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Optum Provider Training for Mass General Brigham Health Plan – Mass General Brigham ACO Model A (Medicaid)

Published January 2024

Introductions & Background

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Introductions and Background

Mass General Brigham Health Plan

Effective Jan. 1, 2023, AllWays Health Partners became Mass General Brigham Health Plan

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Optum, the behavioral health partner for **Mass General Brigham Health Plan** is a leading health services organization dedicated to making the health system work better for everyone.

Mass General Brigham ACO currently partners with MassHealth as the payer. Starting April 1, 2023, Mass General Brigham (the delivery system) will partner with Mass General Brigham Health Plan for ACO patients. Members who have MGB ACO today will remain with MGB ACO unless they opt for another plan/provider.

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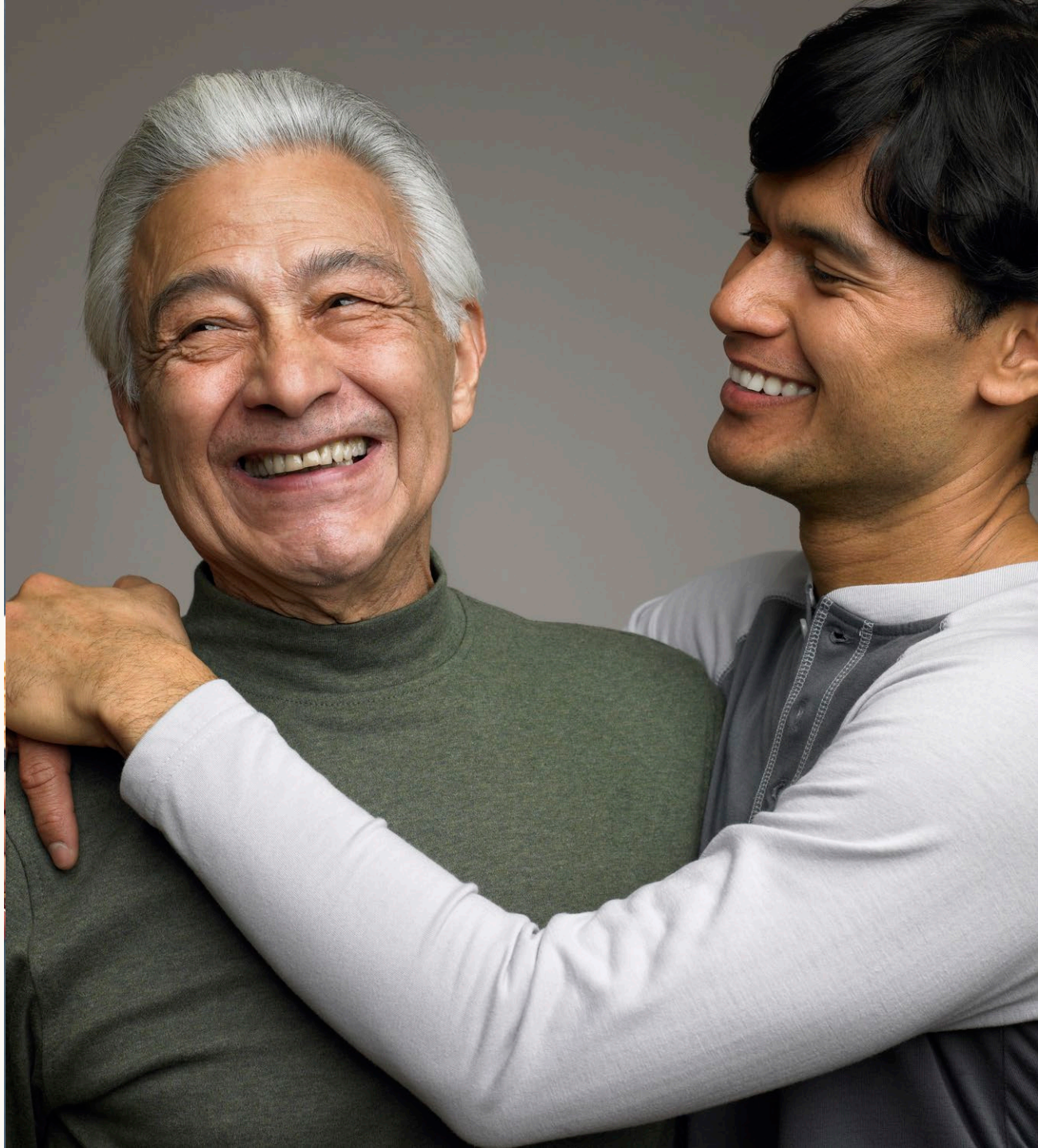
Definitions



Key Definitions

- *Licensed provider*: a professional licensed by the state to deliver behavioral health services
- *Procedure Code*: codes used to identify what service was provide to or given to a patient
- *Modifier*: a two-character descriptive add-on to a procedure code; modifiers can be a combination of alpha numeric characters
- *Non-independently licensed provider*: a Master's level provider professional who is NOT independently licensed by the state; may be able to deliver behavioral health services under the supervision of an independently licensed provider if employed by a group/agency
- *Paraprofessional*: a person to whom a particular aspect of a professional task is delegated but who is not licensed to practice as a fully qualified professional
- *Peer Provided Services*: Medicaid coverage includes services provided by peers with "lived experience" who meet performance specification, such as Recovery Coaches.
- *Rostered provider*: an independently licensed provider employed by a credentialed group/agency with a Group Agreement that requires submission and on-going maintenance of a roster of their employed, independently licensed providers
- *Supervision*: an independently licensed supervising provider has regular, in-person, one-on-one supervision with the non-independently licensed provider to review the treatment provided to members. Supervision must be clinical in nature, documented and kept on file. Up to two (2) multi-disciplinary staff or group supervision meetings may be counted for two in-person supervision sessions per month so long as the supervising provider is in attendance

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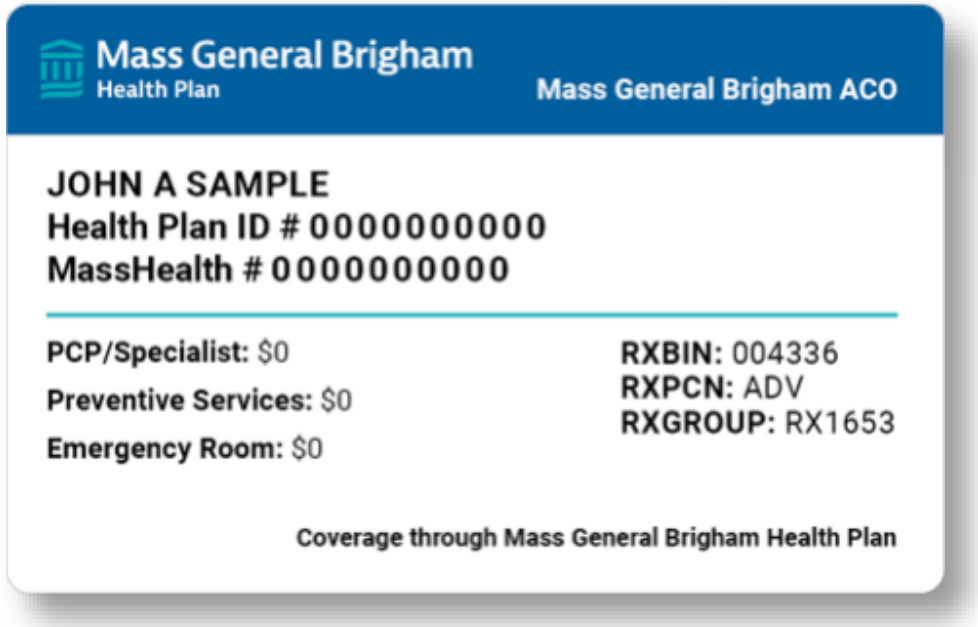
Member ID Cards

Member identification card, front, ACO, Model A (Medicaid) plan



Member identification card, back, ACO, Model A (Medicaid) Plan

Members

Customer Service:
800-462-5449 (TTY 711)

For behavioral health services (mental health or substance use) Optum Behavioral Health Services:
800-462-5449 (TTY 711)

CVS Caremark Prescription Services:
866-546-0662

Call your treating provider within 48 hours of an emergency visit.

Visit **member.mgbhealthplan.org**, a secure member portal for detailed plan and provider information.

MassGeneralBrighamHealthPlan.org

Providers

Claims Info and Provider Manual:
provider.mgbhealthplan.org

Where to submit claims

Mass General Brigham Health Plan:
855-444-4647 | Payer ID: 04293

Behavioral Health: Optum
844-451-3519 | Payer ID: 87726

For more information, visit **mgbhealthplan.org/claims**

Pharmacy Help Desk:
CVS Caremark | 800-421-2342

This card does not guarantee coverage. *ID-05 (01/23)*

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Benefits and Eligibility

Understanding covered benefits

Clinical Criteria standardize the interpretation and application of terms of the member's Benefit Plan; including terms of coverage, exclusions and limitations.

Clinical Criteria can be found on Provider Express, Optum's industry leading provider website: *providerexpress.com*

Mass General Brigham Health Plan ACO Model A Medicaid members benefits are determined by MassHealth.

Check a member's benefits and eligibility on Provider Express, through secure Transactions.

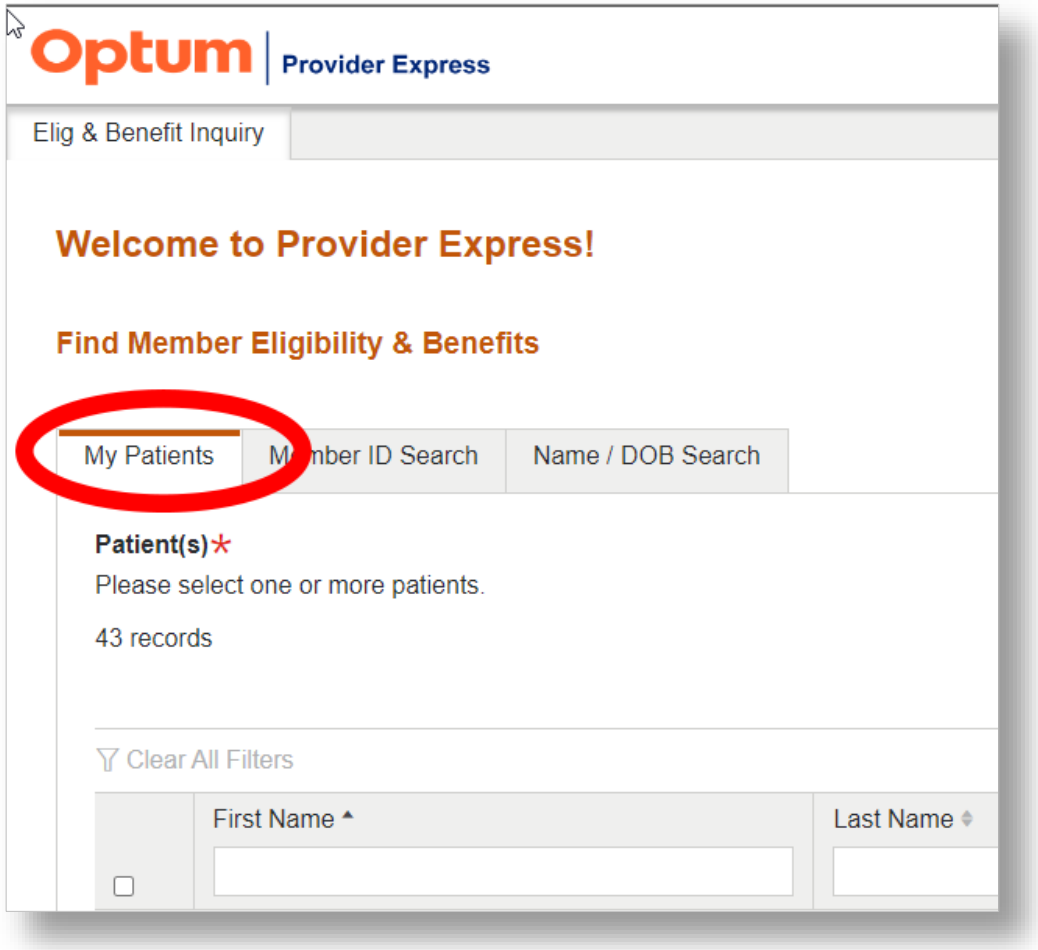
Eligibility and benefits verification using Provider Express

Provider Express - *providerexpress.com*

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

“Eligibility & Benefits” allows users to search for a member’s eligibility by using My Patients list, Member ID Search or the Name/DOB Search. The My Patients list is also built using this transaction.

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



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Covered Services and Authorizations

Covered Services, Inpatient

Inpatient services: *24-hour services, delivered in a licensed hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both.*

- Inpatient Mental Health Services
- Inpatient Substance Use Disorder Services (ASAM Level 4)
- Observation/Holding Beds
- Administratively Necessary Day (AND) Services
  - Available to Medicaid members only
  - AND Services must be requested and authorized through a single case agreement
  - Reimbursement will be at the published state Medicaid rate for Administrative Days
  - Billing must be done using revenue code 0169

Covered Services, Diversionary Services

Diversionary Services: *these services provide clinically appropriate alternatives to Behavioral Health Inpatient Services, or support returning to the community following a 24-hour acute placement; or provide intensive support to maintain functioning in the community*

24-hour diversionary services:

- Community Crisis Stabilization (CCS)
- Community-Based Acute Treatment for Children and Adolescents (CBAT)
- Intensive Community-Based Acute Treatment for Children and Adolescents (ICBAT)
- Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)
- Clinical Support Services (CSS) for Substance Use Disorders (Level 3.5)
- Residential Rehab Services (RRS), High Intensity, Population Specific (Level 3.1), MassHealth members only
- Residential Rehab Services (RRS), Low Intensity (Level 3.1), MassHealth members only
- Transitional Care Unit (TCU) for DCF Youth, MassHealth members only

Covered Services, Diversionary Services

Non-24-hour diversionary services:

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

Covered Services, Standard Outpatient Services

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

Authorization and Notification Definitions

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

Services Requiring Authorization and/or Notification

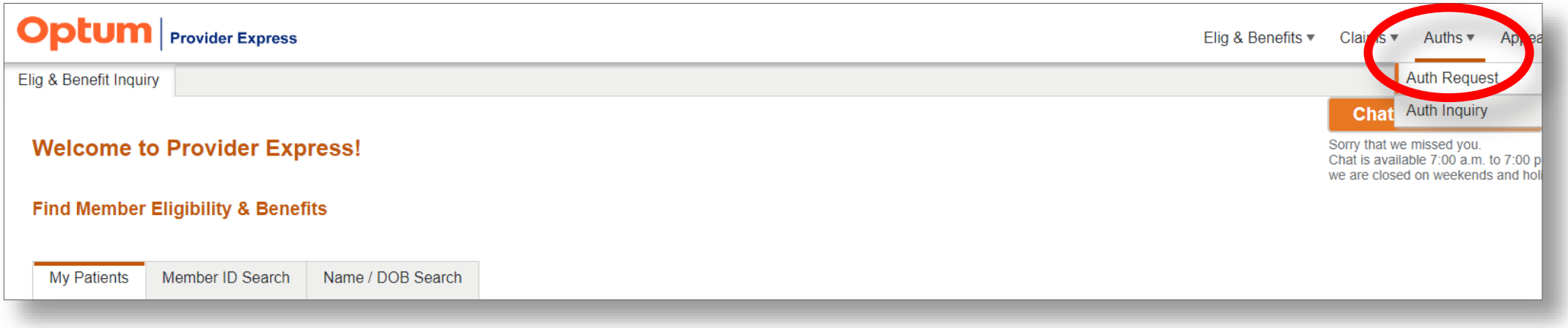
Services Requiring Authorization	Services Requiring Notification
Partial Hospitalization, Intensive Outpatient (IOP), and Day Treatment	Acute Inpatient Psychiatric Hospitalization (within 72 hours of admission)
Psych testing greater than 5 hours	Community Based Acute Treatment (CBAT)/Intensive Community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

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

Authorization process

Authorizations can be requested in two ways:

1. Contracted providers can request authorizations for most services via the online portal system on Provider Express (*providerexpress.com*). You will need to log in to request authorizations.
   - View authorization details



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

Discharge planning

- Effective discharge planning:
  - Addresses how a member's needs are met during a level of care transition or change to a different treating provider
  - Begins at the onset of care and should be documented and reviewed over the course of treatment
  - Focuses on achieving and maintaining a desirable level of functioning after the completion of the current episode of care
- Discharge instructions should be specific, clearly documented and provided to the member prior to discharge:
  - Members discharged from an acute inpatient program must have a follow-up appointment scheduled prior to discharge for a date that is **within seven (7) days of the date of discharge**
- Throughout the treatment and discharge planning process, it is essential that members be educated regarding:
  - The importance of enlisting community support services
  - Communicating treatment recommendations to all treating professionals
  - Adhering to follow-up care

Discharge Planning – Experiencing or at Risk of Homelessness

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

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

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

Medical necessity

Medically necessary services are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity.

Medically necessary services are appropriate when there is no other medical service or site of service, comparable in effect, available and suitable for the member requesting the service, that is more conservative or less costly

Medically necessary services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality.

Utilization management statement

Care Management decision-making is based only on the appropriateness of care as defined by:

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

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

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

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Children's Behavioral Health Initiative (CBHI) and Outpatient Management, for Medicaid Members

Covered Services: Intensive Home or Community Based Services for Youth (CBHI)

The Children's Behavioral Health Initiative (CBHI) is an interagency undertaking whose mission is to strengthen, expand and integrate behavioral health services for children.

Mental health and substance use disorder services provided to (MassHealth) youth members up to age 21 in a community-based setting such as home, school, or community. (e.g., CBHI Services):

- Family Support and Training
- Therapeutic Mentoring
- Intensive Care Coordination (ICC)
- In-Home Behavioral Services
  - Behavior Management Therapy
  - Behavior Management Monitoring
- In-Home Therapy Services
- Youth Mobile Crisis Intervention
- Intensive Hospitalization Diversion

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

All behavioral health providers treating children and adolescents who are enrolled in MassHealth and under the age of 21 must use the CANS tool as part of the clinical assessment process. The CANS must be updated every 90 days to ensure that treatment plans address strengths and needs as they evolve.

Services that Require Use of the CANS:

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

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

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Cultural Sensitivity

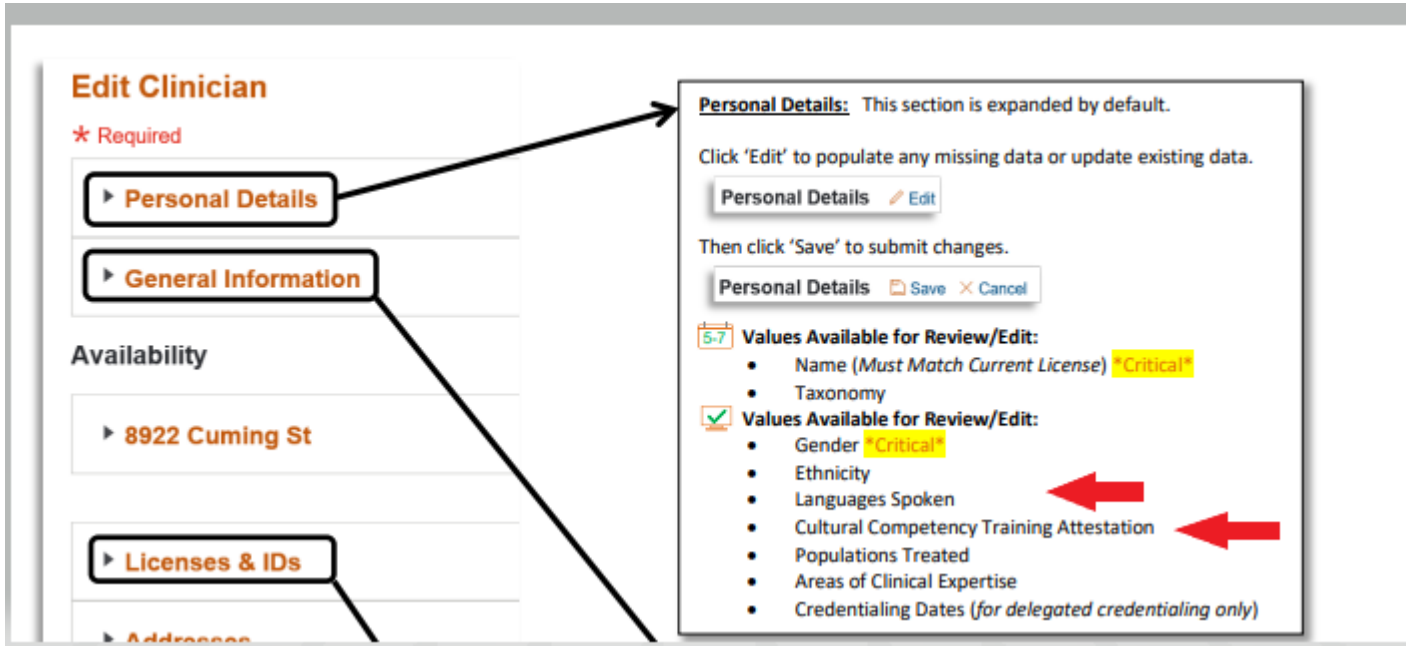
Cultural sensitivity for providers

As a health care provider, it is important for you to remember to be culturally sensitive to the diverse population you serve:

- All services should be conducted in accordance with Title VI of the Civil Rights Act of 1964 and should be provided in a manner that respects the Member's cultural heritage and appropriately utilizes natural supports in the Member's community.
- Remember that statistics do not apply to individuals.
- Be aware that there are differences within cultures and from generation to generation.
- Evaluate each person using all available cultural "clues".
- Ask questions in a culturally sensitive fashion.

Cultural sensitivity for providers

Providers are required to verify the demographic information listed in the provider directory every 90 days, including information on languages spoken and attestation to Cultural Sensitivity Training. Log in to “My Practice Info” on the secure portal from provider express to update and attest to your information as it appears in the provider directory.



Cultural competency

Some additional resources for information on Cultural Sensitivity:

- Equal Opportunity and Civil Rights Information | CMS– Office of Civil Rights
- LEP.gov – Limited English Proficiency (LEP): Site promotes importance of language access to federal programs and federally assisted programs
- ncihc.org – National Council on Interpreting in Health Care: Organization promotes culturally competent health care

Advancing Health Equity

Our mission is to help people live healthier lives and make the system work better for everyone.

- Promoting and instilling the values of culture, inclusion and diversity are critical to achieving this mission and truly making a difference
- As part of this commitment, Optum offers two Cultural Sensitivity Training courses – **free and on-demand** – for in-network behavioral health professionals:
  - LGBTQ+ Mental Health Training (1.5 CEUs)
  - Unconscious Bias Training (Certification)

Provider Express Resources:
Provider Express > Clinical Resources > Cultural Sensitivity Trainings

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Provider Clinical Audits

Provider audits

- Organizational providers (including facility-based services, partial hospital programs, intensive outpatient programs, residential programs and most agencies) that do not have a national accreditation [such as The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), etc.] will require on-site clinical audits at the time of credentialing and recredentialing.
- Clinical audits may also be completed to investigate a quality of care (QOC) concern or a sentinel event.
- Record review audits are completed of providers who render services to Mass General Brigham Health Plan members of any age.
- A sample of providers are randomly selected for review on an annual basis.

Documentation standards

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

- Providers must have criteria outlining the conditions for release of information about members
- Providers must have a signed release of information to respond to an outside request for information
- All staff members within the provider agency/group are subject to the same confidentiality requirements
- A release of information should be obtained to allow communication and collaboration with other treating providers (including previous treating providers)

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Adverse Incident Reporting

Behavioral health adverse incident reporting

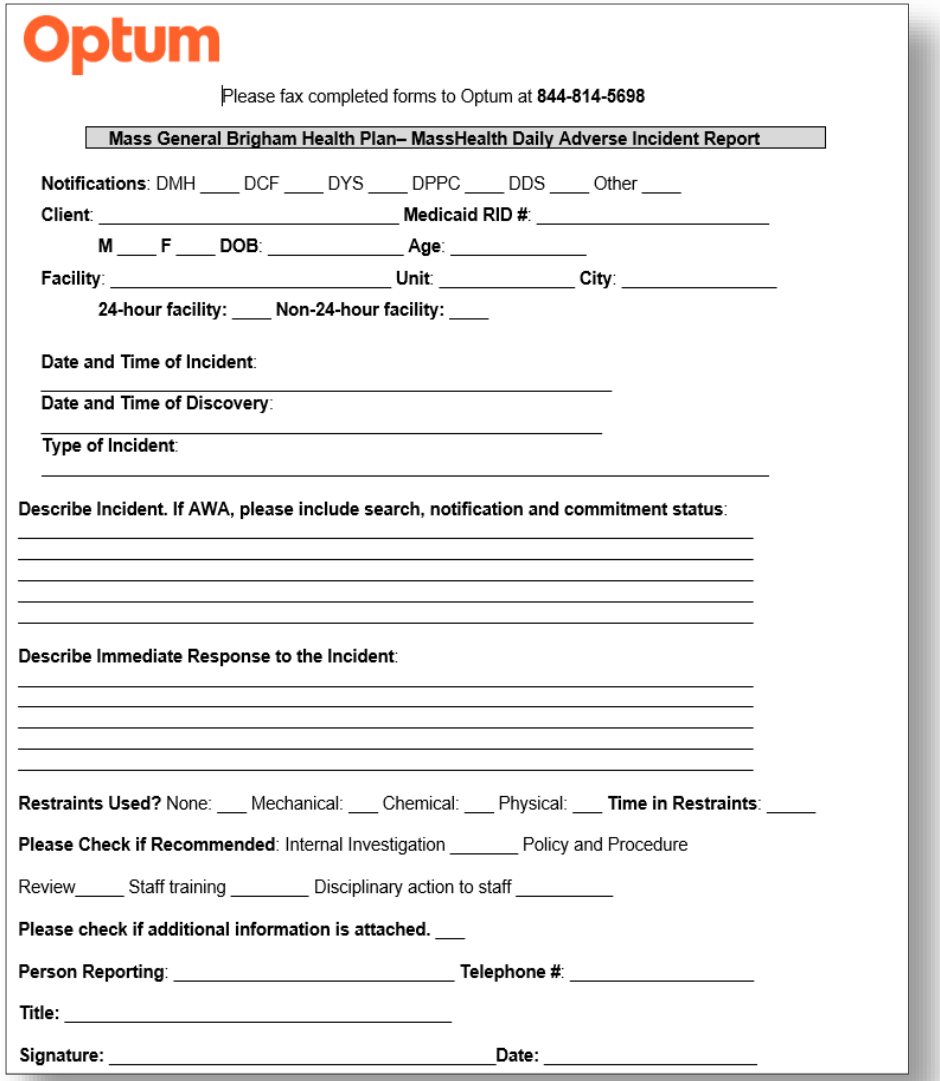
Behavioral Health reportable adverse incidents include, but are not limited to, the following:

- Any death (include cause of death if known)
- Any absence without authorization (AWA)
- Any serious injury resulting in hospitalization
- Any sexual assault or alleged sexual assault
- Any sexual activity in a 24-hour level of care facility
- Any violation or alleged violation of the Department of Mental Health physical restraint and/or seclusion regulations
- Any physical assault or alleged physical assault on or by a covered individual or by staff
- Any contraband found prohibited by provider policy
- Any injury or illness requiring transportation to an acute care hospital for treatment while in a 24-hour program

Report submission instructions

- When an adverse incident occurs, the provider must complete the applicable Adverse Incident Report form and submit it to Optum within 24 hours of discovery of the incident; if the incident occurs on a holiday or weekend, the form must be submitted on the next business day
- All forms are posted to Provider Express: from the Home page, select Our Network > Welcome to the Network > Massachusetts > Mass General Brigham Health Plan > Adverse Incident Report Forms

Adverse incident report form, MassHealth



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

Mass General Brigham Health Plan– MassHealth Daily Adverse Incident Report

Notifications: DMH ____ DCF ____ DYS ____ DPPC ____ DDS ____ Other ____

Client: _____ **Medicaid RID #**: _____

M ____ **F** ____ **DOB**: _____ **Age**: _____

Facility: _____ **Unit**: _____ **City**: _____

24-hour facility: ____ **Non-24-hour facility:** ____

Date and Time of Incident:

_____

Date and Time of Discovery:

_____

Type of Incident:

_____

Describe Incident. If AWA, please include search, notification and commitment status:

_____
_____
_____
_____
_____

Describe Immediate Response to the Incident:

_____
_____
_____
_____
_____

Restraints Used? None: ___ Mechanical: ___ Chemical: ___ Physical: ___ **Time in Restraints**: _____

Please Check if Recommended: Internal Investigation _____ Policy and Procedure

Review_____ Staff training _____ Disciplinary action to staff _____

Please check if additional information is attached. ___

Person Reporting: _____ **Telephone #**: _____

Title: _____

Signature: _____**Date:** _____

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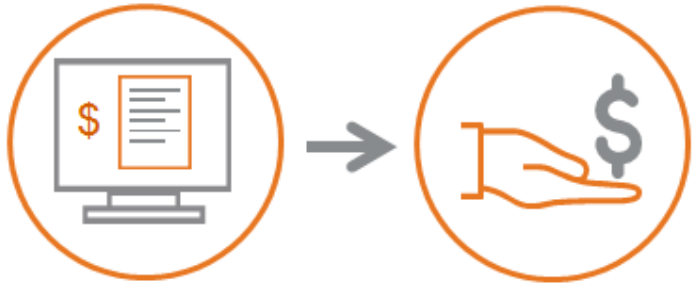
Claim Billing Reference Guide

Claims filing made easy

File your claim electronically for a fast, secure and convenient claims experience



Benefits of Electronic Filing:

- **It's fast** - Eliminate mail and paper processing delays
- **It's convenient** - Easy set-up and intuitive process
- **It's secure** - Data security is higher than with paper-based claims
- **It's efficient** - Electronic processing helps prevent errors
- **It's cost-efficient** - you eliminate mailing costs, and the solutions are free or low-cost

Claims submission option 1, Online: Provider Express

Our network providers report the highest level of satisfaction when they submit claims online through *Provider Express:*

- Free
- Available 24/7
- Intuitive and easy-to-use
- HIPAA compliant
- Real-time, quick claims processing
- Available to providers and groups
- Outpatient behavioral claims

Get started today with your One Healthcare ID:

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

Tips for timely and accurate payments, Provider Express

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

Missing or incomplete information	Member demographic info has errors	Unclear or illegible information
Provider Express "Claim Entry" prevents the submission of claim if required fields are blank *Examples*: NPI number, ICD-10 derived diagnosis code	Member information is auto-populated when you use *"Claim Entry"* on *Provider Express* *Examples:* Name, DOB, ID number	The Claim Entry form on *Provider Express* ensures legibility *Examples*: Provider or Member information illegible, diagnosis code unclear

Claims submission option 2: EDI/ Electronically

Submit batches of claims electronically, right out of your practice management system software:

- Ideal for high volume Providers
- Can be configured for multiple payers
- Clearinghouse may charge small fee

To learn more about Electronic Data Interchange, visit Provider Express. From the Home Page, select Admin Resources > Claim Tips > EDI/Electronic Claims

Claims submission option 3: Paper

If you are unable to file electronically, follow these tips to ensure smooth processing of your paper claim:

- Use an original 02/12 Form 1500 claim form (no photocopies)
- Type information to ensure legibility
- Use a DSM-5 derived ICD-10 code for primary diagnosis (Hint: the DSM-5 includes ICD codes along with the DSM diagnostic info)
  - Please Note: BH preventive pediatric services only requires a symptom code to be billed (z code)
- Complete all required fields (including ICD indicator and NPI number)

Claims submission option 3: Paper

- Institutional claims must be submitted using the UB-04 claim form
- Paper claims submitted via U.S. Postal Service should be mailed to:

Medicaid

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

Claim tips

To support clean claim submissions, remember:

- NPI numbers are always required on all claims
- A complete diagnosis is required on all claims
- The correct date of service corresponding to the date the service occurred must be listed on the claim form; do not list the claim submission date as the date of service

Claims filing deadline:

- Mass General Brigham Health Plan allows claim submissions up to ninety (90) days from the date of service

Claims Processing:

- Clean claims, including adjustments, will be adjudicated within forty-five (45) days of receipt of the claim

Balance Billing:

- The member cannot be balance billed for behavioral services covered under the contractual agreement

Claim tips

Member eligibility:

- Provider is responsible to verify member eligibility through providerexpress.com

Examples of coding Issues related to claim denials:

- Incomplete or missing diagnosis
- Invalid, missing or incorrect pairing of HCPCS/CPT codes and modifiers
- Use of codes that are not covered services
- Required data elements missing, (e.g., number of units)
- Provider information is missing or incorrect
- Required authorization missing
- Units exceed authorization (e.g., 10 inpatient days were authorized, facility billed for 11 days)

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Appeals

Appeals

Provider Disputes

Optum has a formal process for handling practitioner/facility disputes that is compliant with the standards and regulations set forth by National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) and state/federal regulations. These standards and regulations serve as guidelines to ensure that:

- Review turnaround time requirements are met;
- Appropriately qualified professionals are involved in the review of practitioner/facility disputes;
- Relevant clinical/administrative information is consistently gathered and reviewed as part of the investigation;
- Practitioners/facilities are informed of the rationale for disputes that are upheld, in whole or in part.

One (1) level of internal dispute review is available through Optum, unless required by state law or contractual requirement.

Appeals: standard and expedited

Non-Urgent (Standard)	Urgent (Expedited)
• MassHealth (Medicaid): must be requested within 60 calendar days from receipt of the notice of adverse determination. • Optum will make an appeal determination and notify the in writing within 30 calendar days of receipt of request.	• Practitioner/facilities can file an urgent appeal on behalf of a member • Must be requested as soon as possible after the adverse determination • Optum will make a reasonable effort to contact you prior to a determination on the appeal. If Optum is unsuccessful in reaching you, an urgent appeal determination will be made based on the information available to Optum at that time • Notification will occur as expeditiously as the member's health condition requires, not exceeding 72 hours of the receipt of the request.

Appeals: contact information

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

Fax: 1-855-312-1470
Phone: 1-866-556-8166

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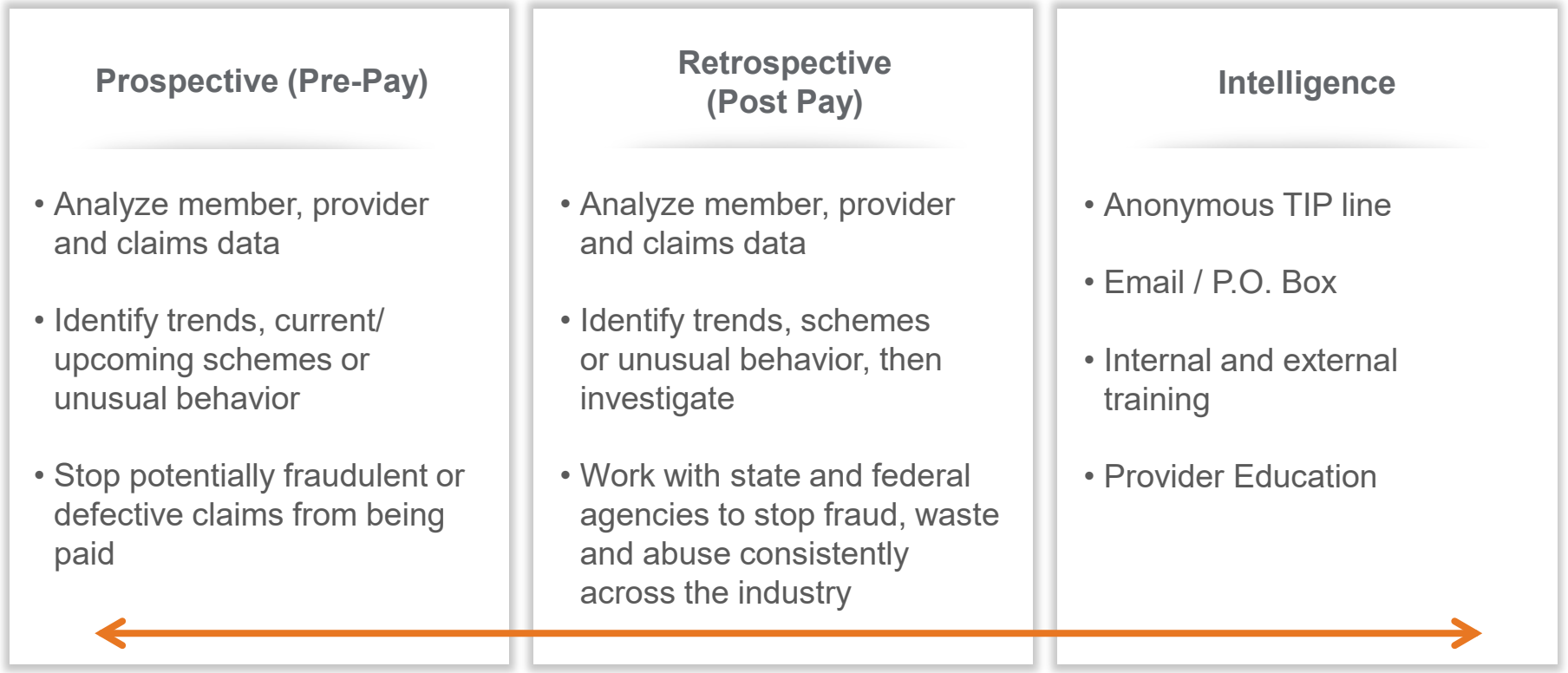
Fraud, Waste, Abuse and Error (FWAE)

Optum Program & Network Integrity (PNI) Department

- A dedicated group responsible for working with providers to prevent, detect, investigate and ultimately resolve potential issues of fraud, waste, abuse and error (FWAE)
- Skilled and trained investigators, providers, data analysts and medical coding personnel

The department consists of three main investigative pathways:



What PNI (FWAE) looks 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)

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FWAE market research and collaboration

General Market Research (all markets)

Prospective Flagging & Retro Investigations

- Identification of “hot spot” trends in claims data on nationwide, state-by-state, or plan basis
- Specific analytics are created from research trends, pooling potential FWAE providers & members
- Provider flags / tips placed based on outcome of provider and member reviews, thereby requiring the provider to submit additional documentation
- Projects revamped on periodic basis to adjust for current trends and market asks

Algorithms and Analytics

- Specific activities identified by policy or code that should not occur are placed into an algorithm to either prospectively prevent such actions from occurring, or retrospectively identify and recoup
- These actions do not require additional records, as they are a strict deny or recoup activity

Customer Collaboration

- Program and Network Integrity works alongside of the customer to assist in identifying potential FWAE activity in schemes or trends that may be specific to the market
- Insight and referrals from the customer are put through our due diligence process to validate and identify if actual FWAE potential exists
- A PNI specific point of contact will be given for all FWAE concerns and questions, should any arise at any point

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Roster and Group Address Maintenance

Roster Maintenance

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

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

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

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

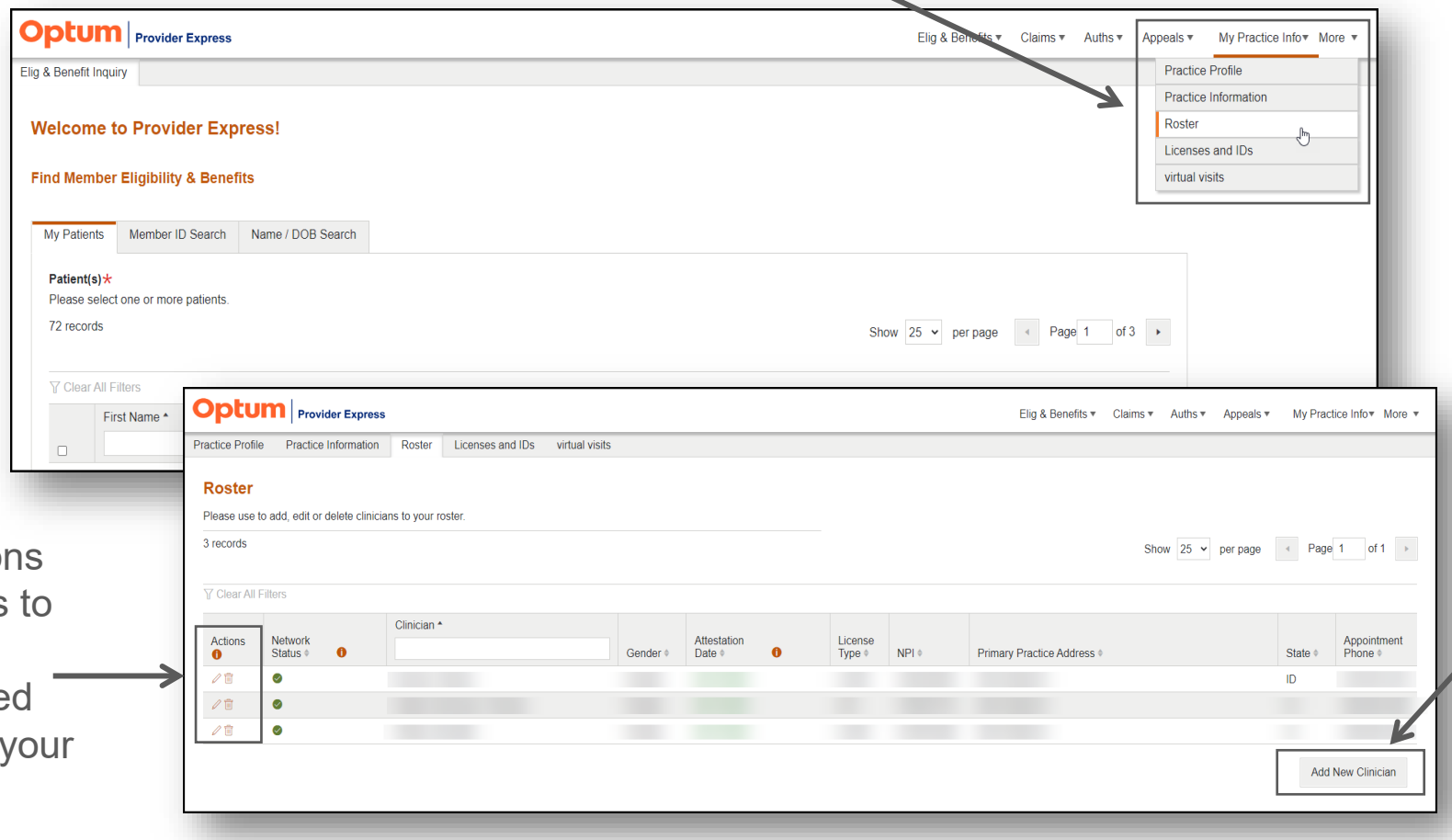
Notify us at providerexpress.com within ten (10) calendar days whenever there are changes to your provider roster.

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

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

Roster Maintenance

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

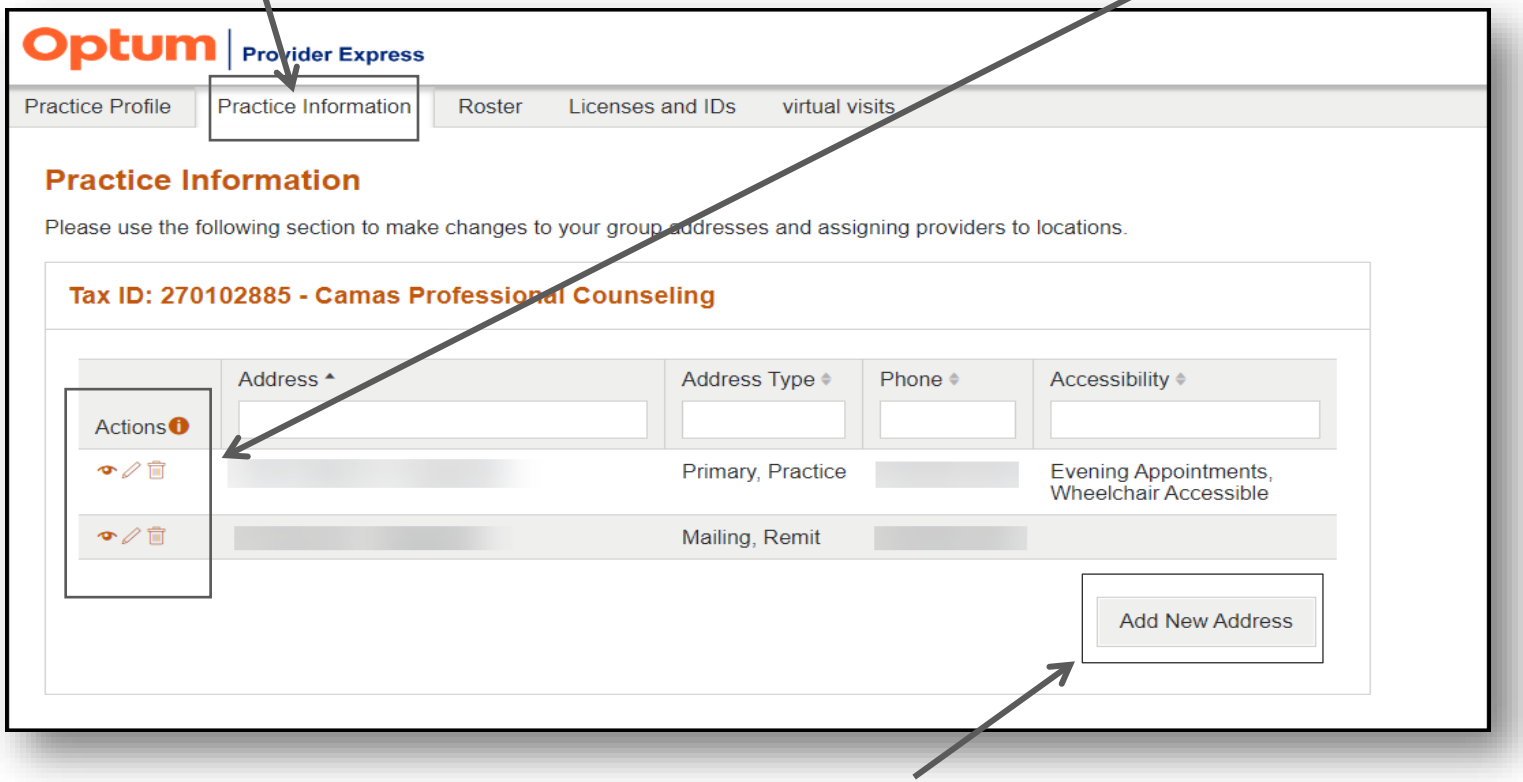


Use the options under Actions to view, edit or delete licensed providers on your roster.

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

Group Address Maintenance

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



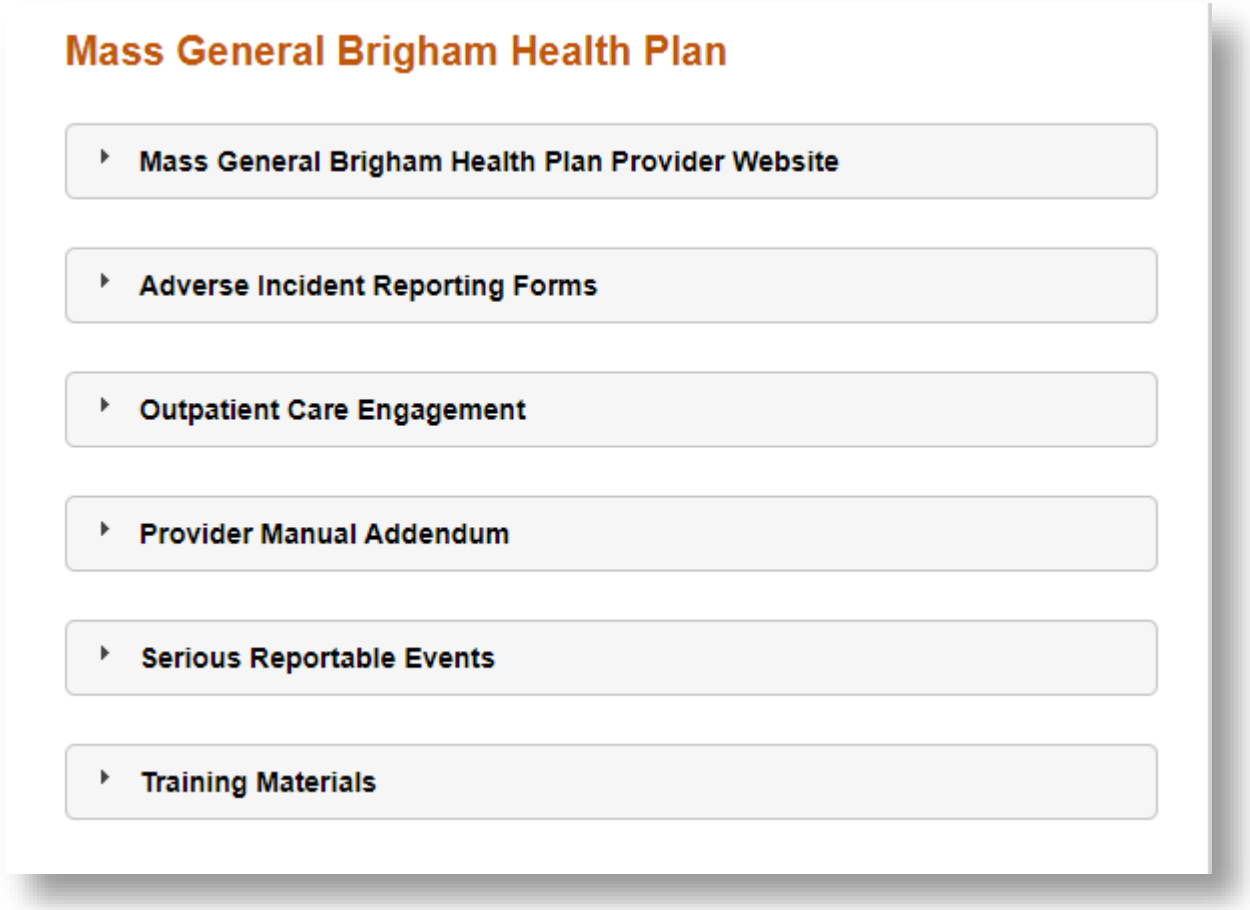
To add a new practice location or a new mailing or remit address, click on the “Add New Address” button.

Optum

Resources

Mass General Brigham Health Plan Provider Express page

[Welcome Massachusetts (providerexpress.com)]



Provider Resources

Provider Express - providerexpress.com

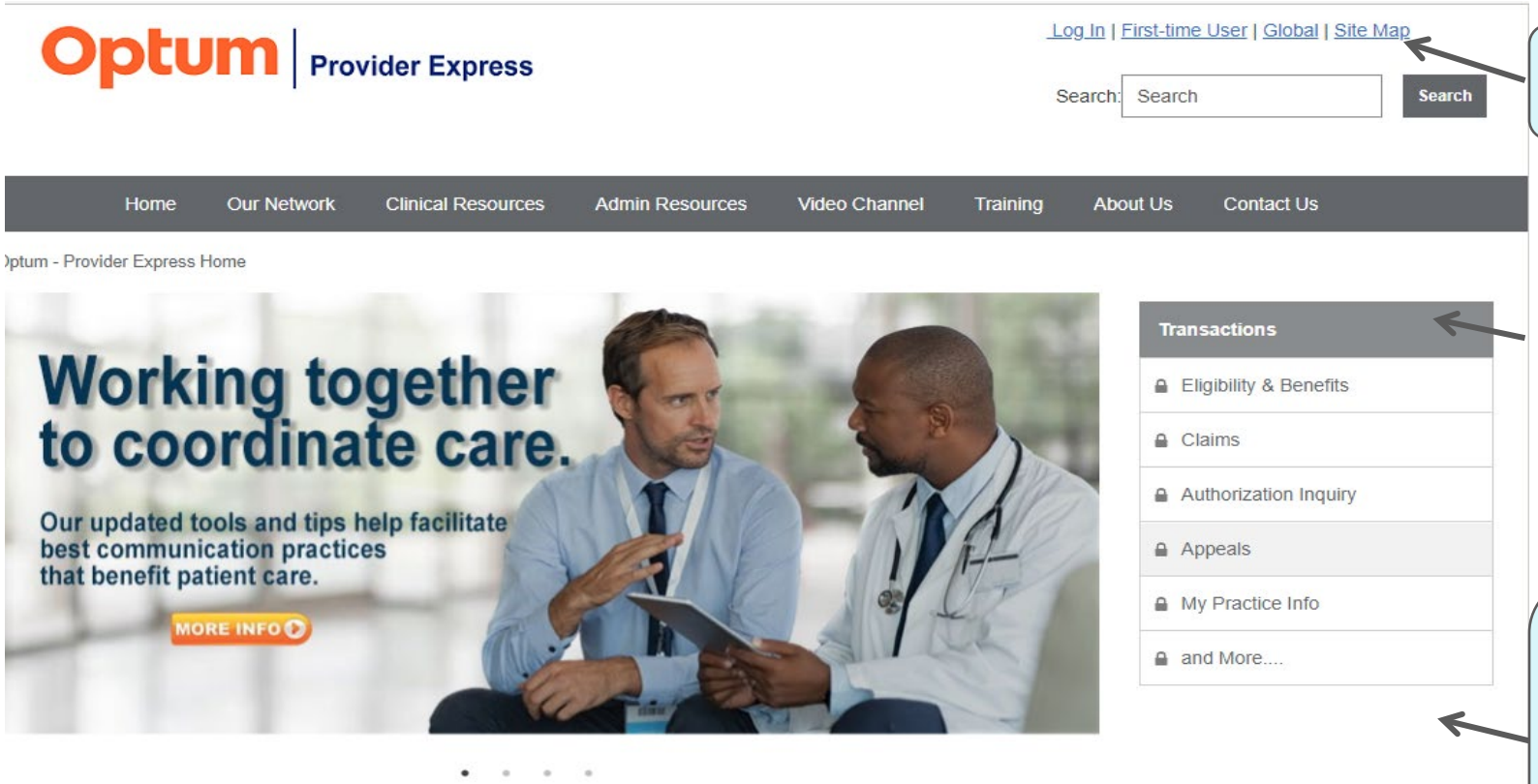
Our industry-leading provider website:

- Includes both public and secure pages for behavioral health providers
- Public pages
  - General updates and useful information
  - Behavioral Health Toolkit for Medical Providers
- Secure pages:
  - Require registration
  - The password-protected “secure transactions” offers providers access to provider-specific information including the ability to update your practice information

Optum

Secure Provider Portal

Provider Express: Secure Provider Portal



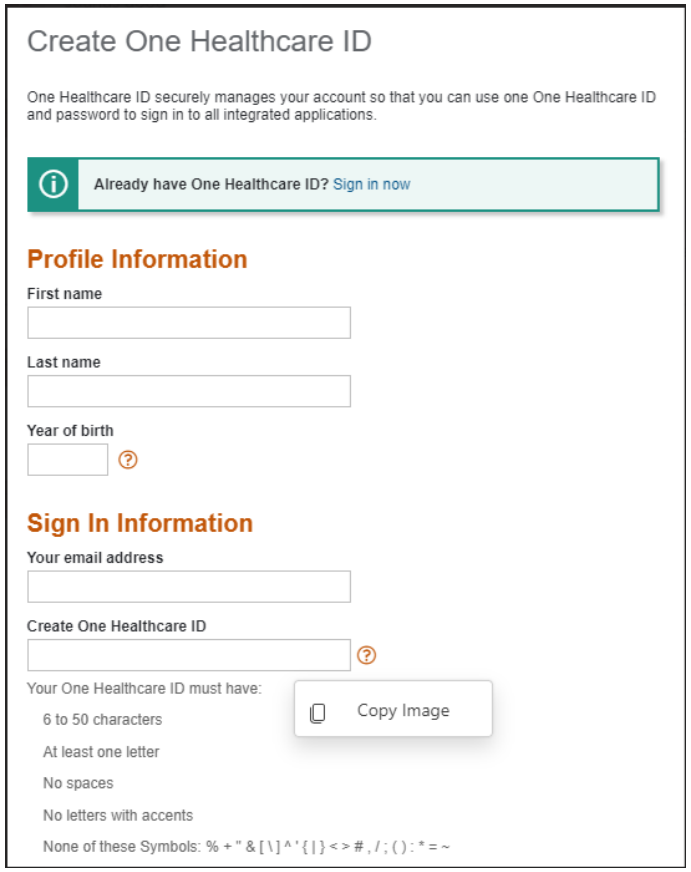
Secure pages require registration

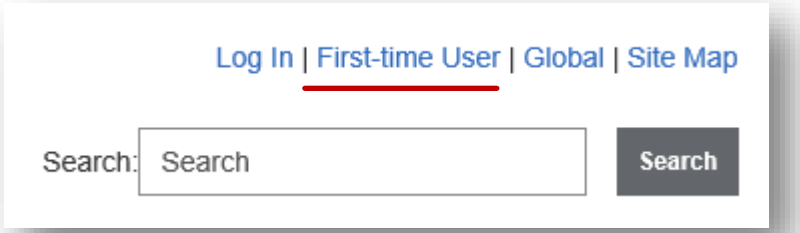
Secure "Transactions" gives you access to Member- and Provider-specific information

Quick Links give easy access to items providers commonly use

Provider Express: Secure Provider Portal

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





You will be prompted to create a One Healthcare ID

Provider Express: Secure Provider Portal

Provider Express offers a range of secure transactions

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

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

Receive payments faster

Benefits of Optum Pay™

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

Registering for Optum Pay is easy!

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

Provider Express Video Channel

Optum

Provider Customer Service

Provider customer service

Because the customer service phone number is different based on the type of business or employer, when calling customer service, you should call the phone number on the back of the member's card. If you do not have a copy of the card, please utilize the numbers below dedicated to the specific line of business:

- Mass General Brigham Health Plan (Medicaid): 1-844-451-3519

Join our network

- The participation process begins with submission of the provider application:
  - Go to Provider Express home page > Our Network. Under “Join Our Network” select “Individually-Contracted providers” and respond to prompts
  - Providers contracting on an individual basis complete the CAQH universal application online at caqh.org
  - Agencies pursuing group contracts complete the Optum Agency application
- Additional required application materials include:
  - Signed Optum Provider Agreement
  - State required credentialing documents (attestation forms, licensures)
- Approval by Optum Credentialing
- Credentialing requirements can be found at providerexpress.com under “Join Our Network”
- Orientation to Optum clinical and administrative protocols via webinars or review of provider resources posted on providerexpress.com

Recredentialing

- Recredentialing is completed every 36 months (3 years):
  - Timeline is established by NCQA
- Several months prior to the recredentialing date, a recredentialing packet will be sent to the primary address on file for the provider
- Completion of the entire recredentialing packet is required for the recredentialing process to be completed
- Site audits will be completed for organizational providers as indicated by Optum policy
- Failure to complete the recredentialing paperwork or participate in the recredentialing site audit (when applicable) will impact the provider's status in the network