/desktopdefault/+/Default.aspx
  - ➢Click on: Provider Master List spreadsheet
  - ➢Search excel by NPI or Medicaid ID
  - ➢Make certain that the NPI Crosswalk Effective dates and Medicaid Claims Eligibility dates are active
  - ➢If State Table needs to be updated/corrected, please contact AHCA directly at: 1-800-289-7799

Corrected Claims

Submitting Corrected (or Void) Claims

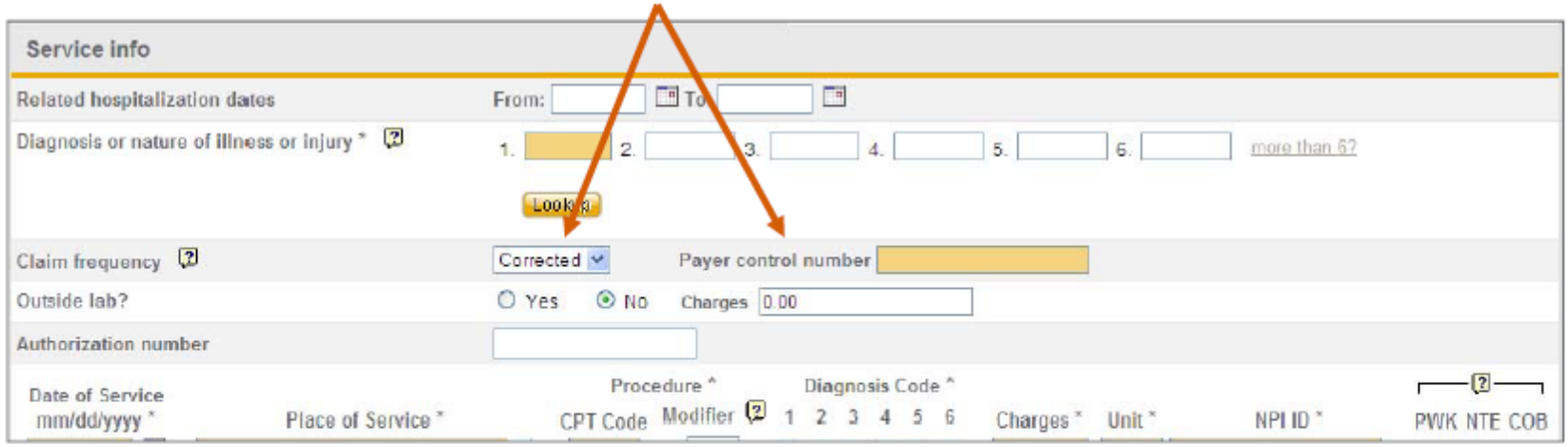
- Regardless of the claim form (short or long), you do have the ability to submit a corrected or void claim request as well, when a previously-submitted claim had incorrect information on it.
- In the Service info section, the “Claim frequency” code is what is used to determine the type of claim you are filing. Provider Express defaults to ‘Original’ but you can change it to ‘Corrected’ or ‘Void’.



Corrected Claims

Submitting Corrected (or Void) Claims

- As the help icon next to this section indicates:
  - **Claim frequency -** To submit a Corrected or Void claim, you will need to enter the Claim Number found on the claim record in Claim Inquiry. The claim number will also be reported on the paper remittance advice or electronic 835 file. You can not submit a Corrected or Void claim until a claim number has been assigned.



"Payer control number" = Claim number

Corrected Claims

Submitting Corrected Claim vs Claim Adjustment

Q: When should I submit a corrected claim via Claim Entry vs an adjustment via Claim Inquiry?

A: Use the following guidelines to help in your decision:

- If the issue with the claim was because of a problem in how it was originally filed by the provider/group that now needs to be corrected, submit a corrected claim via Claim Entry *(see pg 25)*

  e.g. filing an incorrect procedure code; forgetting a modifier

- If the issue with the claim was because of an alleged problem in how Optum processed it, submit an adjustment request via Claim Inquiry

  e.g. processing against member's deductible when it was already met; noting an auth was required when there is an auth on file

(please reference the Guided Tour video titled "Claim Inquiry and Claim Adjustment Request" for additional information)

Claims Customer Service/Centralized Appeal Line

Claims Customer Service:

Please refer to the phone number on the ID card or on the Provider Remittance Advice (PRA)

Centralized Appeals Dedicated Support Line:

866-556-8166

OPTUM INITIATIVES

Join Optum's *Express Access Network* and Optum will direct more referrals your way.

Want to increase your practice volume and generate more revenue? Sure you do. And Optum wants to help. We've created an innovative new provider subnetwork we call *Express Access Network*.

When you sign a contract addendum promising to offer Optum Members a routine appointment within 5 business days of a request, we will direct more referrals your way.

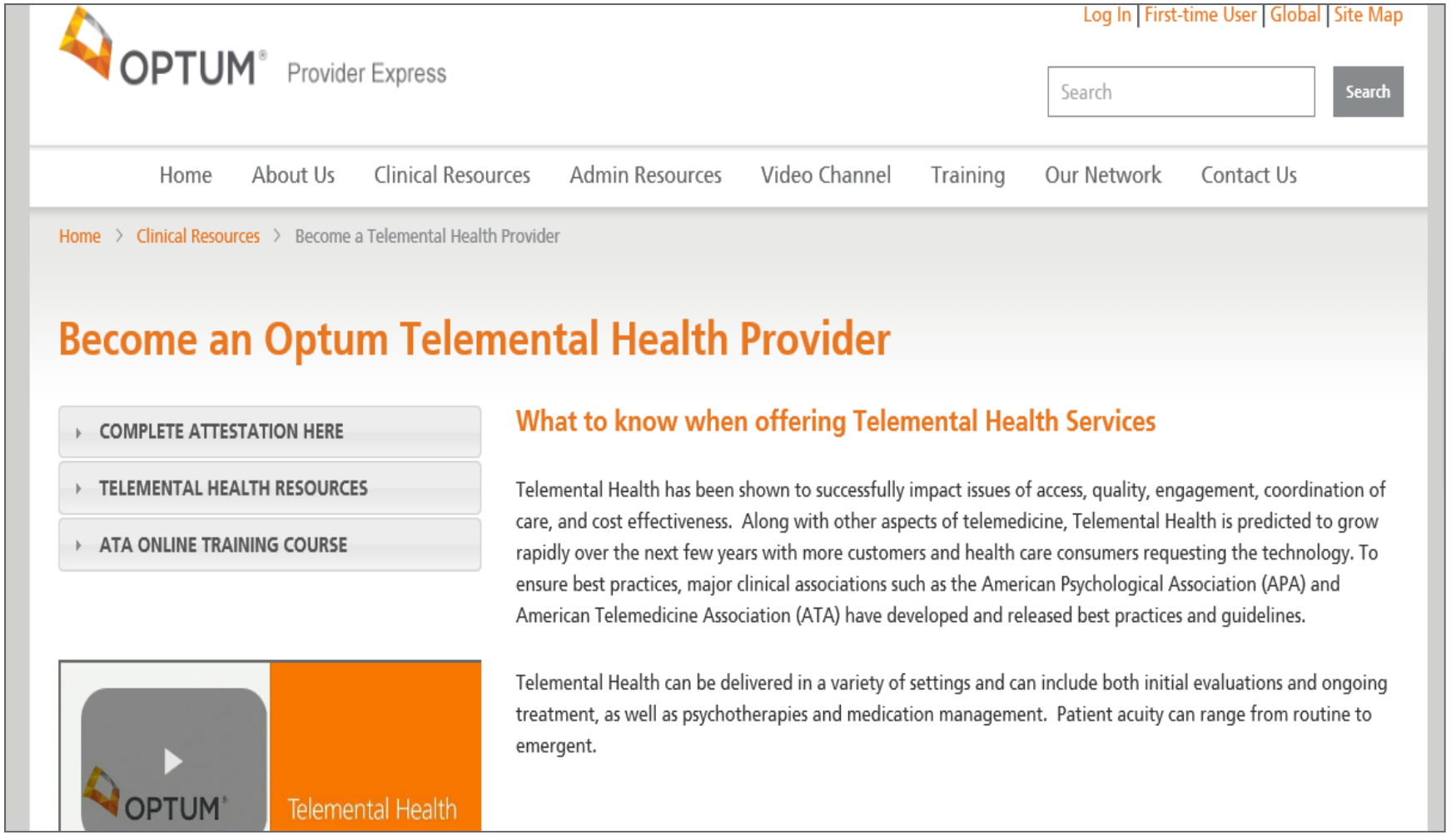
We do that by placing a stopwatch icon next to your name on our online provider directory, liveandworkwell.com. This stopwatch icon indicates to members and care advocates that you have promised to see members faster than other clinicians. We may also alert our key Optum customers in your area of your participation in the *Express Access Network*.

For more information or to receive a contract addendum, please contact your local Optum Network Manager or visit **www.ProviderExpress.com** .

Express Access Network

Become part of Optum's *Express Access Network* and start getting more referrals today.

Telemental Health



ACHIEVEMENTS IN CLINICAL EXCELLENCE

- Raises the bar on provider performance with new cost and quality measures, and additional tier levels

- Creates transparency which helps providers improve results (dedicated Optum team conducts regular review meetings to discuss improvement plans)

- Offers transparency to members to guide provider selections

- Includes technology to support providers' achievement

- Integrated incentive model that rewards top providers

PROVIDER RESOURCES

Resources Available on www.providerexpress.com

Site: www.providerexpress.com	Key Materials and Information
Clinical https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources.html	• Guidelines/Policies & Manuals • **Optum Network Manual** • **Level of Care Guidelines** • Best Practice Guidelines • Coverage Determination Guidelines • Credentialing Plans • Psychological Testing Guidelines • Newsletters • Forms • Recovery and Resiliency Toolkit
Administrative https://www.providerexpress.com/content/ope-provexpr/us/en/admin-resources.html	• ALERT Program • Claim Tips • Electronic/EDI information • Forms (administrative) ***Add/Change Form** • **Fraud, Waste and Abuse Information**
Technical https://www.providerexpress.com/content/ope-provexpr/us/en/admin-resources/technical-resources.html	• Web Browser Requirements • Encryption Information

Resources Available on www.providerexpress.com

Site: www.providerexpress.com	Key Materials and Information

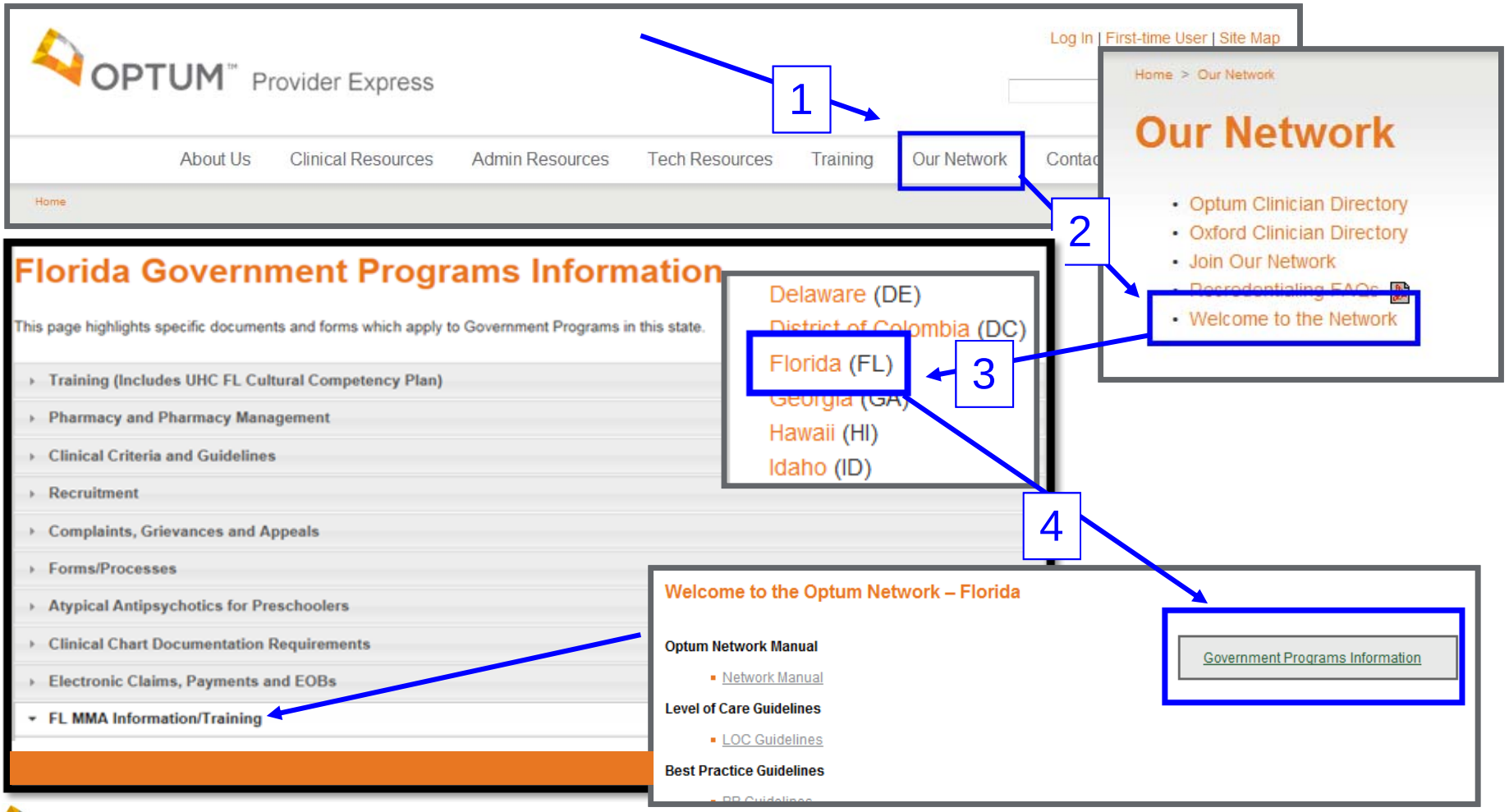
Trainings
https://www.providerexpress.com/content/ope-provexpr/us/en/training.html
	• Webinars/Training Resources
	• Guided Tours
	  • ALERT
	  • Auth Inquiry/Request
	  • Claim Entry
	  • Claim Inquiry and Adjustment
	  • Eligibility and Benefits
	  • My Provider Express
	  • Overview of Filing COB and Corrected Claims
	  • Message Center

Our Network https://www.providerexpress.com/content/ope-provexpr/us/en/our-network.html	• **Link to Live and Work Well – Provider Directory** • Join our Network page • Welcome to the Network page • Health Plan Partners information

Contact Us
https://www.providerexpress.com/content/ope-provexpr/us/en/contact-us.html
	• Contact Information for:
	  • Claims (Claim Issues, EDI, electronic payments and statements, appeals and provider dispute resolution)
	  • Network Management (Join Network, Provider Record Maintenance, Network Management Contact Information)
	  • Website (Technical Support)

Accessing a Copy of Today's Presentation

- providerexpress.com > 1 Our Network > 2 Welcome to the Network > 3 Florida (FL) > 4 Government Programs Information



Provider Relations Resources

Call Provider Service line at 877-614-0484 or
Call or Email the Network Manager for your Area/Region

Amy S. Rice, Director Behavioral Network Services, SE Region	amy.rice@optum.com 813-877-6829
Jennifer Durgee-Hemminger Network Manager (Region 3)	jennifer.durgee-hemminger@optum.com 612-632-5350
Jean Higgins, Senior Network Manager (Central FL)	jean.higgins@optum.com 770-200-6725
Rebeca Oliva Arzola, Senior Network Manager (South FL)	rebeca.oliva@optum.com 612-632-5668
Vonisha Lambert, Network Manager (In Training – South FL)	vonisha.lambert@optum.com
Desa Stevens, Network Manager (Central & North Florida)	desa.stevens@optum.com 763-361-7563

Questions

Thank you