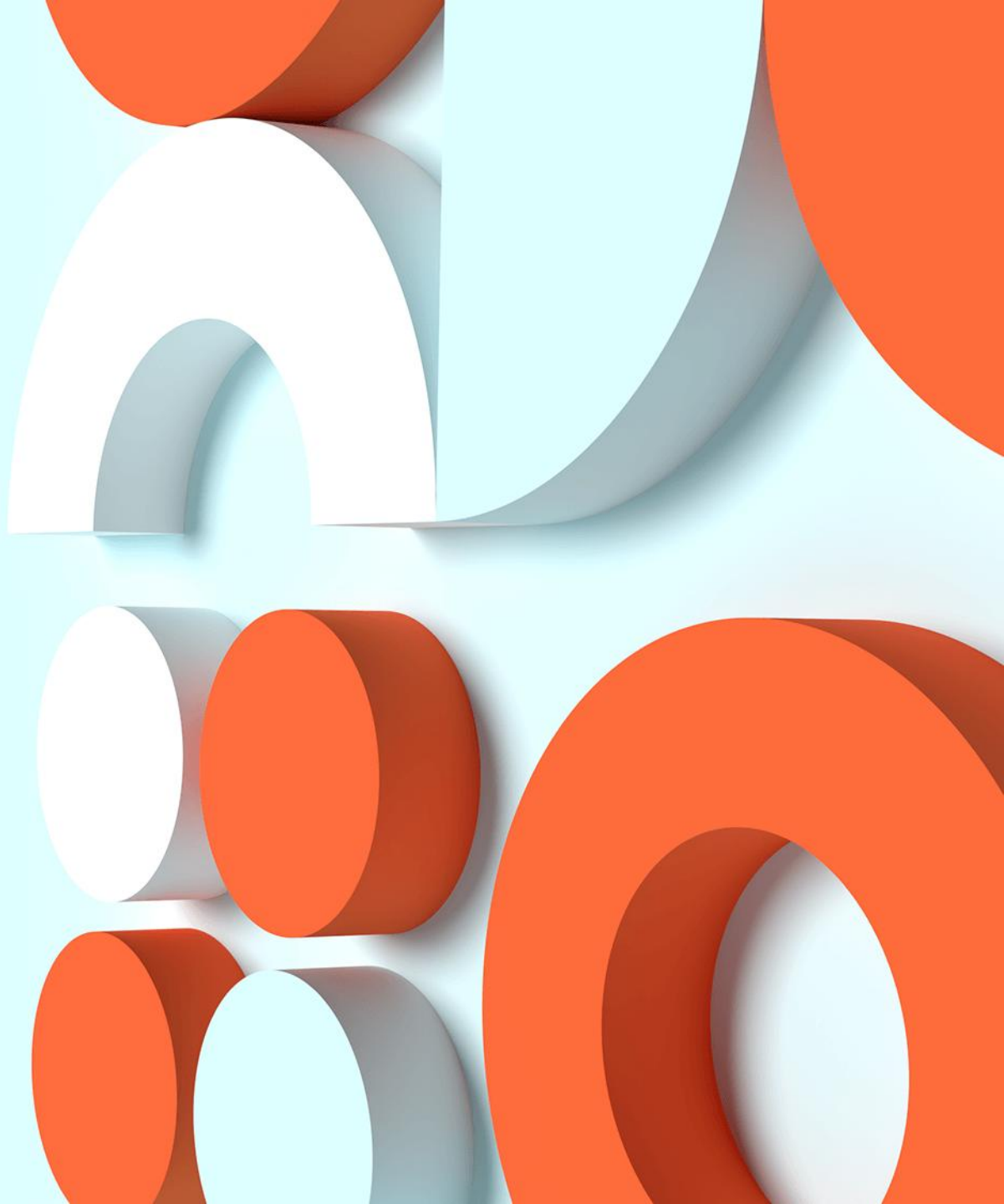
Optum

Welcome to Optum Behavioral Health

Provider Orientation

December 2025



Welcome to Optum

1. Introduction to Optum / Massachusetts Health Plans
2. Optum Behavioral Health Network
3. 21st Century Cures Act Contracting Requirements
4. Provider Responsibilities
5. Cultural Competency Training
6. Provider Express Secure Portal
7. Demographic Updates
8. Benefits, Eligibility, Claims, Appeals and more
9. Providerexpress.com Website
10. Massachusetts State Webpage
11. Clinical Program and Network Integrity
12. Contacting Optum and Understanding the Service Model

Introduction to

Optum Behavioral Health / Massachusetts Health Plan Partners

Who is Optum?

Optum is a leading health services organization dedicated to making the system work better for everyone.

Our core values:

Integrity | Compassion | Relationships | Innovation | Performance

Optum

Massachusetts Health Plan Partners

UnitedHealthcare®

Helping people live healthier lives

Health care coverage and benefits:

- Employer & Individual
- Medicare & Retirement
- Community & State
  - Senior Care Options (SCO)
  - One Care
- Military and Veterans
- Global

Mass General Brigham Health Plan

- Medicaid
- Commercial/Exchange
- Medicare Advantage
- Senior Care Options (SCO) effective 01/01/2026
- One Care effective 01/01/2026

The Optum Behavioral Health Network

Network Participation Status

Credentialing Plans

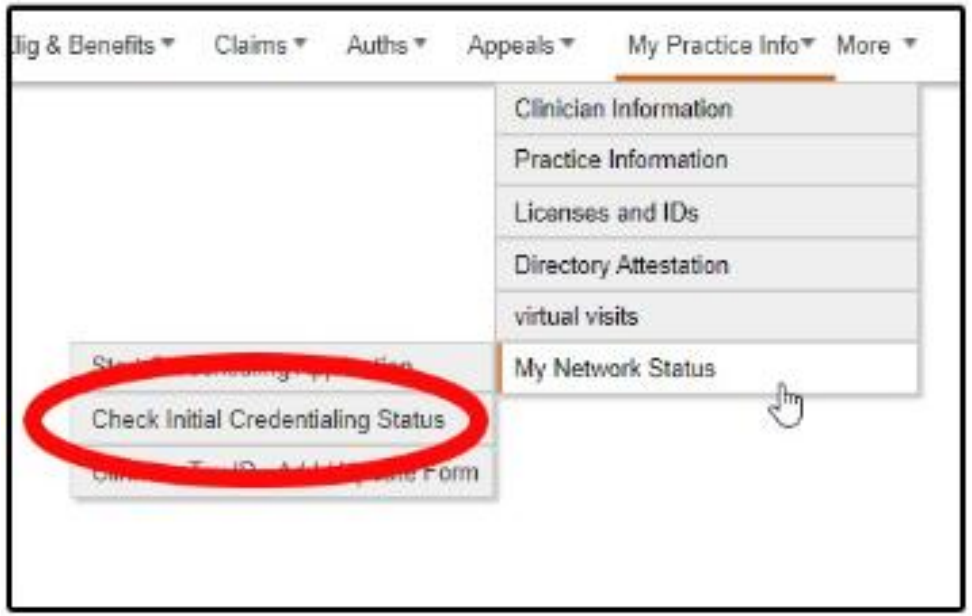
These plans provide an overview of Optum Behavioral Health policies for provider credentialing, recredentialing and ongoing monitoring. The process described in these plans will be initiated only after we make a preliminary determination that we want to pursue contracting or re-contracting with the applicant. Please review for more information.

Optum Behavioral Health - National

Initial Credentialing Status

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 Provider Express secure portal:

- Go to Providerexpress.com
- Log In (upper right) with your One Healthcare ID/password
- Hover over *My Practice Info* > *My Network Status*
- Click on *Check Initial Credentialing Status*.



Checking Network Effective Date and Plan Participation

You can verify your network status and which plan(s) you are contracted for at any time using the secure portal. Log in using your One HealthCare ID > My Practice Info > My Networks

For assistance with the credentialing tool in the secure portal, you can chat with a live representative or call the help desk at 1-866-209-9320.

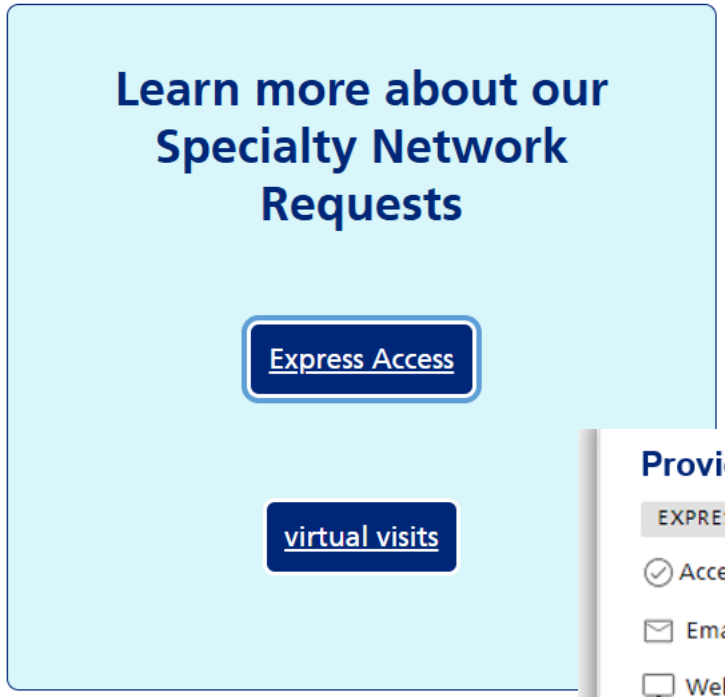
Network	Network Status	Effective Date	Termination Date
	Active		
Applied Behavior Analysis Network	Active	11/18/2024	12/31/9999
MA ABA Medicaid	Active	11/18/2024	12/31/9999
MA Medicaid	Active	08/01/2023	12/31/9999
MA One Care MMP	Active	10/01/2023	12/31/9999
Mass General Brigham Employees	Active	09/01/2022	12/31/9999
Mass Senior Care Option	Active	10/01/2023	12/31/9999
Medicare	Active	02/27/2017	12/31/9999
UBH General	Active	01/01/2019	12/31/9999

Please note:

- The Massachusetts Medicaid network is equivalent to Mass General Brigham Health Plan ACO
- The United Behavioral Health (UBH) general network is equivalent to the Optum commercial line of business

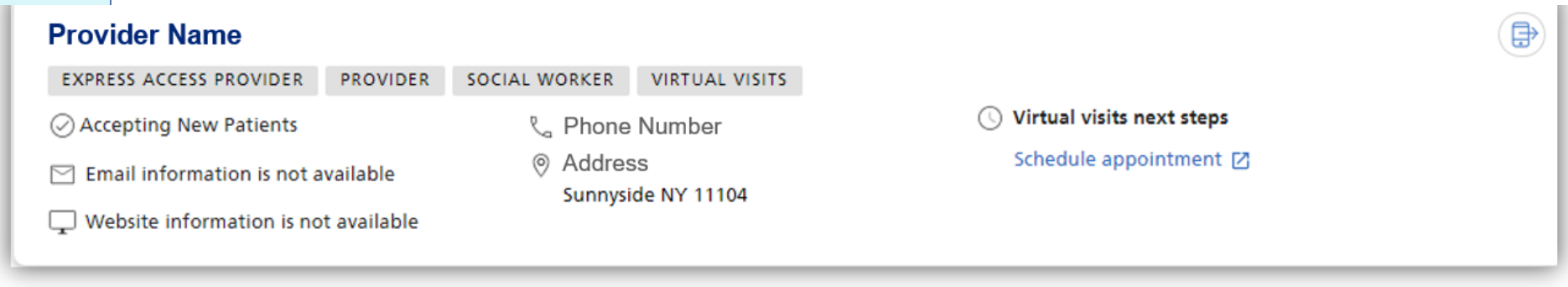
Express Access Network

Express Access Network is a network of Optum-credentialed providers who have agreed to offer Optum members, on all lines of business including EAP, a **routine** appointment within 5 business days of a member's request.



Learn more: [Express Access Network]

Enroll: [Click here]



21st Century Cures Act Contracting Requirements

21st Century Cures Act

Overview

In accordance with 21st Century Cures Act regulations, all providers rendering services to Medicaid or Medicare members must be enrolled with the State in which those members are covered. MCE complies with those regulations and the guidance outlined by MassHealth for providers rendering services to Senior Care Options and One Care members.

Contracting Requirements

All Optum network providers must have two provider contracts in place:

1. A network provider contract with Optum; and
2. A MCE nonbilling network-only contract with MassHealth.

Enrollment with MassHealth is not currently required to join the network. However, to remain in the network, providers must obtain a Medicaid ID within 120 days of joining. Providers who do not enroll and obtain a Medicaid ID within 120 of acceptance into network, will be terminated. Consequently, they will no longer be eligible to receive payment for services rendered to Massachusetts Medicaid members.

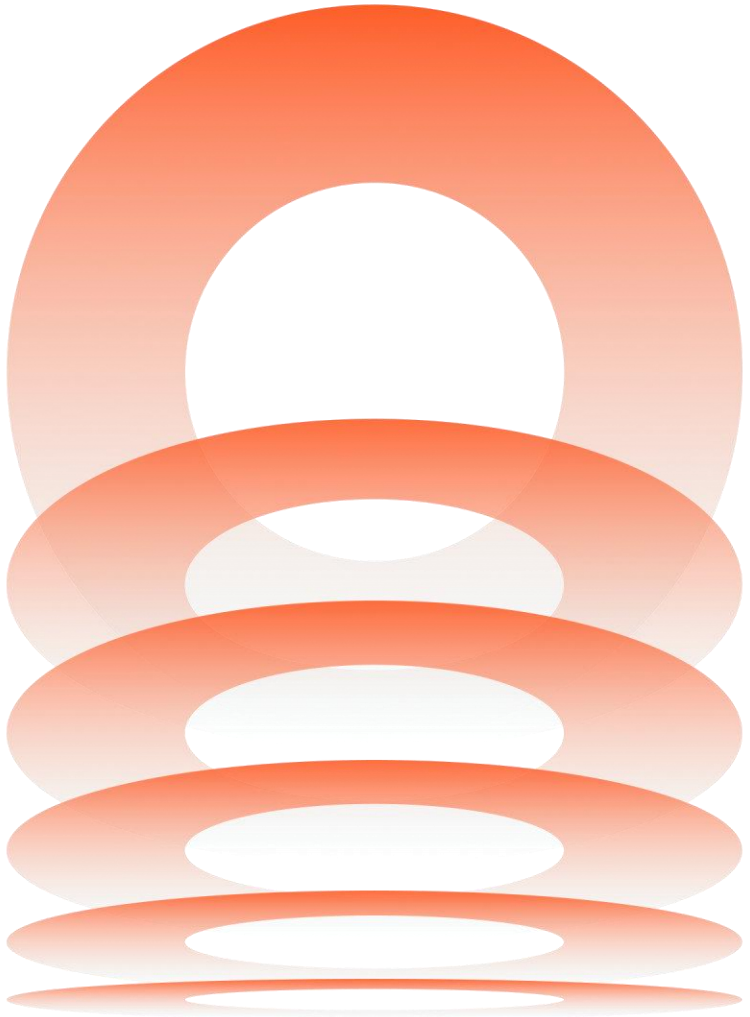
Questions?

- Email MassHealth at provider@masshealthquestions.com or call 1-800-841-2900.
- Call the Optum Provider Service Line at 1-877-614-0484 and request that a case be opened and routed to an appropriate resource to assist
- **Credentialing/Contracting Questions:** Review the 21st Century Cures Act MassHealth Frequently Asked Questions

Provider Responsibilities

Provider Responsibilities

- **Render services to members in a non-discriminatory manner**
  - Maintain availability for a routine level of need for services
  - Offer routine non-urgent appointments within 10 days of the request for services
  - Provide after-hours coverage
  - Support members in ways that are culturally and linguistically appropriate
- **Determine if members have benefits** through other insurance coverage
- **Advocate for members** as needed
- **Update your demographic information within 10 calendar days** in the Provider Express secure portal whenever you make changes to your office location, billing address, phone number, Tax ID number, entity name, or active status (e.g., close your business or retire). This includes roster management.
  - Go to Providerexpress.com > Log In > My Practice Profile



Recredentialing

- Recredentialing is **completed every 36 months (3 years)** – this timeline is established by NCQA
- Providers are required to **attest to their data every 90 days**, as outlined in the Consolidated Appropriations Act (CAA)
- 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 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

Billing Under Supervision

Outpatient services rendered under supervision are generally performed by unlicensed practitioners working toward clinical licensure or other practitioners who are not eligible to practice independently.

Providers are required to practice within the scope of their license when supervising another clinician.

- **Massachusetts Medicaid:** Please review the MA Medicaid QRG Billing Under Supervision on Billing Under Supervision and update your billing practices accordingly. This guidance applies exclusively to Massachusetts Medicaid claims.
- **Commercial:** Please view the commercial reimbursement policy for billing Services Rendered Under Supervision
- **Medicare:** Medicare does not permit supervisory billing. While this approach is common under Medicaid and some Commercial insurance plans, it is expressly prohibited by Medicare regulations.

Cultural Competency

Cultural Competency

Advancing health equity for those we serve

Sign up for new on-demand Cultural Sensitivity Training courses

Review training options

At Optum, we believe it is critical for providers to understand Cultural Competency in order to ensure members get culturally sensitive and appropriate care.

- Cultural competency may be viewed in terms of a continuous progression of growth, development and change.
- It's important both for individuals and organizations to continuously and intentionally work to develop and strengthen competencies in order to provide effective services to diverse populations.

Using the Provider Express Secure Portal

24/7 Access to Member and Claim Info

Benefits of Using the Provider Express Secure Portal

Available 24/7, Provider Express makes it fast and easy to complete member-specific and claim-related tasks – and it helps reduce paper and telephone transactions.

Use the Secure Portal to:

- Verify member eligibility and plan benefits
- Request prior authorization and check status of requests
- Submit claims, check claim status and submit corrected claims
- Request reconsideration of claims and submit appeals
- Update your demographic information – office address, phone number, your license info and more
- Attest to the accuracy of your information every 90 days

Training on many of these tools is available on Providerexpress.com > Training

Technical support: Call the Provider Express help desk at 1-866-209-9320 for assistance with troubleshooting your secure portal account.

Optum

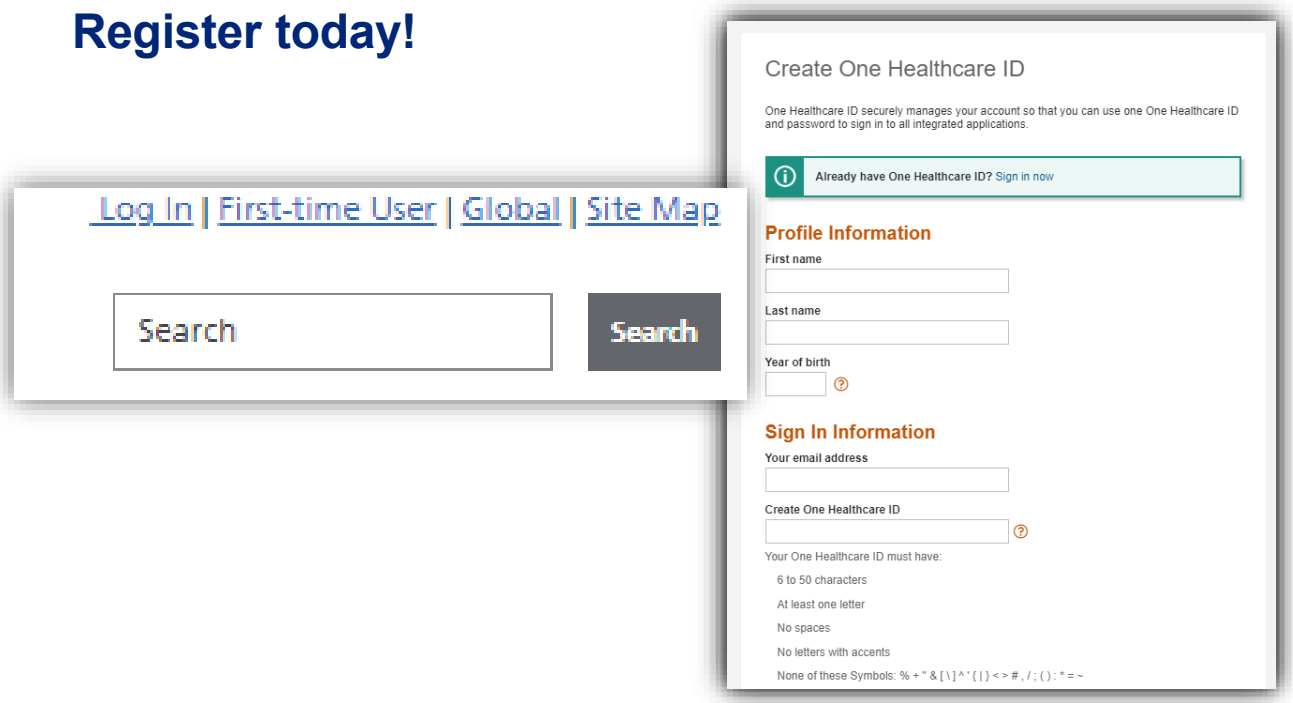
Registering for the Optum Provider Express Secure Portal

The Provider Express secure portal gives you 24/7 access to patient- and practice-specific information.

Through the Provider Express secure portal you can:

- Submit credentialing applications to join our network
- Review member eligibility and benefits
- Check prior authorization requirements and submit requests
- Update your provider and practice information, and more!

Register today!



It's easy!

- ✓ Go to Providerexpress.com
- ✓ Select "First-time User" in the upper right corner
- ✓ Follow the prompts to create your One Healthcare ID and password

Need help?

- Review the guide to create your log-in ID
- Contact the Provider Express Support at **1-866-209-9320**
  - Available 7 a.m. – 7 p.m. CT
  - Live chat feature also available

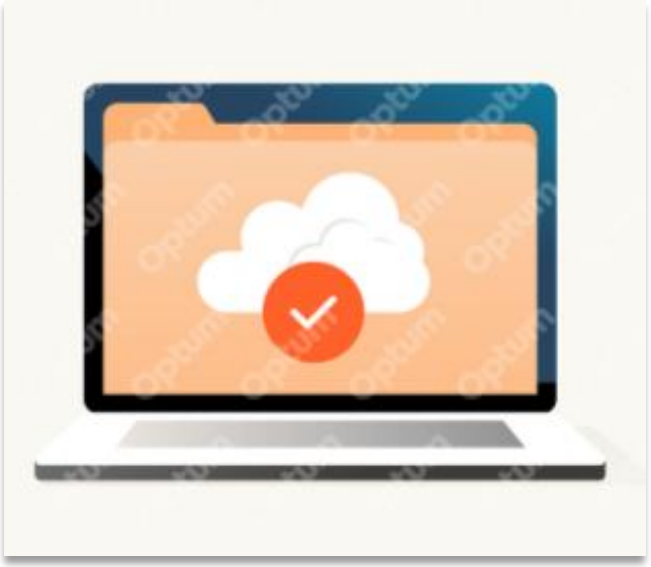
Optum

New – On-Demand Portal Training Available 24/7

Training on your time, any time.

The training courses are easy to review from any device

- Step-by-step instructions on how to complete various tasks in the portal
- The course MENU outlines all topics and tasks covered within the course
- Review the course from start-to-finish OR
- Select a specific topic you need for quick reference
- Switch to a different course at any time

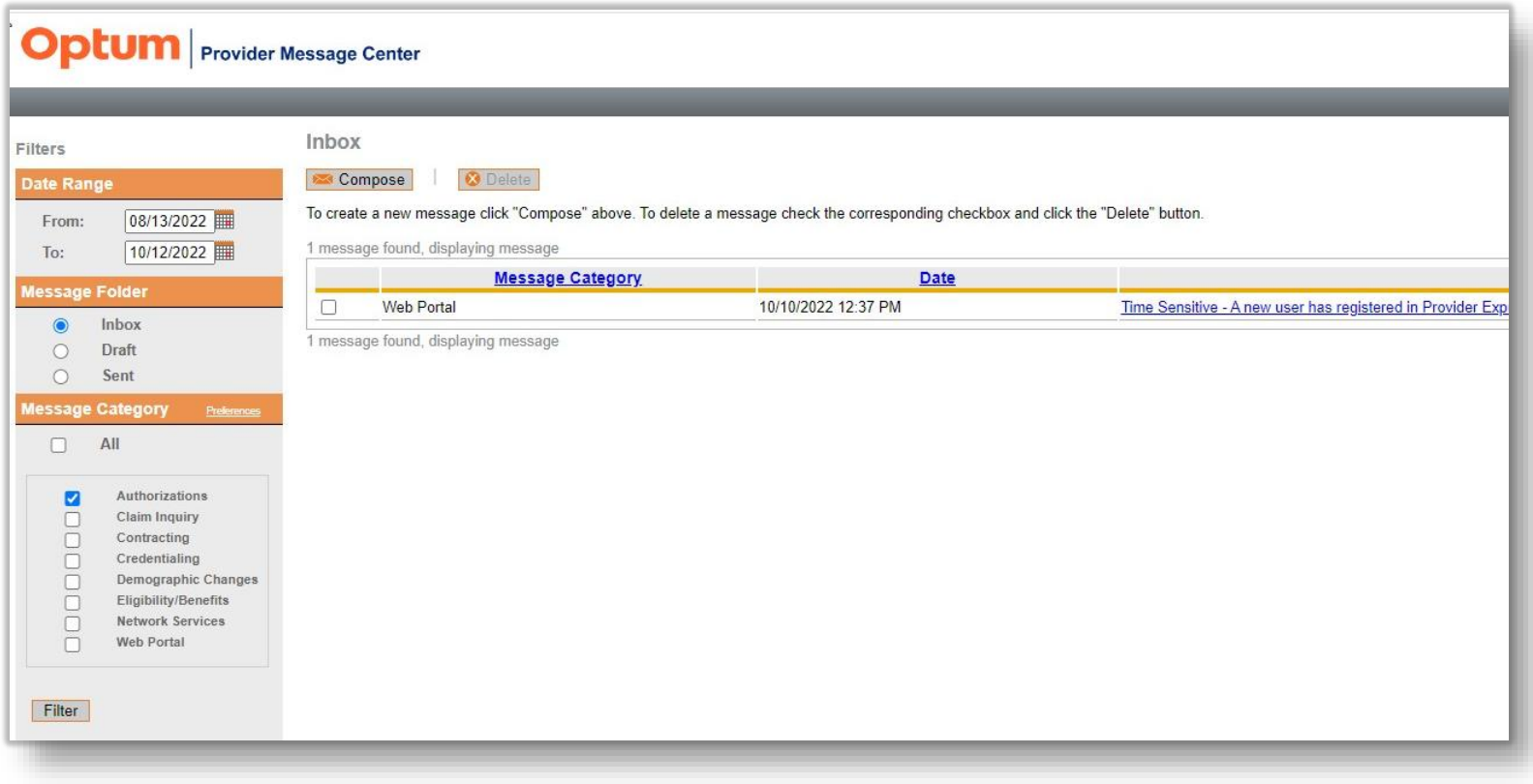


No need to contact your Advocate, wait for an email reply or pause your work until the Provider Service line opens – The help you need is just a few clicks away.

Go to Providerexpress.com > Training. Additional courses are being added weekly.

Message Center

Message Center is an online tool within the Provider Express secure portal that enables you and Optum staff to communicate with each other within a secure channel.



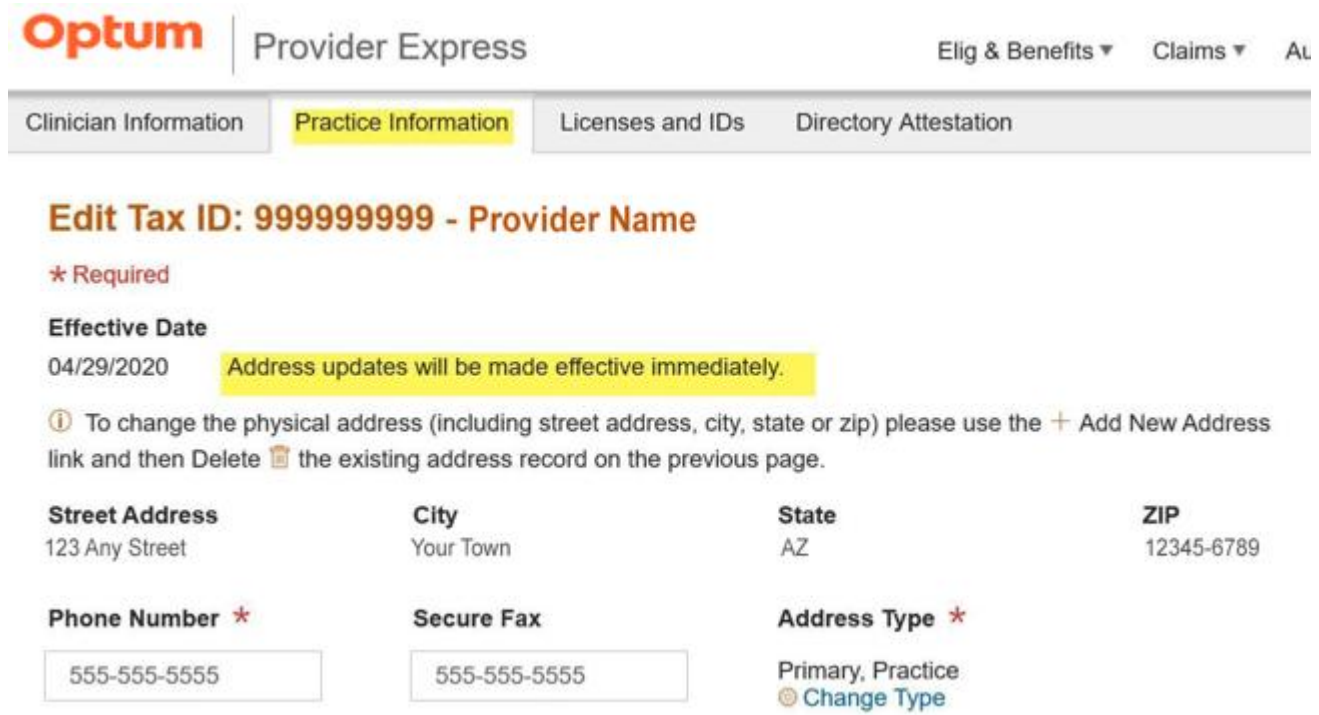
Demographic Updates

Keep Your Information Current With *My Practice Info*

Having the most up-to-date information at Optum ensures that you get reimbursed promptly and accurately, and that members who are referred to you can schedule appointments.

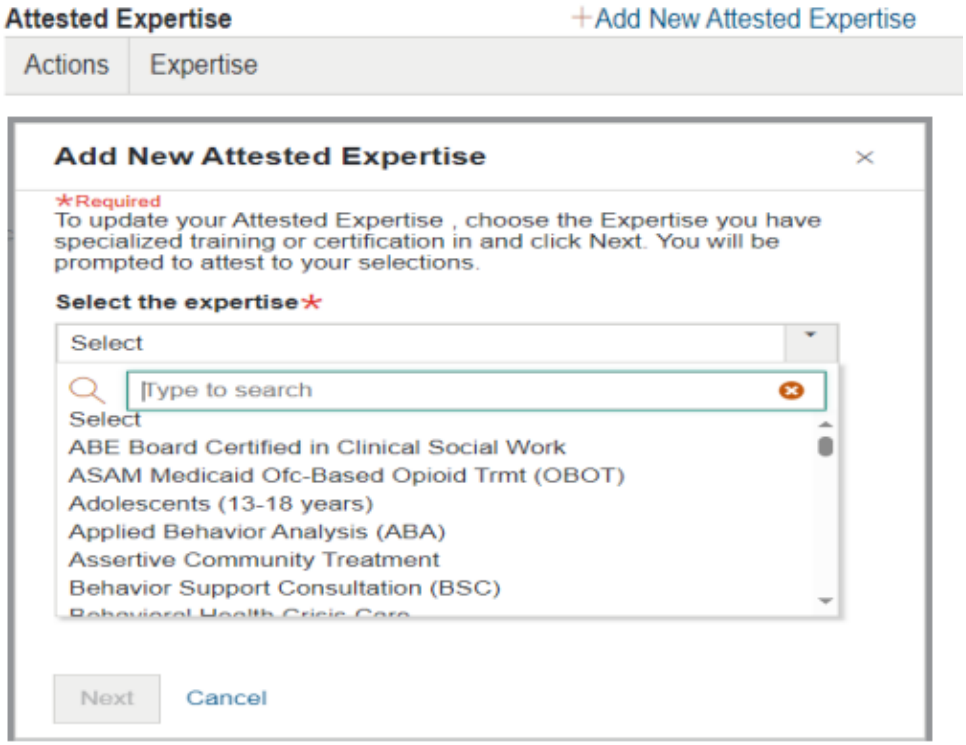
You are required to verify demographic information listed in the provider directory every 90 days.

- 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



My Practice Info – Updating Area of Expertise

Area of Expertise (AOE) is an indicator within our provider directory that displays your unique experience, training and certifications. These indicators help members identify a clinician who can best meet their behavioral health needs.



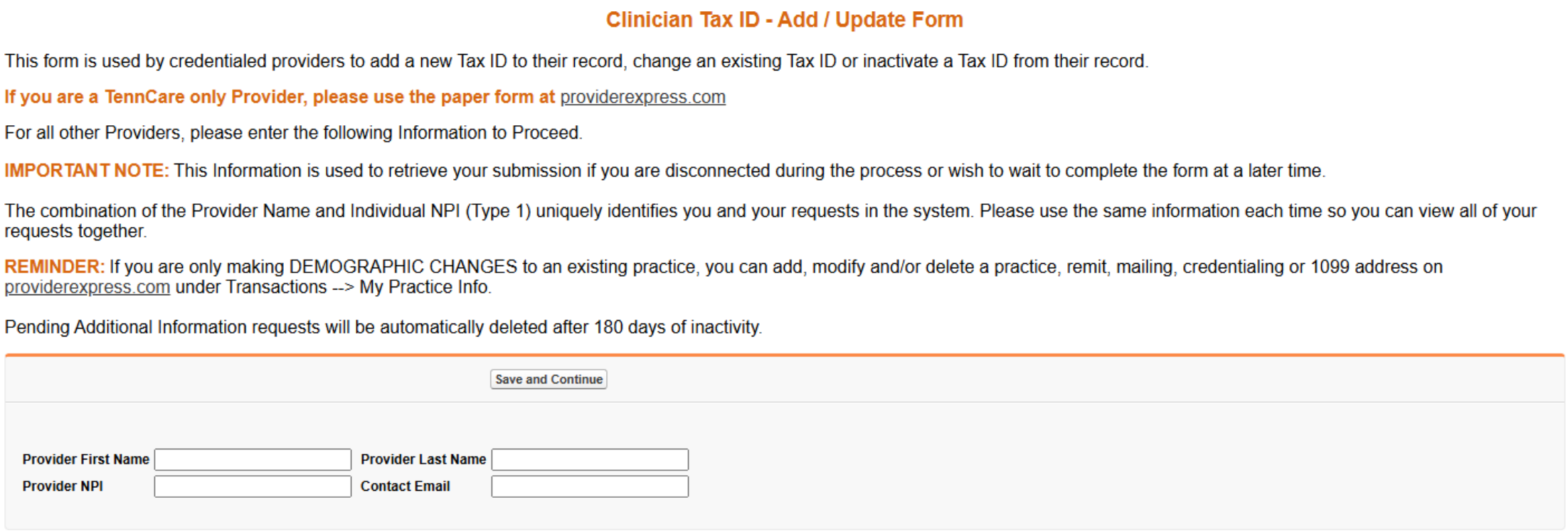
When you review and update your demographic information, be sure to review your area of expertise designations.

Individually contracted providers can add or delete expertise as well as submit the required documentation for attested area of expertise.

Provider Tax ID add/update

The Add/Update 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.

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



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.

If you are a TennCare only Provider, please use the paper form at providerexpress.com

For all other Providers, please enter the following Information to Proceed.

IMPORTANT NOTE: This Information is used to retrieve your submission if you are disconnected during the process or wish to wait to complete the form at a later time.

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.

Pending Additional Information requests will be automatically deleted after 180 days of inactivity.

Save and Continue

Provider First Name | Provider Last Name

Provider NPI | Contact Email

Eligibility and Benefits

Understanding Covered Benefits

Massachusetts members have a variety of behavioral health benefits available to them

- Benefits vary by plan

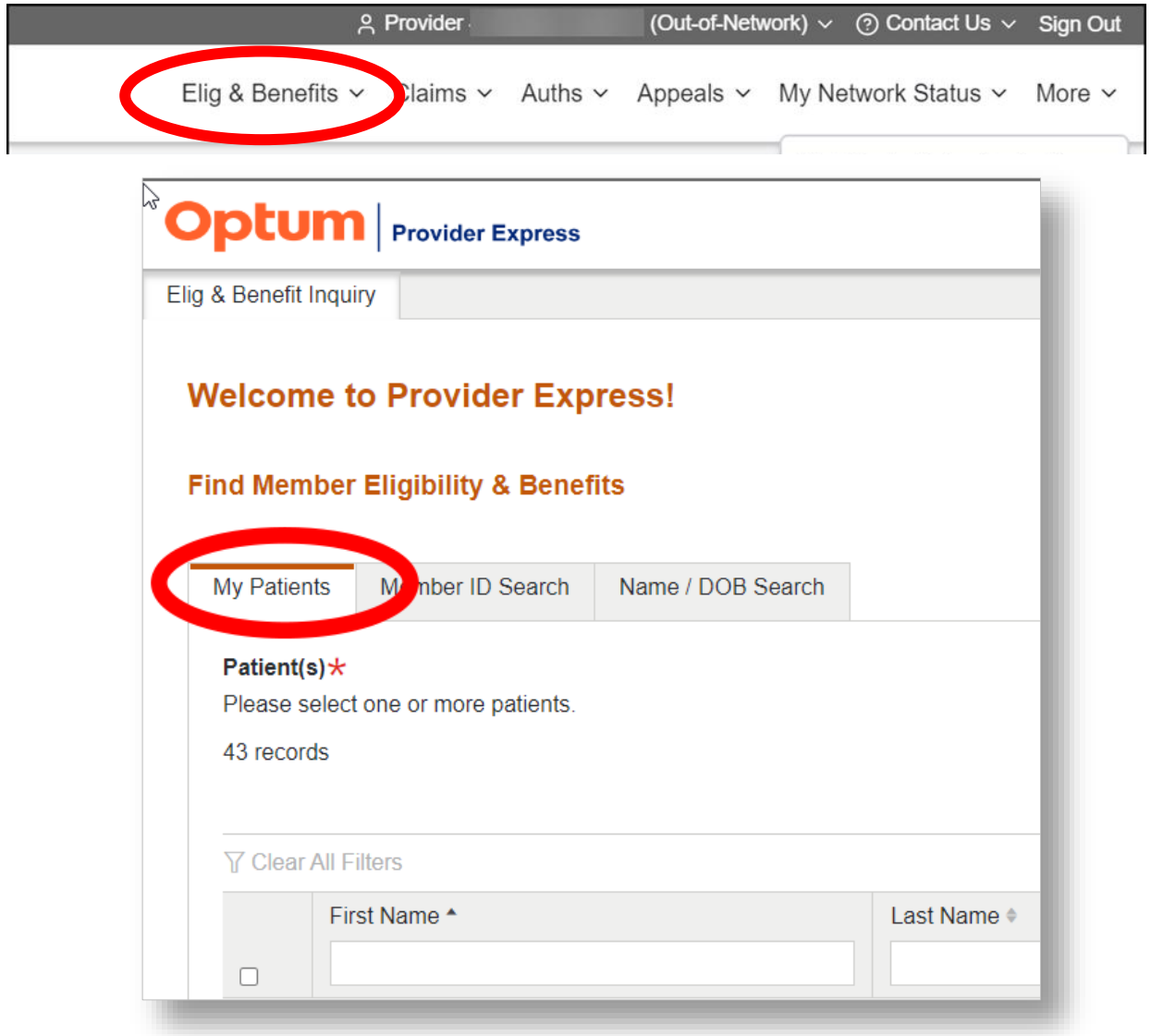
Always check benefits before providing services to an Optum Behavioral Health member:

- Through the Provider Express secure portal, OR
- Calling the number on the back of the member's ID card

Follow evidence-based clinical criteria to develop treatment plans

- Optum uses proprietary clinical criteria as well as criteria from organizations such as the American Society of Addiction Medicine (ASAM) and others to make coverage determinations
- In using its clinical Criteria, Optum takes individual circumstances and the local delivery system into account when determining coverage of behavioral health services.

How to Check Eligibility and Benefits



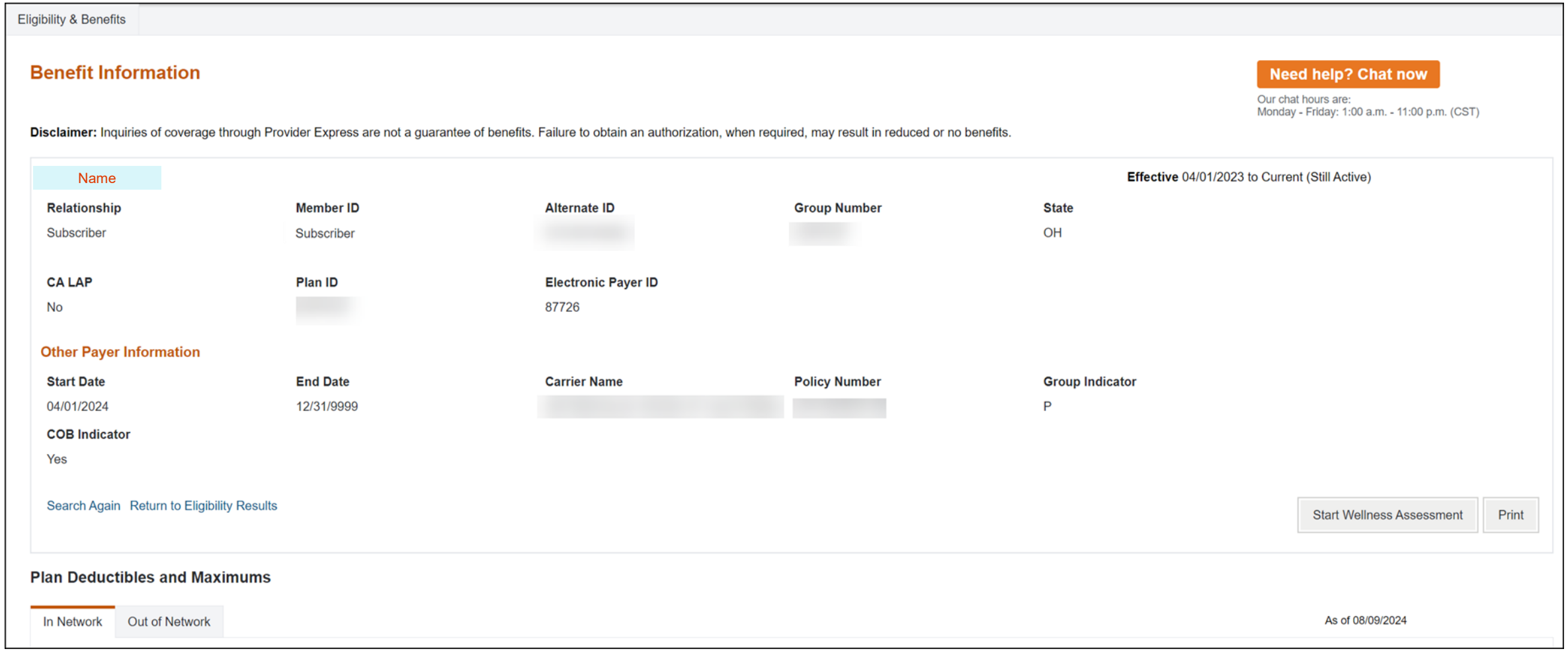
There are 3 ways to search for a member's eligibility:

- My Patients list
- Member ID Search
- 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.

My Patients list is also customizable at a user level – If you have admin staff supporting you, each can maintain their own list.

Benefit Information



Deductibles and Out-of-Pocket Limits

In-Network or Out-of-Network

Plan Deductibles and Maximums

In Network | Out of Network

As of 08/09/2024

Deductible

	Individual	Family
Plan Amount	$0.00	$0.00
Met Year To Date	N/A	N/A
Remaining Amount	**$0.00**	**$0.00**

Out of Pocket

	Individual	Family
Plan Amount	$0.00	$0.00
Met Year To Date	N/A	N/A
Remaining Amount	**$0.00**	**$0.00**

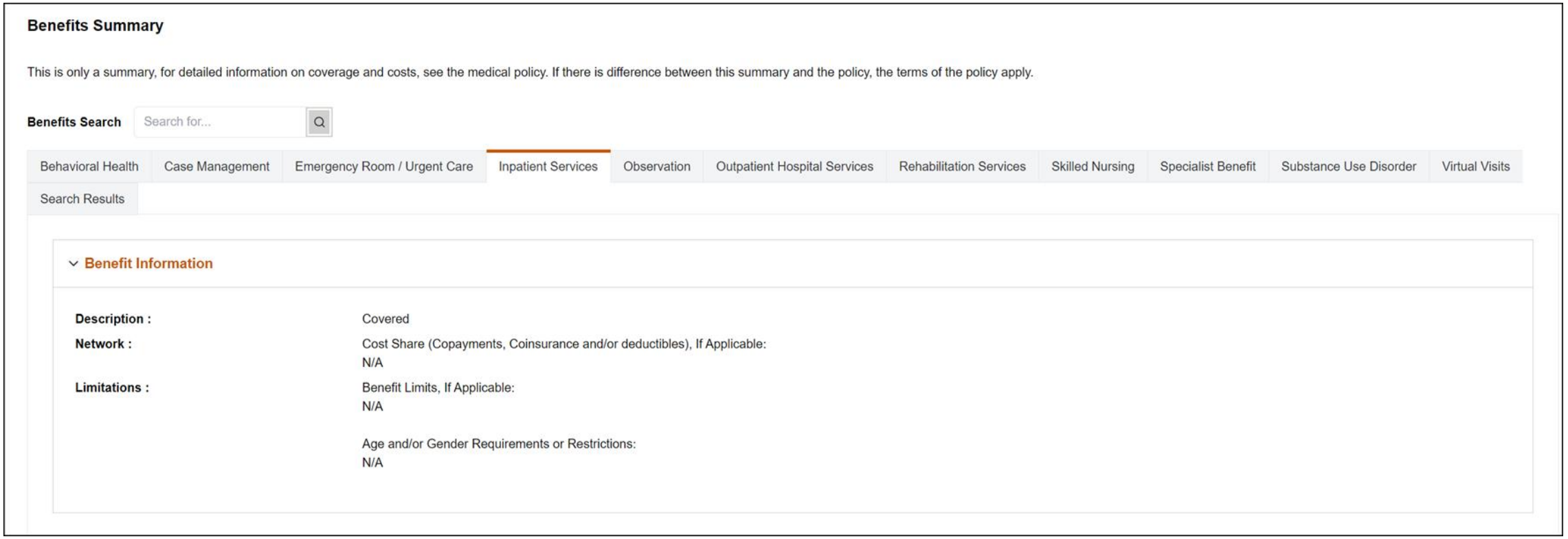
Out of Pocket 2

	Individual	Family
Plan Amount	N/A	N/A
Met Year To Date	N/A	N/A
Remaining Amount	**N/A**	**N/A**

Copayment Maximum

	Individual	Family
Plan Amount	N/A	N/A
Met Year To Date	N/A	N/A
Remaining Amount	**N/A**	**N/A**

Benefits Summary



Prior Authorizations

Checking Prior Authorization Requirements

Most routine outpatient services do not require prior authorization

Common services that require authorization

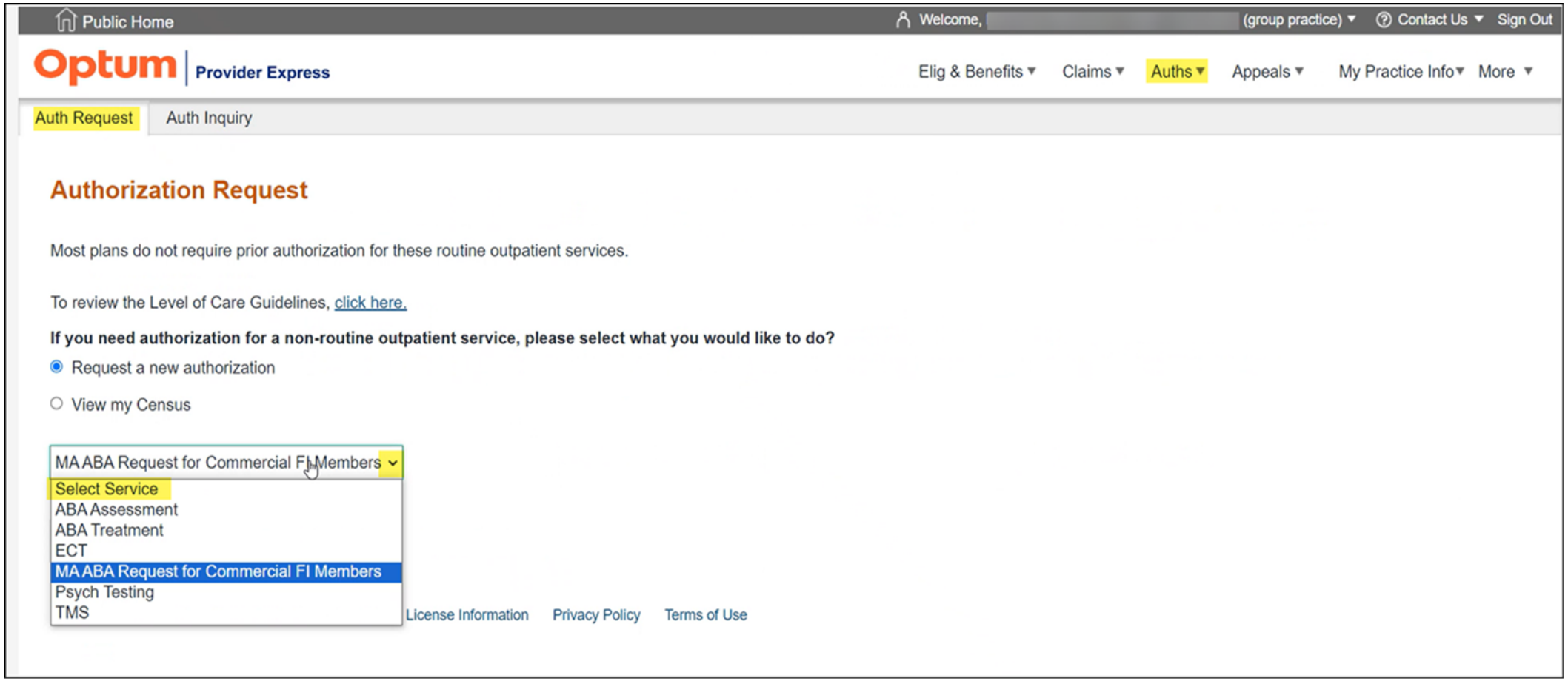
- Psych/neuropsych testing
- Partial hospitalization programs (PHP)
- Intensive outpatient treatment (IOP)
- Residential substance use disorder treatment

Two ways to check requirements

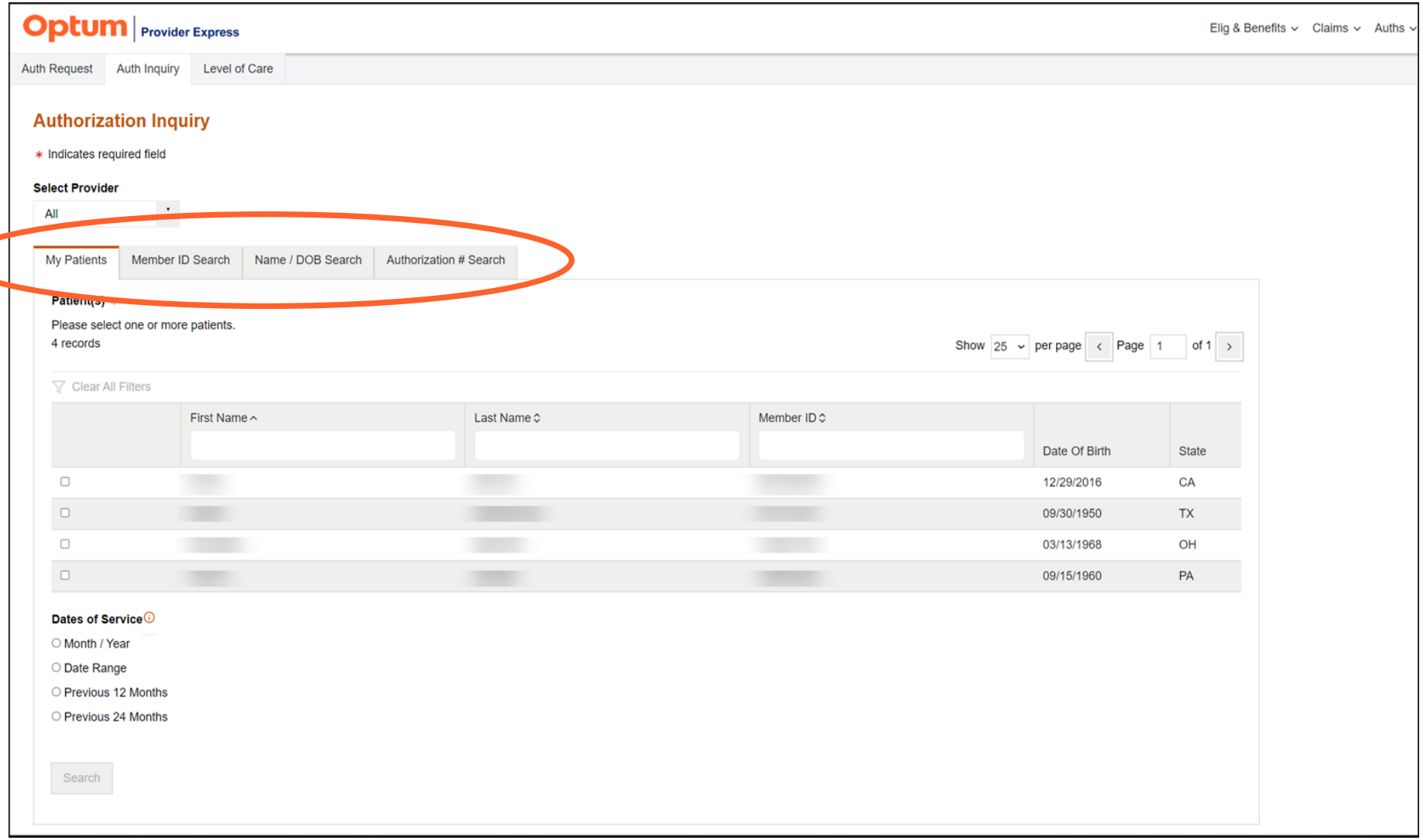
1. **Prior Authorization and Notification for Optum Behavioral Health**
   On our website, you'll find lists of billing codes that require authorization, organized by line of business (Commercial, Medicaid, etc.) and then by plan.

2. **Eligibility and Benefits check within the Provider Express secure portal**
   The Benefits Summary page will detail applicable requirements

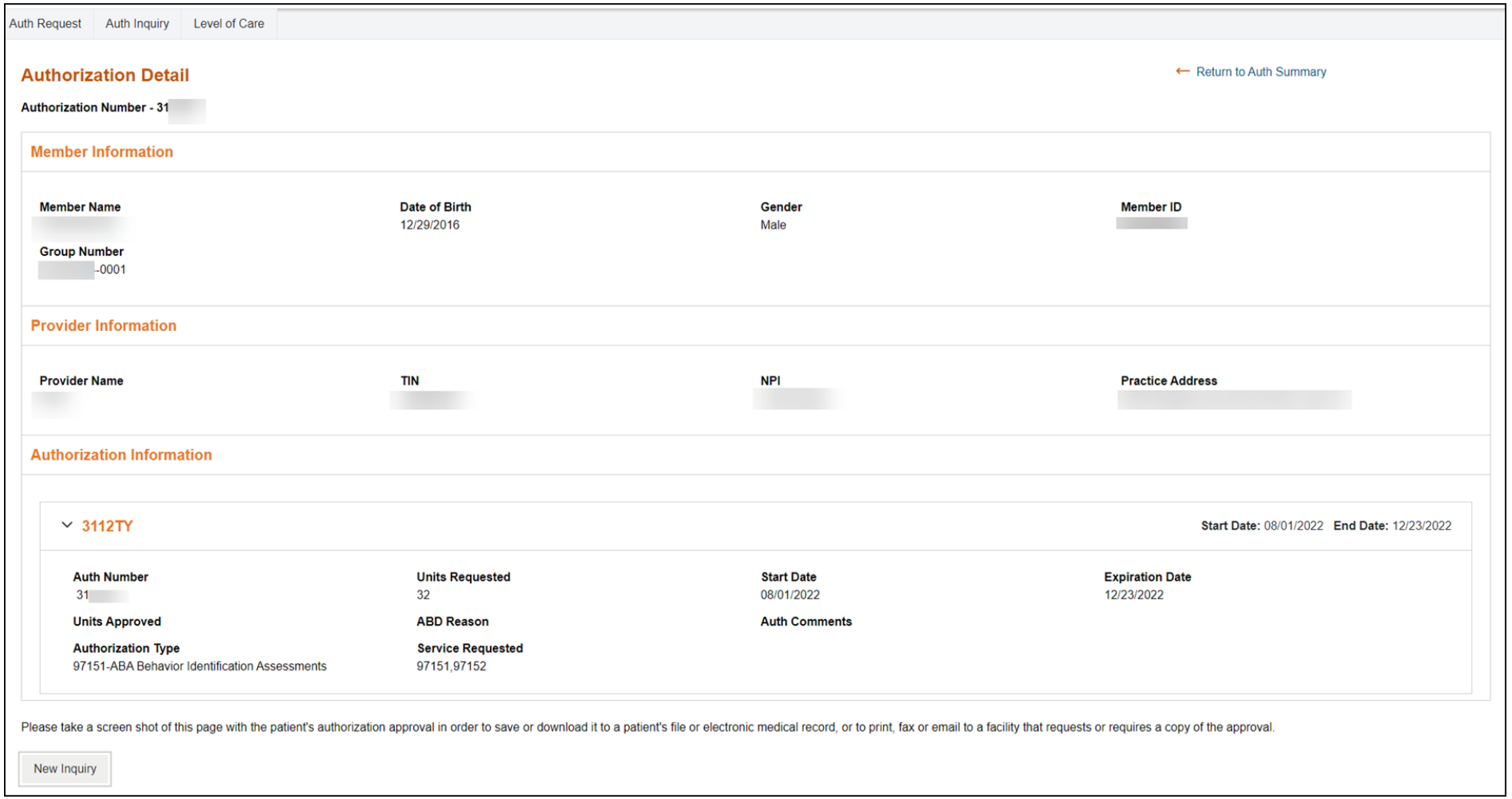
How to Submit a Prior Authorization Request



Authorization Inquiry



Authorization Detail



Claims / Billing

Receive payments faster

Benefits of Optum Pay™

- Easy setup, free to use the basic edition
- 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

Electronic Claim Submission Options

Electronic Data Interchange (EDI)

- Secure, efficient and cost-effective
- You may use any clearinghouse vendor to submit claims
- Payer ID for submitting claims to Optum is **87726**
- Additional information is available on Providerexpress.com > Admin Resources > Claim Tips > EDI/Electronic Claims

Learn more about EDI

Claim Entry through the Provider Express secure portal

- Secure HIPAA-compliant transaction streamlines the claim submission process
- Submitting claims closely mirrors the process of manually completing a Form 1500
- Allows claims to be paid quickly and accurately
- You can check the status of your claims in the portal, regardless of how the claim was submitted.

Filing Paper Claims

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: Behavioral health preventive pediatric services only requires a symptom code to be billed (z code)
- Complete all required fields (including ICD indicator and NPI number)
- For paper claims that you mail to Optum Behavioral Health, you should verify the mailing address. Often, the claims payment address for a medical claim is different than the address for a behavioral health claim. To verify, call the number on the member's ID card.

Tips for Timely and Accurate Payment

Filing electronically can help prevent these common errors:

Missing or incomplete information	Member demographic info has errors	Unclear or illegible information
Claims cannot be submitted if required fields are blank *Examples*: NPI number, DSM-5 derived diagnosis code	Member information is auto-populated when you use *"Claim Entry"* on *Provider Express* *Examples:* Name, DOB, ID number	Electronic submission ensures legibility *Examples*: Cannot read the provider or member information because it is illegible, diagnosis code unclear

Timely Filing of Claims

Providers contracted with Optum Behavioral are required to submit claims for services rendered to Optum members within 90 days of the date of service, or as allowed by state or federal law or the member's specific benefit plan.

- All information necessary to process claims must be received by Optum during this time period
- Any corrections or additions to a claim should be made within 90 days of receipt of the initial claim

Be aware:

- Claims received after this time period may be denied/rejected for payment, at the discretion of Optum and/or the payor
- You may not bill the member for claim submissions that fall outside these established timelines.

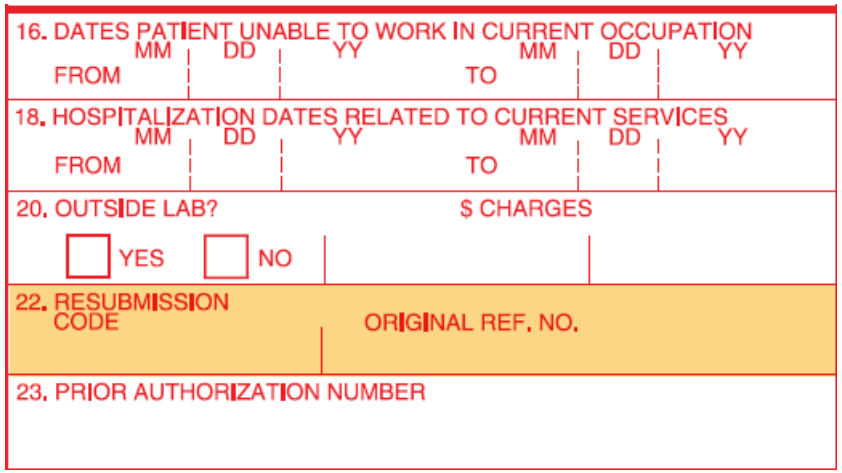
More information can be found in the
National Network Provider Manual

Corrected Claim Submission After Claim Denial

Corrected claims are typically submitted when the original claim had an error in the data supplied.

Timelines to submit a corrected claim

- **Commercial** – Within180 days from the date on the Provider Remittance Advice
- **Medicare** – Within180 days from the date on the Provider Remittance Advice
- **Medicaid** – Within 365 days from the date on the Provider Remittance Advice



Instructions – To notate that a corrected claim is being submitted, you must enter "7" in the appropriate EDI or paper claim field:

- Electronic Data Interchange/EDI Transaction: Box 12A
- Paper Form 1500: Field 22 (highlighted above)

Disputes and Appeals

Provider Disputes

For practitioner/facility disputes, Optum Behavioral Health has a formal process that is compliant with the standards and regulations set forth by the National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC) and state/federal regulations.

These standards and regulations help 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 level of internal dispute review is available through Optum, unless required by state law or contractual requirement.

Appeals

Standard (Non-Urgent)

Request timelines*

- MassHealth (Medicaid): Within 60 calendar days
- Commercial: Within 12 months
- Medicare Advantage: Within 12 months

Decision timeline

Optum will make a decision and notify you in writing within 30 calendar days of receipt of request.

*Timelines are based the date you receive the notice of adverse determination.

How to submit an appeal request

- **MassHealth (Medicaid):** Send a written request explaining why you believe the claim should be approved to:

  Optum Appeals & Grievances
  P.O. Box 30512
  Salt Lake City, UT 84130-0512

- **Commercial or Medicare Advantage:** You must follow a 2-step process if you disagree with the outcome of a clinical prior authorization request or claim processing decision.

  This process is outlined on pages 78-79 of the National Network Manual and in this Quick Reference Guide.

Appeals Part 2

Expedited (Urgent)

Providers/facilities can file an urgent appeal on behalf of a member

Request timelines
Must be requested ASAP after you receive notice of an adverse determination

Decision timeline
As expeditiously as the member's health condition requires and will not exceed 72 hours from when Optum receive the expedited request

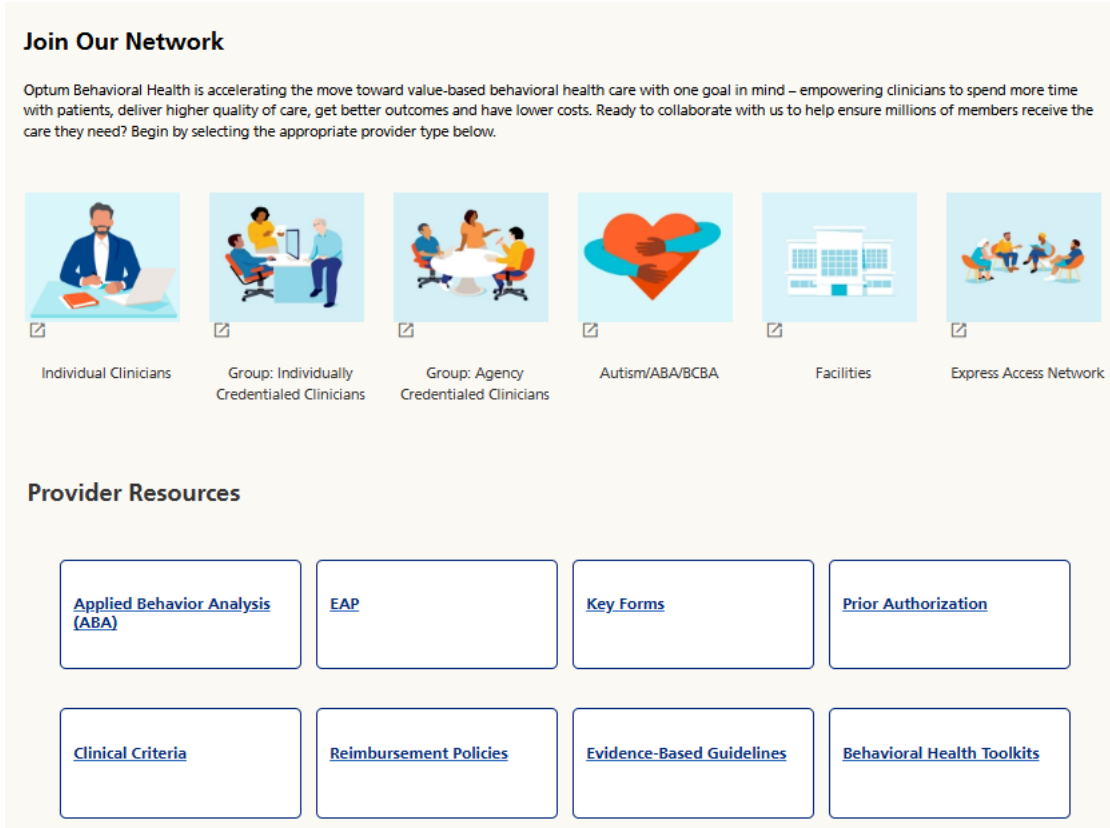
How to submit an appeal request

- 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

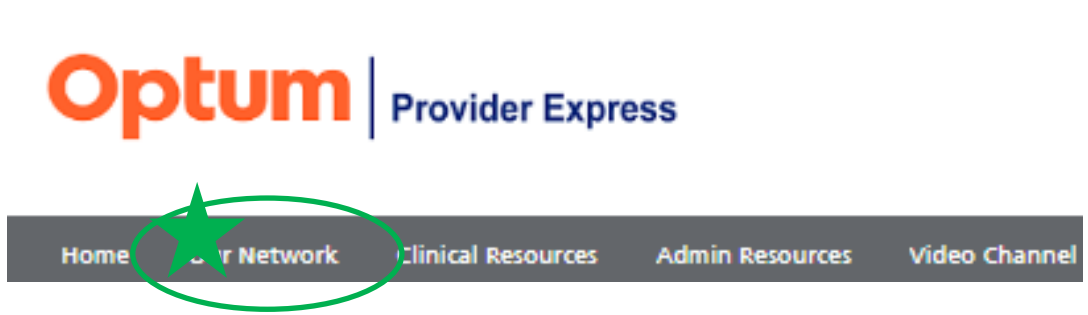
Providerexpress.com

Providerexpress.com – The Behavioral Health Provider Website

Information and updates to help us work together – from changes to administrative processes and state-specific notifications, to product-specific news and other key topics – all without needing to log in

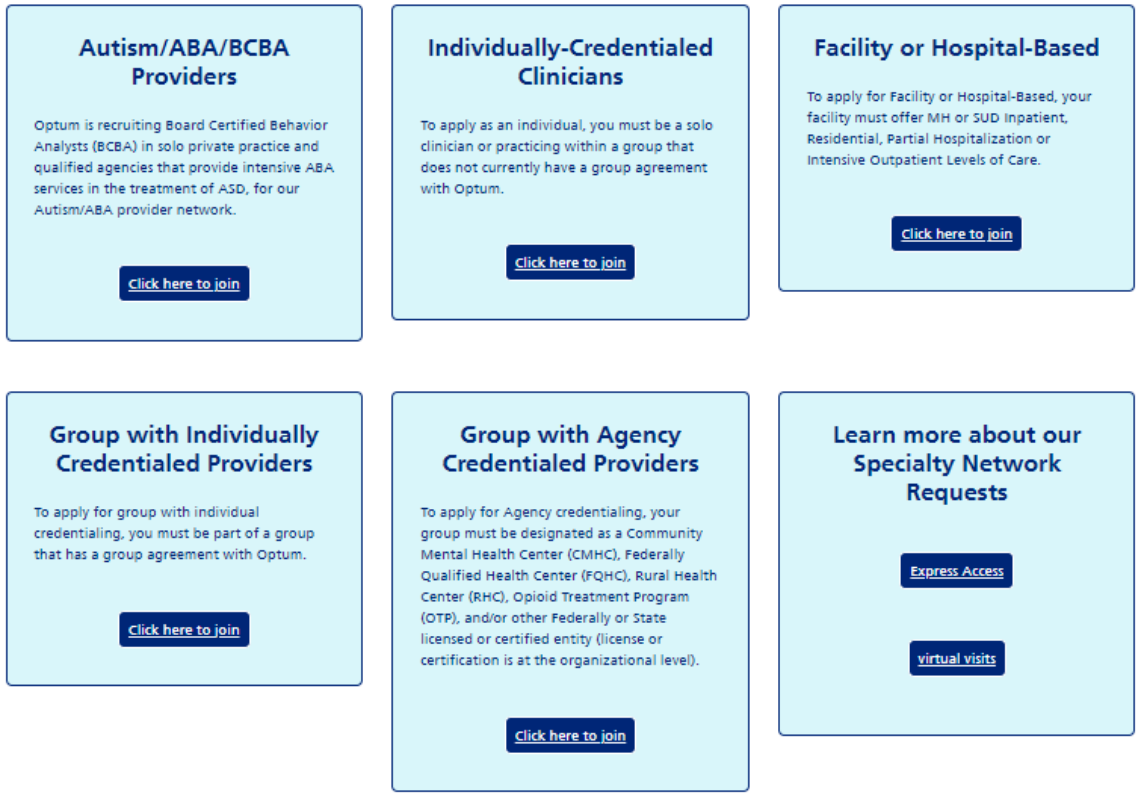


Key Resources – Join the Optum Behavioral Health Network

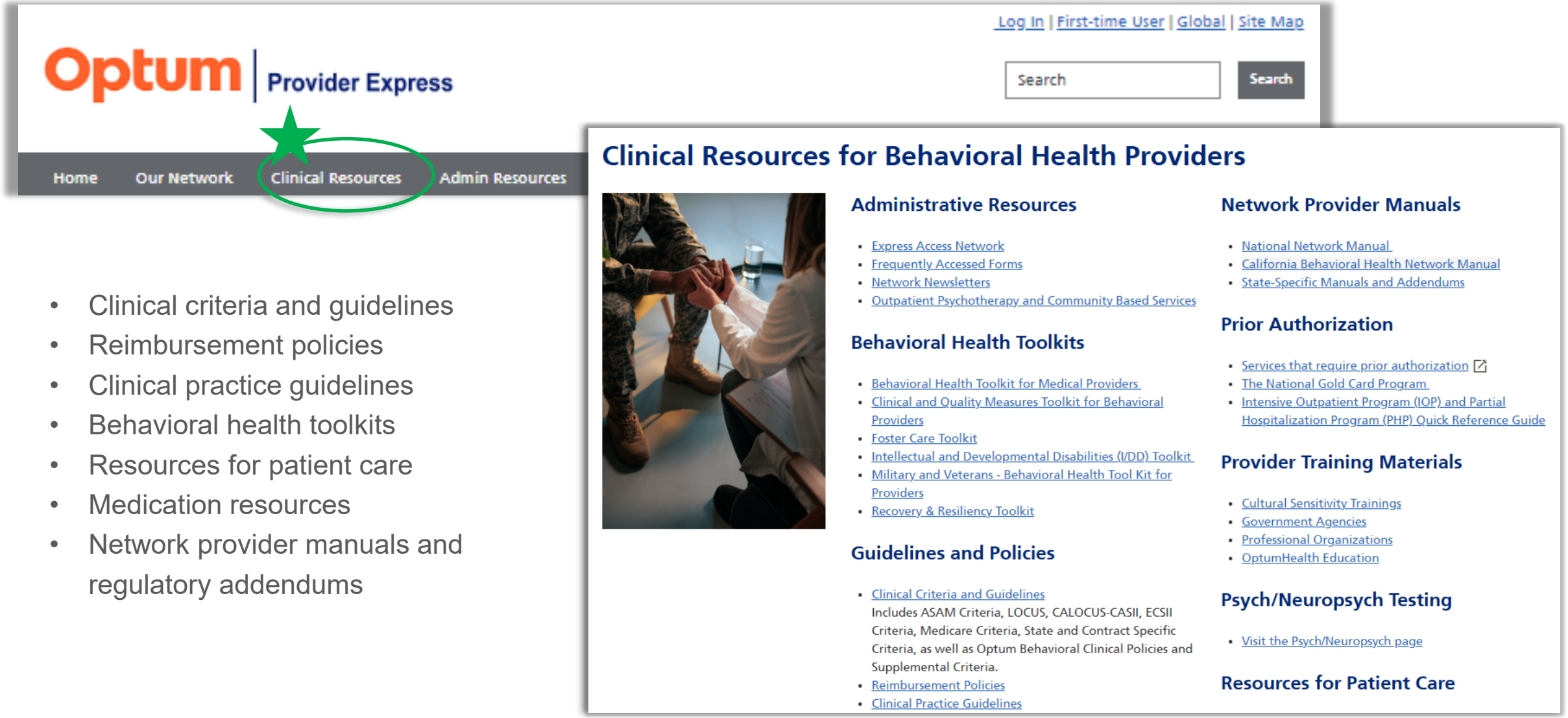


- Instructions and links specific to the type of provider, group or facility
- Annual credentialing plan
- Specialty information

★ Here's another way to access individual state pages and information



Key Resources – Clinical

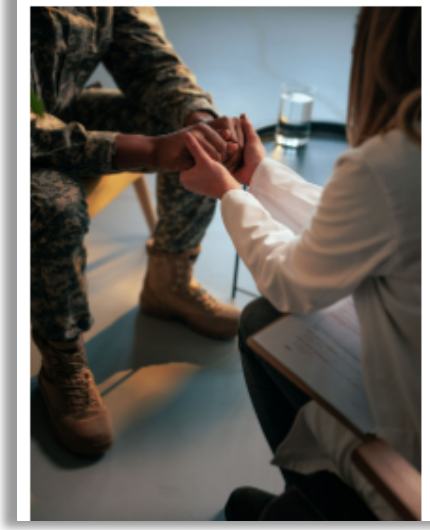


- Clinical criteria and guidelines
- Reimbursement policies
- Clinical practice guidelines
- Behavioral health toolkits
- Resources for patient care
- Medication resources
- Network provider manuals and regulatory addendums

Clinical Criteria and Guidelines

Optum - Provider Express Home > Clinical Resources

Clinical Resources for Behavioral Health Providers



Guidelines and Policies

- Clinical Criteria and Guidelines
  Includes ASAM Criteria, LOCUS, CALOC
  Criteria, Medicare Criteria, State and C
  Criteria, as well as Optum Behavioral C
  Supplemental Criteria.
- Reimbursement Policies
- Clinical Practice Guidelines
  Guidance about evidence-based practi
  nationally recognized entities such as
  Psychiatric Association, the American A
  and Adolescent Psychiatry, and the Am
  Addiction Medicine.

Resources fo

Behavorial Health Toolkits

Optum - Provider Express Home > Clinical Resources > Clinical Criteria and Guidelines

Clinical Criteria and Guidelines

Clinical Criteria based on sound clinical evidence

Optum behavioral health uses Clinical Criteria based on sound clinical evidence to make coverage determinations, as well as to inform discussions about evidence-based practices and discharge planning. In using its Clinical Criteria, Optum Behavioral Health takes individual circumstances and the local delivery system into account when determining coverage of behavioral health services. The following are the Clinical Criteria used by Optum Behavioral Health to make coverage decisions. Please note other Clinical Criteria may apply outside of or in addition to the following criteria due to superseding federal or state requirements, and/or specific contractual requirements.

Externally Adopted Clinical Criteria

- American Society of Addiction Medicine (ASAM) Criteria®, Third Edition: Criteria developed by the American Society of Addiction Medicine used to make determinations for substance-related disorder benefits.
  - Introduction to the ASAM Criteria
  - Summary of 4th Edition updates
  - Training and education resources
  - Frequently asked questions

- Level of Care Utilization System (LOCUS): Standardized level of care assessment tool developed by the American Association of Community Psychiatrists used to make determinations and placement decisions for adults ages 18 and older.

- Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII): Standardized assessment tool developed by the American Academy of Child and Adolescent Psychiatry and the American Association of Community Psychiatrists used to make determinations and to provide level of service intensity recommendations for children and adolescents ages 6-18.
  - CALOUS-CASII Patient, Family and Provider Guide
  - Access the CALOCUS-CASII Criteria here

Optum

Behavioral Health Toolkits to Support Providers and Patients

Clinical Resources for Behavioral Health Providers

Administrative Resources

- Express Access Network
- Frequently Accessed Forms
- Network Newsletters
- Outpatient Psychotherapy and Community Based Services

Behavioral Health Toolkits

- Behavioral Health Toolkit for Medical Providers
- Clinical and Quality Measures Toolkit for Behavioral Providers
- Foster Care Toolkit
- Intellectual and Developmental Disabilities (I/DD) Toolkit
- Military and Veterans - Behavioral Health Tool Kit for Providers
- Recovery & Resiliency Toolkit

Network Provider Manuals

- National Network Manual
- California Behavioral Health Network Manual
- State-Specific Manuals and Addendums

Prior Authorization

- Services that require prior authorization
- The National Gold Card Program
- Intensive Outpatient Program (IOP) and Partial Hospitalization Program (PHP) Quick Reference Guide

Provider Training Materials

- Cultural Sensitivity Trainings
- Government Agencies

Peer Support Specialists in Action

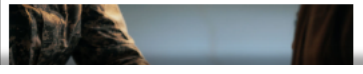
owerment Toolkit

ill find resources for those living with and supporting individuals with substance use and behavioral cerns and diagnoses.

- is Recovery, Resiliency & Empowerment
- very organizations and resources for everyone
- very organizations and resources for families
- very organizations and resources for provider agencies
- ucational material for provider agencies
- Peer support specialists as service providers
- Resources to use with members
- Tools you can use in your recovery practice
- More just for youth

Network Provider Manuals

Clinical Resources for Behavioral Health Providers



Administrative Resources

- Network
- cessed Forms
- sletters
- ychotherapy and Community Based Services

Health Toolkits

- alth Toolkit for Medical Providers
- uality Measures Toolkit for Behavioral
- olkit
- d Developmental Disabilities (I/DD) Toolkit
- eterans - Behavioral Health Tool Kit for
- siliency Toolkit

Network Provider Manuals

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- State-Specific Manuals and Addendums

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Provider Training Materials

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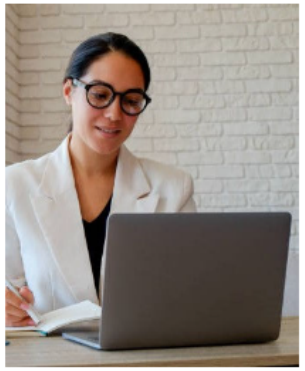
National Network & State-Specific Manuals and Addendums



National Network Manuals

- National Network Manual - effective Aug. 15, 2024
- National Network Manual - effective Dec. 1, 2023 - Aug. 14, 2024

Previous National Network Manuals

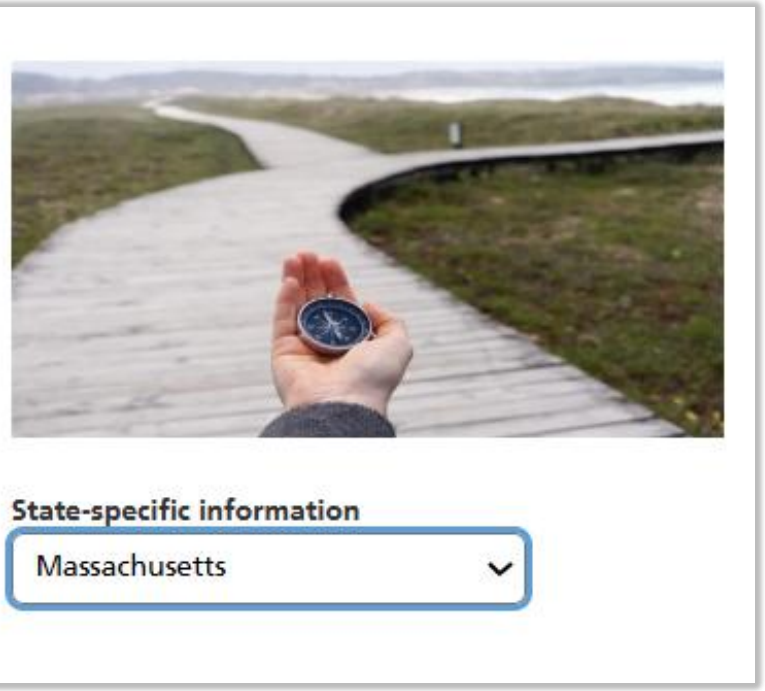
- National Network Manual – effective September 23, 2022 – August 31, 2023
- Change Index (September 2022)

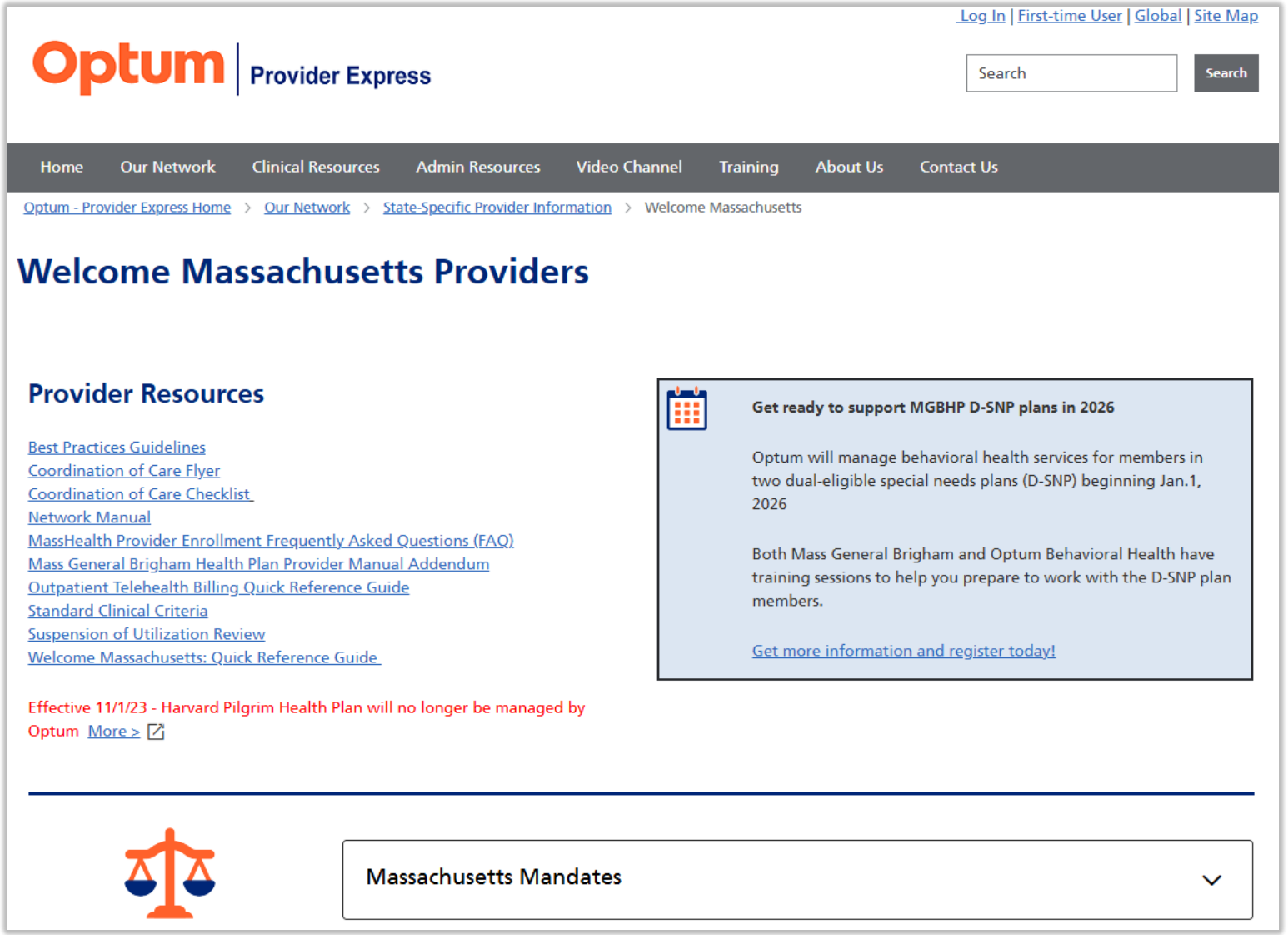
State-Specific Manuals & Addendums

- California Behavioral Health Network Manual
- Disability Solutions Manual
- Harvard Pilgram Health Program Addendum
- KS KanCare Provider Manual
- Maryland National Manual Addendum
- Massachusetts Manual Addendum
- Mass General Brigham Provider Manual Addendum
- Community Behavioral Health Center Directory
- MS MSCAN/MSCHIP Manual Addendum
- New Jersey Medicaid Provider Manual Addendum updated
- New York Provider Manual
- Rhode Island Appendices
  - RI ASAM Criteria: RIte Care and Rhody Health Partners ACA
  - RI Rhody Health Partners ACA Appendix
  - RI Manual Addendum
  - RI Medicaid Appendix for Rhody Health Partners
  - RI Medicaid Appendix for Children with Special Healthcare Needs
- Texas Provider Administrative Guide
- Texas STAR Kids Manual
- Texas CHIP, STAR, STAR+PLUS Manual
- Virginia UnitedHealthcare Community Plan, a CCC Plus Plan
- Washington State UnitedHealthcare Community Plan Care Provider Manual

Massachusetts Provider Express Page

Welcome Massachusetts





Massachusetts Provider Express Page

Mass General Brigham Health Plan

- Provider Resources
- Adverse Incident Reporting Forms
- Outpatient Care Engagement
- Provider Manual Addendum
- Training
- Medicaid Authorizations
- Clinical Criteria

Massachusetts Medicaid

- Provider Alerts & Bulletins
- Medicaid Disclosures
- Performan
- MOUD/MA Treatment
- Authorizat

Provider Guidance and Training Resources

Claim Billing Guide – Billing under Supervision
MA BHCA Provider FAQ
One Care Medicare-Medicaid Plan Provider Training
United Behavioral Health BHCA Provider Training: Phase 2

Prior Authorization Forms

Massachusetts Authorization/Notification, Assessment and Treatment Forms

Applied Behavior Analysis Services Prior Authorization Request Standard Form

Massachusetts One Care BH Day Treatment Authorization Form

For more information and forms visit Guidelines/Policies & Manuals and Frequently Accessed Forms pages.

Designated Community Behavioral Health Centers

Billing Guidance and FAQ
Bundled Billing Specs

Medicaid Enrollment & Participation FAQ

21st Century Cures Act MassHealth Enrollment Frequently Asked Questions

Newsletter Archives

April 2024
January 2024
October 2023
July 2023

Clinical / Program and Network Integrity

Utilization Management

Care Management decision-making is based only on the appropriateness of care

Appropriateness is defined by sound clinical practices and evidence-based practices established by a number of professional organizations and societies:

- Externally adopted level of care guidelines and criteria
- Optum Psychological and Neuropsychological Clinical Criteria
- Behavioral Health Clinical Policies
- American Society of Addiction Medicine (ASAM) Criteria

Optum Behavioral Health takes individual circumstances and the local delivery system into account when determining coverage of behavioral health services.

Optum

Payment Integrity

To help make health care more affordable for everyone, we partner with you to prevent waste, error, fraud and abuse.

As a managed care organization, Optum Behavioral Health is expected to be a good steward of the financial responsibility entrusted to us – by our members, by the employers we work with, by CMS and other government entities, and by the states who contract us to administer Medicaid services.

How We Detect Fraud, Waste and Abuse

Prospective Claim Reviews (Pre-Pay)

- Analyze member, provider and claims data
- Identify trends, current/ upcoming schemes or unusual behavior
- Stop potentially fraudulent or defective claims from being paid

Retrospective Claim Reviews (Post-Pay)

- Analyze member, provider and claims data
- Identify trends, schemes or unusual behavior, then investigate
- Work with state and federal agencies to stop fraud, waste and abuse across the industry

Intelligence

- Anonymous TIP line
- Email / PO Box
- Internal and external training
- Provider Education

What We Look For

Inconsistent coding patterns within a group practice	Coding at high levels for Evaluation and Management (E&M) Services	Services not rendered due to no records submitted, incorrect name of Member, incorrect date of service or illegible records	Unbundling of procedures and services	Diagnosis concerns -- does diagnosis make sense to documentation studied?
Inadequate documentation -- missing pages, no Member name on every page submitted, dates of service are missing or appear altered	Misrepresentation of rendering provider -- different provider then billing provider	Misrepresentation of non-covered services as covered	Double billing	Improper use of modifiers

(Medical Record Auditor, AMA 3rd Edition, 2011)

Payment Integrity Resources

- **Payment Integrity** website – Additional information and resources about payment audits

- **Behavioral Health Services Documentation** – Outlines medical record requirements that should be maintained for every Optum Behavioral Health member

Payment Audit Resources

- **Payment Integrity Portal** – This portal is specific to payment audits and is not part of the Provider Express secure portal. You'll use the Payment Integrity Portal to submit medical records that are requested for claim payment reviews. It's also where you can check payment review status 24/7.
  - **Payment Integrity Portal Training**
  - **Quick Reference Guide - Payment Integrity Portal**
  - For portal questions or support, please email **PI_Portal_Support@optum.com**

Questions?

If you have received a letter from our Payment integrity Team, please contact them directly at PNI Customer Service 1-877-972-8844 or pnieducation@optum.com with the reference ID# from your letter and your TIN/NPI. Our team of certified coders will respond in 10 business days.

How We Support You

Our Service Model

Optum Behavioral Health has call centers and teams dedicated to supporting providers and members

Provider Service Line

When to use: Inquiries related to:

- Credentialing/Recredentialing
- Network status
- Contracting/Fee schedules
  - To request a change in fee schedules, please email: psl_feechange_requests@optum.com

Call: 1-877-614-0484

Member Services / Intake

When to use: Questions related to one of your patients, including:

- Claims
- Patient eligibility
- Benefit information
- Authorizations
- ASO funding information

Call: Use the phone number on the back of the member's ID card

Provider Relations Advocate

When to use: If you need help with escalated concerns or have a question PSL cannot answer

Call: Two ways to reach out

- Use the contact information your Provider Advocate gives you
- Call the Provider Service line and request that a case be opened and routed to a Provider Relations Advocate (PRA).

Helpful Links and Phone Numbers

- Massachusetts - Provider Express
- National - Provider Express
- Provider Express Support - Contact Us
- Surest Health Plan (formerly Bind) Surest Health Plan
- Student Resources Provider Page
- ABA Network Contact
- VACCN Contact: Region 1: 1-888-901-7407
- UMR Provider Portal
- UMR: Contact Us
- Optum Pay Support Team **1-877-620-6194**

Thank You