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UnitedHealthcare Medicaid Advantage Plus

MAP Behavioral Health Provider Training

April 1, 2024

Welcome To UnitedHealthcare Medicaid Advantage Plus (MAP) Training

Agenda

1. MAP Overview
2. Utilization Management
3. Case Management
4. Quality Improvement
5. Member ID & Eligibility Verification
6. Billing & Claims
7. Provider Resources
8. Q & A

MAP Overview

Medicaid Advantage Plus Overview

A Medicaid Advantage Plus (MAP) plan is a D-SNP combined with a type of MLTC plan offered through the same insurance company.

Plan administers Medicare, Medicaid, long-term care benefits, and drug coverage.

Coverage includes doctor office visits, hospital stays, Part D benefits, LTSS, behavioral health care, dental care, and nursing home care.

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United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum

Medicaid Advantage Plus Eligibility Criteria

- Consumer must be 18 or older
- Must reside in the plan service area (Erie, Genesee, Monroe, Niagara, Orleans, Wyoming)
- Must enroll in UnitedHealthcare Medicare Advantage Plan
- Qualify as a Full Benefit Dual-Eligible entitled to both Medicare Parts A and B or be enrolled in a Part C plan
- Be eligible for nursing home level of care at the time of enrollment
- Must be capable, at the time of enrollment, of returning to or remaining in their home and community without jeopardy to their health and safety
- For consumers in a community setting, they are expected to need at least one of the following community-based long-term services covered by Medicaid Advantage Plus for more than 120 days from the effective date of enrollment:
    - Nursing services in the home
    - Therapies in the home
    - Home health aide services
    - Personal care services in the home
    - Private duty nursing
    - Adult day healthcare
    - Consumer Directed Personal Assistance Services

MAP Benefit Overview - OMH Services Carve-In Crosswalk

Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Mental Health (MH) Services							
OMH Service	**OMH Regulation**	**MAP Medicaid Coverage (Before Jan 2023)**		**MAP Medicaid Coverage (Beginning Jan 2023)**		**MAP Medicare Coverage**	
		Hospital	**Freestanding**	**Hospital**	**Freestanding**	**Hospital**	**Freestanding**
Psychiatric Inpatient	Parts 580, 582, and 587	Covered (days in excess of the Medicare 190-day lifetime maximum)		Covered		Covered (Medicare 190-day lifetime maximum)	
Mental Health Outpatient Treatment and Rehabilitative Services	Part 599	Covered	Covered	Covered	Covered	Covered	Covered
Assertive Community Treatment (ACT)	Part 508	Carved-out		Covered		Not Covered	
Continuing Day Treatment (CDT)	Sections 587.10 & 588.7	Carved-out		Covered		Not Covered	
Comprehensive Psychiatric Emergency Program (CPEP)	Parts 590 & Part 591	Carved-out		Covered		Not Covered	
Partial Hospitalization (PH)	Sections 587.12 & 588.9	Carved-out		Covered		Not Covered	
Personalization Recovery Oriented Services (PROS)	Part 512	Carved-out		Covered		Not Covered (except for the clinic component)	
Crisis Residence	Part 589	Carved-out		Covered		Not Covered	

MAP Benefit Overview – OASAS Services Carve-In Crosswalk

Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Substance Use Disorder (SUD) Services							
OASAS Service	**OASAS Regulation**	**MAP Medicaid Coverage (Before Jan 2023)**		**MAP Medicaid Coverage (Beginning Jan 2023)**		**MAP Medicare Coverage**	
		Hospital	**Freestanding**	**Hospital**	**Freestanding**	**Hospital**	**Freestanding**
Medically Managed Detox – Inpatient	Section 816.6	Covered		Covered		Covered	
Medically Supervised Detox – Inpatient	Section 816.7	Covered	Carved-out	Covered	Covered	Covered	Not Covered
Medically Supervised Detox – Outpatient	Section 816.8 and Part 822	Covered	Covered	Covered	Covered	Covered	Not Covered
Inpatient Rehabilitation	Part 818	Covered	Carved-out	Covered	Covered	Covered	Not Covered
Addiction Treatment Center - State Operated Inpatient Rehabilitation	Part 818		Carved-out		Covered		Not Covered
Residential Services	Part 820		Carved-out		Covered		Not Covered
Outpatient Clinic	Part 822	Covered	Covered	Covered	Covered	Not Covered (see note*)	Not Covered (see note*)
Outpatient Rehabilitation	Part 822	Covered	Covered	Covered	Covered	Not Covered (see note*)	Not Covered (see note*)
Opioid Treatment Program	Part 822	Carved-out	Carved-out	Covered	Covered	Covered	Covered

***Medicare Coverage Note:** Medicare eligible services like psychotherapy and some medication assisted treatment are covered only when delivered by a Medicare enrollable practitioner and billed as a practitioner claim.*

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MAP Benefit Overview – OMH/OASAS Services Carve-In Crosswalk

Combined Medicare Advantage and Medicaid Advantage Plus Benefit Package for Behavioral Health Services with Joint OMH and OASAS Oversight							
OMH and OASAS Service	**OMH/OASAS Regulation**	**Medicaid Coverage (Before Jan 2023)**		**Medicaid Coverage (Beginning Jan 2023)**		**Medicare Coverage**	
		Hospital	**Freestanding**	**Hospital**	**Freestanding**	**Hospital**	**Freestanding**
Community Oriented Recovery and Empowerment (CORE) Services	N/A		Carved-out*		Covered		Not Covered
Mobile Crisis	N/A	Carved-out		Covered		Not Covered	

*Community Oriented Recovery and Empowerment (CORE) Services were implemented February 1, 2022. CORE Services are only available to eligible individuals enrolled in Medicaid Managed Care and will become available for eligible MAP enrollees January 1, 2023.

MAP BH Appointment Availability Standards

Service Type	Emergency	Urgent	Non urgent MH/SUD	BH Specialist	Follow up to emergency or hospital discharge	Follow up to jail/prison discharge
MH Outpatient Clinic/PROS Clinic		Within 24 hrs of request	Within 1 wk		Within 5 days of request	Within 5 days of request
ACT		Within 24 hrs of request			Within 5 days of request	
PROS		Within 24 hrs of request		Within 2 wks	Within 5 days of request	Within 5 days of request
Continuing Day Treatment				2-4 wks		Within 5 days of request
IPRT				2-4 wks		
Partial Hospitalization					Within 5 days of request	
Inpatient Psychiatric Services	Upon presentation					
CPEP	Upon presentation					
Crisis Intervention	Upon presentation	Within 24 hours for short term respite			Immediate	

Service Type	Emergency	Urgent	Non urgent MH/SUD	BH Specialist	Follow up to emergency or hospital discharge	Follow up to jail/prison discharge
Community Mental Health Services (These are 599 clinic services offered in the community)		Within 24 hrs of request	Within 1 wk		Within 5 days of request	Within 5 days of request
OASAS Outpatient Clinic		Within 24 hrs of request	Within 1 wk of request		Within 5 days of request	Within 5 days of request
Detoxification	Upon presentation					
SUD Inpatient Rehab	Upon presentation	Within 24 hrs of request				
Opioid Treatment Program		Within 24 hrs of request			Within 5 days of request	
Residential Addiction Services		Within 24 hrs of request		2-4 wks	Within 5 days of request	
Psychosocial Rehabilitation, CPST,Habilitation, and Family Support and Training	n/a	n/a	Within 2 weeks of request		Within 5 days	

These Appointment Availability Standards are consistent with those established for Medicaid Mainstream and HARP and comply with requirements outlined in the New York State (State) Request for Qualifications (RFQ) for Adult Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plans

Utilization Management

How to Obtain Authorization or Make Notification

Electronic	• Electronic Prior Authorization, Notifications and Supporting Documentation (e.g., LOCADTR) can be submitted to: uhcprovider.com > Health Plans by State > New York > UnitedHealthcare Community Plan of New York home page > Prior Authorization and Notification Tool • For additional information on how to use the Prior Authorization and Notification (PAAN) system, go to: providerexpress.com > Our Network > State-Specific Provider Information > New York > Clinical Information • https://www.uhcprovider.com/en/prior-auth-advance-notification/prior-auth-app.html • **Existing Users:** must log in with username and password • **New Users:** New User Registration can be found by selecting “New User & User Access” on: uhcprovider.com/paan Quick Reference Guide and Other Helpful Resources and Videos and Training can be found at: uhcprovider.com/paan
Telephone	Call Toll-free Provider Line (from the back of the Member card): **(866)-362-3368** Follow the below system prompts: • Question: “Why are you calling?” • Say: “Prior authorization” • Question: “What type?” • Say: “Behavioral health” • Question: “What’s the DOB/MM-DD-YYYY?” • Say or enter: Member’s DOB using the dial pad • Question: “What type of behavioral health?” • Say: the level of care you are requesting • Question: “What’s the NPI?” • Say or enter: NPI using the phone dial pad (if the caller fails to enter the NPI two times, then the IVR will ask the caller to enter the provider TIN)

Utilization Management Appeal

Options for submitting Appeals:

Phone: Toll free appeals line: **1-866-504-3267,** say "***Claims Appeal Status***" when prompted. This will correctly route your call to appeal an UM decision

Phone number can be used to check status of an appeal and verbally submit an appeal

- **Note: Any Appeal filed verbally must also be followed up with a written, signed appeal**
- Enrollees/Providers have 60-calendar days from the date of denial to request an appeal
- Only one internal appeal allowed
- Clinical appeal turnaround time is 72 hours

Mail: UM appeals for **ALL Behavioral Health Services** should be sent to:

UnitedHealthcare Community Plan
Attn: UM Appeals Coordinator
P.O. Box 31364
Salt Lake City, UT 84131-0364

CORE Overview

Effective Feb. 1, 2022

- 4 services moved out of Adult BH HCBS into CORE Service array:
  - Community Psychiatric Support & Treatment (CPST)
  - Family Support and Treatment (FST)
  - Empowerment Services – Peer Support
  - Psychosocial Rehabilitation (PSR)
- Impacts HARP/Wellness4Me members only
- Outpatient level of care delivered in member's home/community or provider's office
- No prior authorization or concurrent review for first year
- CORE requires notification within 2 business days of service initiation
- No daily or annual limits
- Referral for CORE can come from any source

Crosswalk of Transitioning Services

Adult HCBS Services prior to Feb. 1, 2022	Transition Plan as of Feb. 1, 2022	Access Pathway as of Feb. 1, 2022
• Community Psychiatric Support & Treatment (CPST) • Family Support and Treatment (FST) • Empowerment Services-Peer Support • Psychosocial Rehabilitation (PSR)	Transition to CORE effective Feb. 1, 2022 PSR expands to include employment and/or education goals	• HARP/Wellness4Me enrollees only • Referrals can come from any source • No Authorization or Concurrent Review for first year
• Prevocational Services • Transitional Employment • Intensive Supportive Employment • Ongoing Supported Employment • Education Support • Habilitation • Non-medical Transportation	Remain in Adult BH HCBS	No changes

Prior Authorization and Notification

Service	Prior Authorization	Initial Notification	Concurrent Review
Mental Health Partial Hospitalization	Yes	N/A	Yes
Mental Health Continuing Day Treatment (CDT)	Yes	N/A	Yes
Mental Health Intensive Outpatient	Yes	N/A	Yes
Personalized Recovery Oriented Services (PROS) Pre- Admission Status	No	N/A	No
PROS Admission; Individualized Recovery Planning	No	N/A	Yes
PROS: Active Rehabilitation	No	N/A	Yes
Assertive Community Treatment (ACT)	No	N/A	Yes
OASAS outpatient rehabilitation programs	No	No	No
OASAS outpatient and opioid treatment program (OTP) services	No	No	No
OASAS Residential Supports and Services (820)	No	Within 2 business days of admission	Beyond 29th day of admission
Crisis Intervention	No	No	No
Crisis Residence	No	Within 2 days of admission	Yes

Prior Authorization and Notification

Service	Prior Authorization	Initial Notification	Concurrent Review
Outpatient Clinic: Services including initial assessment; psychosocial assessment; and individual, family/collateral, group psychotherapy, and Licensed Behavioral Practitioner (LBHP)	No	No	No
Mental Health Clinic Services: Psychiatric Assessment; Medication Treatment	No	No	No
Psychological or neuropsychological testing	Yes	N/A	N/A

Care Management

UnitedHealthcare Case Management Collaboration with Health Home Partners

UHC Behavioral Health Case Management Services

UHC will assign a member with a BH diagnosis to a licensed BH case manager for engagement in case management

The goal of these voluntary services is to ensure the member is linked with appropriate services that meet their unique needs

UHC licensed behavioral health case managers and medical case managers will collaborate with the member and family as appropriate to develop a person-centered plan of care

Help member access the right treatment, right provider, right medication, in a way that makes the most sense for the member

Health Homes

UnitedHealthcare Community Plan contracts with Health Homes across NYS to provide care coordination and comprehensive care management

Value of Health Home Care Management Services: Assist the member to define health and behavioral health needs and gaps in care, and connect with providers who can address those needs

For a list of active Health Homes: health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_map/index.htm

Who can assist a member to access Health Home Care Management Service: Providers, PCPs, Specialists, ER and Inpatient Discharge Coordinators, and other community-based supports

How UHC works with contracted Health Homes: Ongoing meetings that focus on trends, outcomes and member-specific concerns

If your member is not already enrolled: Reach out directly to the area where the member lives. Each Health Home has a referral line or web portal for easy referral

Using data to target members in need: Use Health Home and PSYCKES data to ensure members are connected to care and meeting health goals

Quality Improvement

Sentinel Events/Critical Incidents

What is a Sentinel Event?	A serious occurrence involving a member that potentially represents a quality-of-care issue on the part of the practitioner/facility, such as death or a serious disability, that occurs during a member's treatment A list of sentinel events/critical incidents that must be reported can be found on providerexpress.com
Timeframe for reporting a Sentinel Event:	As soon as possible, no later than one (1) business day following the event
How to report a Sentinel Event?	Standardized reporting form located at providerexpress.com Email: NYBH_QIDept@uhc.com Fax: 1-844-342-7704 Attn: Quality Department
Investigation process:	A UHC Behavioral Health Complaints Specialist will contact the provider to initiate an investigation. Contracted providers are required to cooperate with all aspects of our investigation process.

Quality of care and Quality of Service Complaints

What is a Quality of Care or Quality of Service Complaint?	Members may be unhappy with our health care providers or with us. We respect the members' rights to express dissatisfaction regarding quality of care/services and to appeal any denied claim/service UnitedHealthcare respects the rights of its members to express dissatisfaction regarding quality of care or services and to appeal any denied claim or service.
Who can make a Quality of Care or Quality of Service Complaint?	• The Member • Member's Designee (with member's written consent) and/or parent/guardian for members under 18 • Health Plan Representative
Timeframe for reporting a Complaint:	Quality of Care and Quality of Service Complaints can be made at any time
Timeframe for investigating a Complaint:	• Urgent complaints: resolved within 48 hours after receipt of all necessary information and no more than 7 days from the receipt of report • Non-Urgent complaints: resolved within 45 days after the receipt of all necessary information and no more than 60 days from receipt of report
Reporting a Quality of Care or Quality of Service Complaint:	The Member or Member's Designee can submit a complaint by following the instructions on the back of the Member's UnitedHealthcare ID card
Investigation process:	A UHC Behavioral Health Complaints Specialist will contact the parties involved to initiate an investigation. Contracted providers are required to cooperate with all aspects of our investigation process.

Provider Performance Reviews

Audit tools can be found on providerexpress.com > Our Network > State-Specific Provider Information > New York page

Timing

When can a review be conducted

- At time of credentialing and re-credentialing
- As part of routine monitoring efforts
- As part of a Quality of Care or other complaint investigation

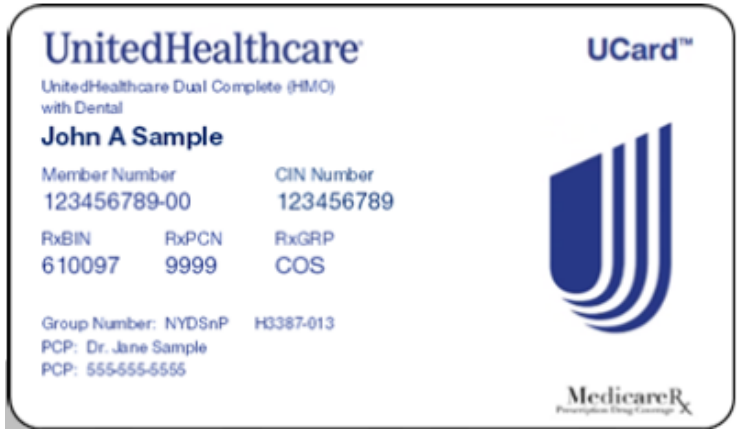
Review

What is evaluated

- Member records
- Coordination of Care with PCPs and BH providers
- Personnel files
- Policies and procedures
- Physical environment

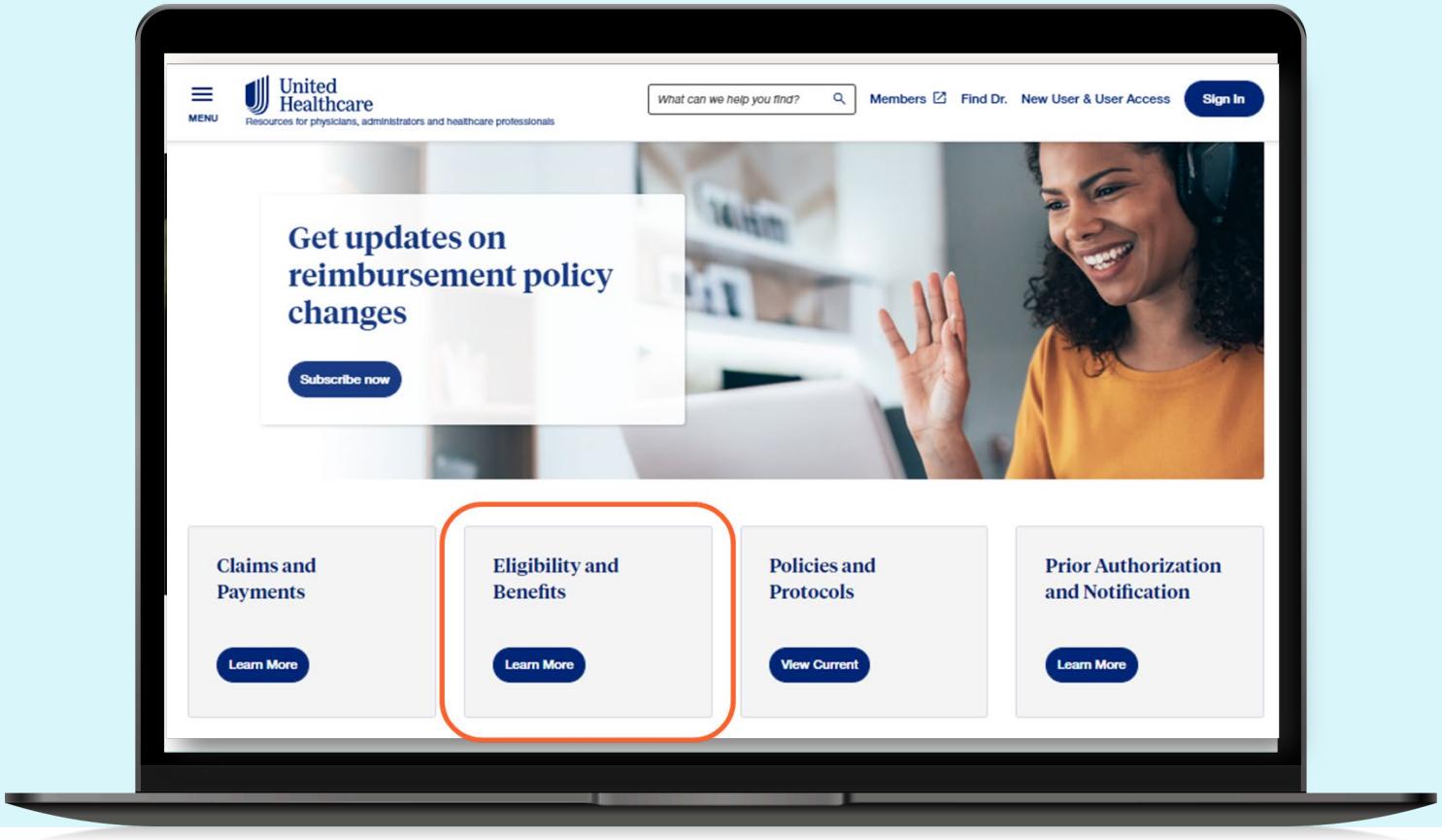
Member ID and Eligibility Verification

UnitedHealthcare MAP Membership Cards:



Sample member ID cards for illustration only; actual information varies depending on payer, plan and other requirements. Not for distribution to retirees or beneficiaries.

Member Eligibility Verification



Providers are **required** to check eligibility with UnitedHealthcare to ensure services is eligible for payment: uhcprovider.com

Medicaid Eligibility Verification (MEV) System:

- Telephone
- ePaces
- X12 270/271 Health Care Benefit Inquiry and Response
- eMedNY Call Center 1-800-343-9000

Billing and Claims

Medicaid Managed Care Plan Claiming

Map Plan supports Paper and electronic claim submission for all claim types. Claims can be submitted using 837i (institutional) or UB-04 (paper) claim form.

Rate codes are required and entered in the header of the claim as a value code. In the value code field type “24” and follow with the appropriate four-digit rate code. (Current Medicaid FFS billing standard)

NYS provides MAP Plans a complete listing of all existing providers and the rate code they bill under as well as rate amounts by Medicaid Management Information System (MMIS) ID (aka Provider ID) and locator code and/or National Provider ID (NPI) and zip. List can be found on the OMH and OASAS websites.

Electronic claim submission requires a minimum of the following:

- 837i or UB-04 claim format
- Medicaid Rate code
- Diagnosis code(s)
- Procedure code(s)
- Procedure code modifiers (as needed)
- Units of service

Note: Billing requirements depend on the type of service provided.

Services Covered by Medicare and Medicaid

Beginning Jan. 1, 2023, MAP Plans will pay the **"higher of"** what Medicare or Medicaid would pay for BH ambulatory services that are reimbursable under both Medicare and Medicaid. With the principle of Medicaid being the payor of last resort, Medicaid is responsible for the remaining balance after the Medicare payment, up to the Medicaid rate if the Medicaid rate for the service is higher than Medicare. Medicaid reimburses 100% of the patient cost-sharing responsibility if the Medicare rate is higher than the Medicaid rate.

The "higher of" requirement applies to the following services:

- Mental Health Outpatient Treatment and Rehabilitative Services
- Personalized Recovery Oriented Services (PROS) (Clinic component)
- Outpatient Medically Supervised Stabilization and Withdrawal (Detox)
- Outpatient Chemical Dependence (CD) Clinic (aka Outpatient Addiction Rehab)
- Outpatient CD Rehabilitation (aka Outpatient Addiction Day Rehab)
- Opioid Treatment Program

NOTE: If the service and the professional performing the service are allowable under Medicaid, but not allowable under Medicare, MAP Plans must reimburse the service as a Medicaid-only service at the Medicaid rate. Typically, the practitioner in these programs is not allowable under Medicare, in which case the MAP Plan must reimburse the service at the Medicaid rate.

Allowable Service Combinations

Allowable Billing Combinations of OMH State Plan Services and CORE Services											
	MHOTRS	ACT [1]	CDT	PHP	PROS w. Clinic[5]	PROS w/o Clinic[5]	CORE CPST	CORE PSR	CORE FST	CORE Peer Support	Crisis Intervention
Mental Health Outpatient Treatment & Rehab Services (MHOTRS)	N/A	No[4]	No[4]	No	No[4]	Yes	Yes[3]	Yes	Yes	Yes[4]	Yes
Assertive Community Treatment (ACT) [1]	No[4]	N/A	No	No	No[2]	No[2]	No	No	No	No	Yes
Adults Continuing Day Treatment (CDT)	No[4]	No	N/A	No	No	No	No	Yes	Yes	Yes	Yes
Partial Hospitalization Program (PHP)	No	No	No	N/A	Yes	Yes	No	Yes	Yes	Yes	Yes
Personalized Recovery Oriented Services (PROS) with Clinic[5]	No[4]	No[2]	No	Yes	N/A	No[4]	No	No	No	Yes	Yes
PROS without Clinic[5]	Yes	No[2]	No	Yes	No[4]	N/A	No	No	No	Yes	Yes
CORE Community Psychiatric Support and Treatment (CPST)	Yes[3]	No	No	No	No	No	N/A	Yes	Yes	Yes	Yes
CORE Psychosocial Rehabilitation (PSR)	Yes	No	Yes	Yes	No	No	Yes	N/A	Yes	Yes	Yes
CORE Family Support and Training (FST)	Yes	No	Yes	Yes	No	No	Yes	Yes	N/A	Yes	Yes
CORE Empowerment Services - Peer Support (Peer Support)	Yes[4]	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A	Yes
Crisis Intervention	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	N/A

[1] Assertive Community Treatment (ACT) services includes Adult, Young Adult and Youth ACT.
[2] ACT and PROS enrollment, co-enrollment is permitted for up to 3 months in a 12-month period. A PROS provider may bill at Level 1, 2 or 3 of the PROS Monthly Base Rate. An ACT provider may bill for the partial step- down payment level of services.
[3] Services comparable to OMH Mental Health Outpatient Treatment and Rehabilitative Services are available through CORE CPST. Enrollees may access non-duplicative services through CORE CPST in a single month for the following purposes:

- Access to a psychiatric prescriber (e.g., psychiatric assessment/evaluation, medication management, health monitoring) if the CORE CPST provider does not have a prescriber. Receiving psychotherapy through OMH Mental Health Outpatient Treatment and Support Services and CORE CPST is duplicative. Medication management and supporting activities through OMH Mental Health Outpatient Treatment and Support Services is duplicative if the CORE CPST provider has a prescriber on staff.
- Transition from CORE CPST to OMH Mental Health Outpatient Treatment and Support Services (including CCBHC), allowing for a warm handoff during the clinic pre-admission process (3 sessions).
- The CORE CPST provider should maintain communication with the prescriber to ensure integrated treatment/care.

[4] See regulations for exceptions: https://omh.ny.gov/omhweb/clinic_restructuring/part599/part-599.pdf
[5] There are no co-enrollment restrictions for an individual in pre-admission status at PROS. Individuals who are in pre-admission do not have the PROS RE codes on their file.

Clean Claim

A claim with no defect or impropriety (including any lack of any required substantiating documentation) is considered a clean claim. All claim submissions must include, but are not limited to:

- Member's name, identification number and date of birth
- Provider's Federal Tax I.D. number (TIN)
- National Provider Identifier (NPI)
- Taxonomy Code
- A complete diagnosis (ICD-10-CM)
- Date of Service
- Duration / Units

- A claims must be on the correct claim form
  - Agency
  - Facility (i.e., Hospital, Residential)
- Correct code(s) corresponding to service provided:
  - Value Codes
  - Rate Codes
  - Revenue Codes
  - CPT/HCPCS Codes
  - Modifiers
  - Etc.

Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at

cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci

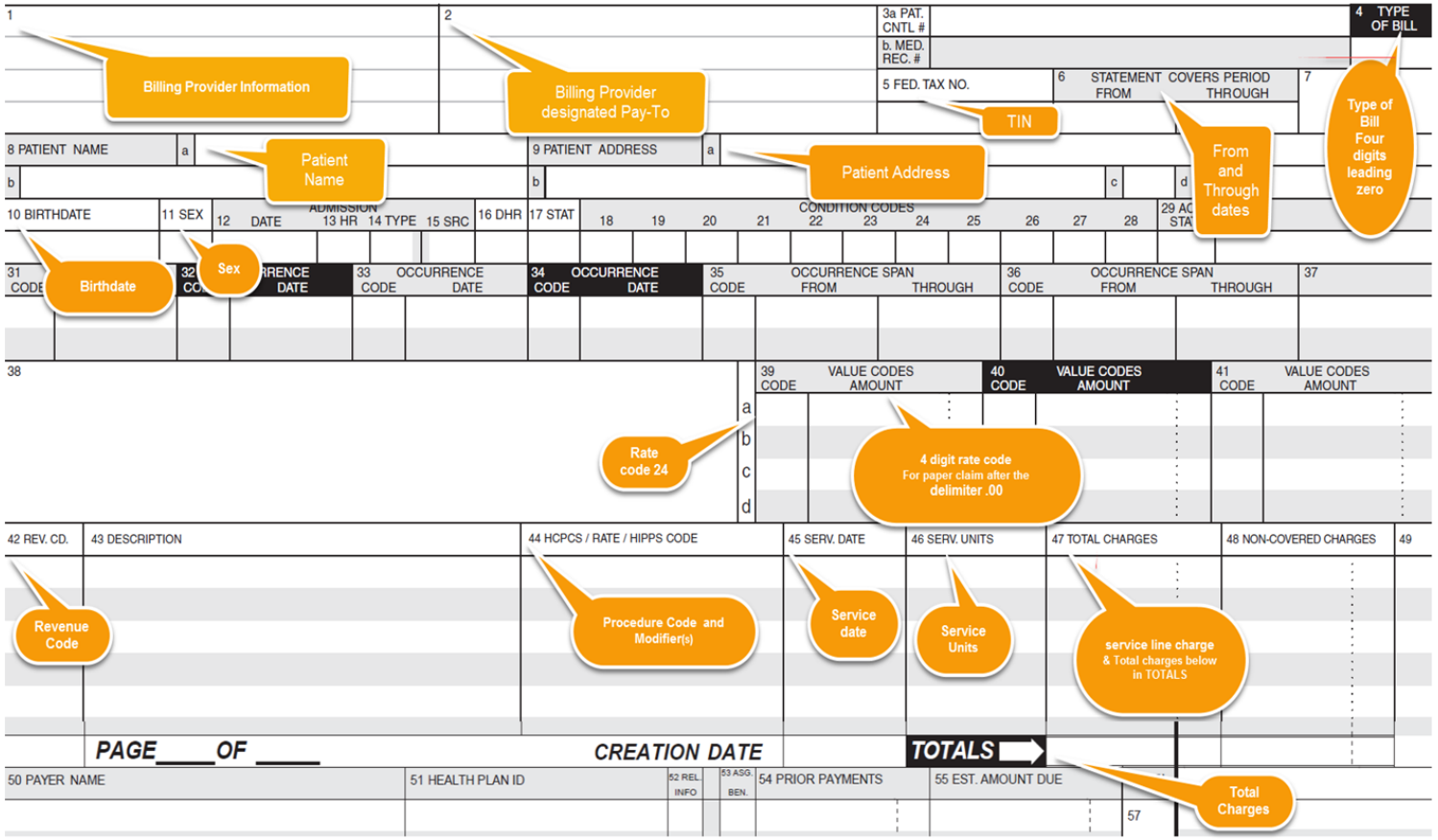
MCTAC Billing Tool: Top section of UB-04 claim form

Billing Overview:

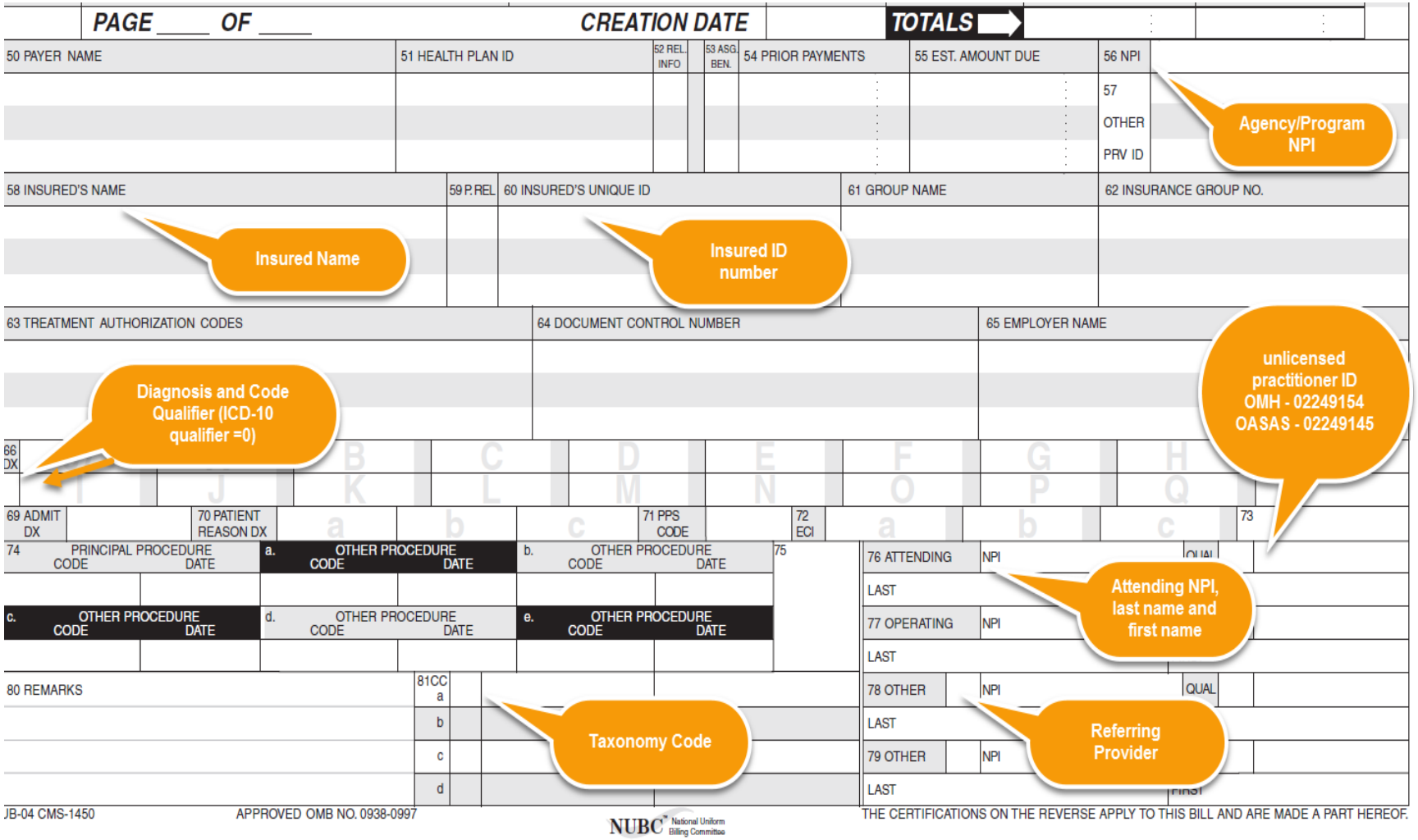
An interactive UB-04 form that walks through the components required to submit a clean claim

MCTAC Billing Tool:

billing.ctacny.org/



Additional Billing Requirements/Guidance For OMH and OASAS Providers



Unlicensed Provider ID: Claim Submission

Unlicensed Practitioner ID as attending:

- OASAS Unlicensed Practitioner ID: 02249145
- OMH Unlicensed Practitioner ID: 02249154
- OCFS Unlicensed Practitioner ID: 05448682

For Electronic/EDI Claims:

- When submitting claims utilizing an unlicensed practitioner ID as Attending, providers will submit the NM1 Attending Provider Loop 2310A as follows:
- NM108 and NM109 will be blank/not sent
- REF Attending Provider Secondary Information will be added
- REF01 G2
- REF02 the OASAS, OMH, or OCFS (CFTSS and HCBS) unlicensed practitioner ID (example: REF*G2*02249145~)

Electronic Data Interchange

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

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

Optum can recommend a vendor that is right for you:

- Contact via phone 1-800-765-6705 or via email: inform@optum.com
- Provide: Name, tax ID, claims volume, single or multi-payer interest

Electronic Payments and Statements through Optum Pay

- Easy set-up, 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

- Go to myservices.optumhealthpaymentservices.com
- Contact Optum Financial Services for assistance: 1-877-620-6194
- Find additional information on providerexpress.com > Quick Links > Optum Pay

Claims Submission

Electronic Claim Submission (837i): payer ID 87726

Preferred method of submission

- Fast
- Convenient
- Secure
- Efficient
- Complete
- Cost-efficient

Paper Claim Submission (UB-04):

If you are unable to file electronically:

- Mail Paper Claims to:

Optum Behavioral Health
P.O. Box 30760
Salt Lake City, UT 84130-0760

Claims Submission Deadline

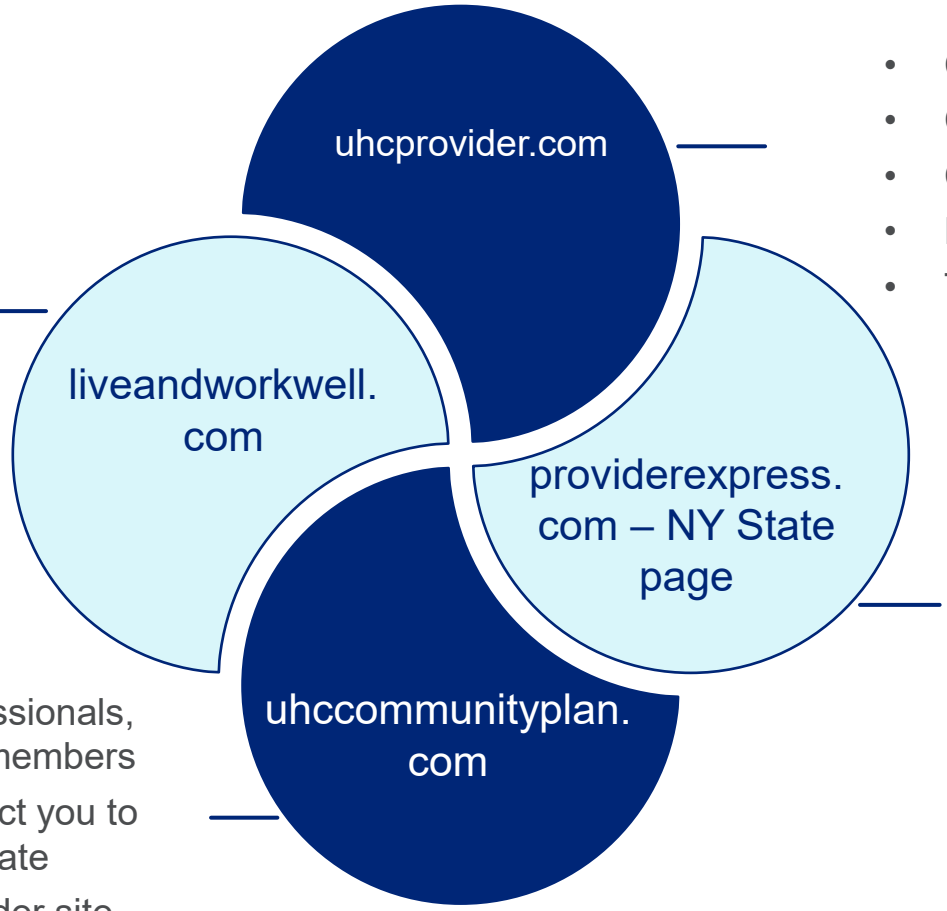
- Providers must initially submit claims within 120 days after the date of service.
- Clean paper claims will be paid within 45 days of receipt
- Clean electronic claims will be paid within 30 days of receipt
- If a provider wants to appeal a claim payment or denial, the appeal must be submitted 90 days after receipt of the Provider Remittance Advice (PRA)
- Providers must notify UnitedHealthcare within one year of the date of service if they feel there is a discrepancy (i.e., incorrect rates, inappropriate denials) in claim processing. There is a one year look back period on claim adjustments.

Provider Resources

UnitedHealthcare Provider Portals and Online Resources
Training Resources

UnitedHealthcare and Optum Online Resources

- Find providers in the network
- Confidential work/life resource center
- Interactive assessments
- Medication database
- Self-help resources



- Check member eligibility
- Check claim status and payments
- Claims reconsideration
- Electronic Data Interchange (EDI) information
- Tools and resources

- A website for health care professionals, community organizations and members
- For providers, the links will direct you to important information in your state
- Directs you to our secure provider site UnitedHealthcare Online®

- NY-specific Provider resources
- Network notifications
- Provider training materials and resources
- Clinical guidelines and policies
- Sentinel Events reporting form

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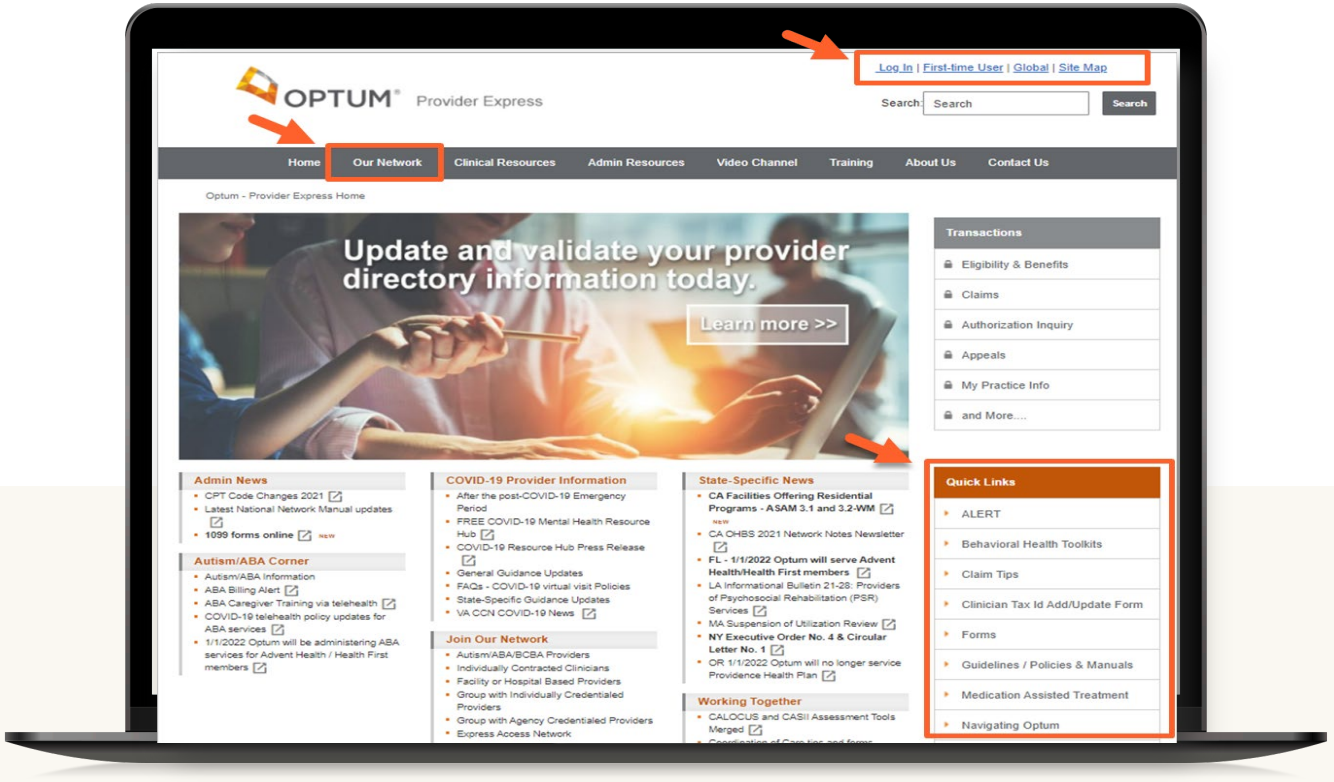
providerexpress.com

Provider Resource:

- State-Specific News
- Quick Links
- Clinical Resources
- Trainings
- Transactions (available to in-network providers only)

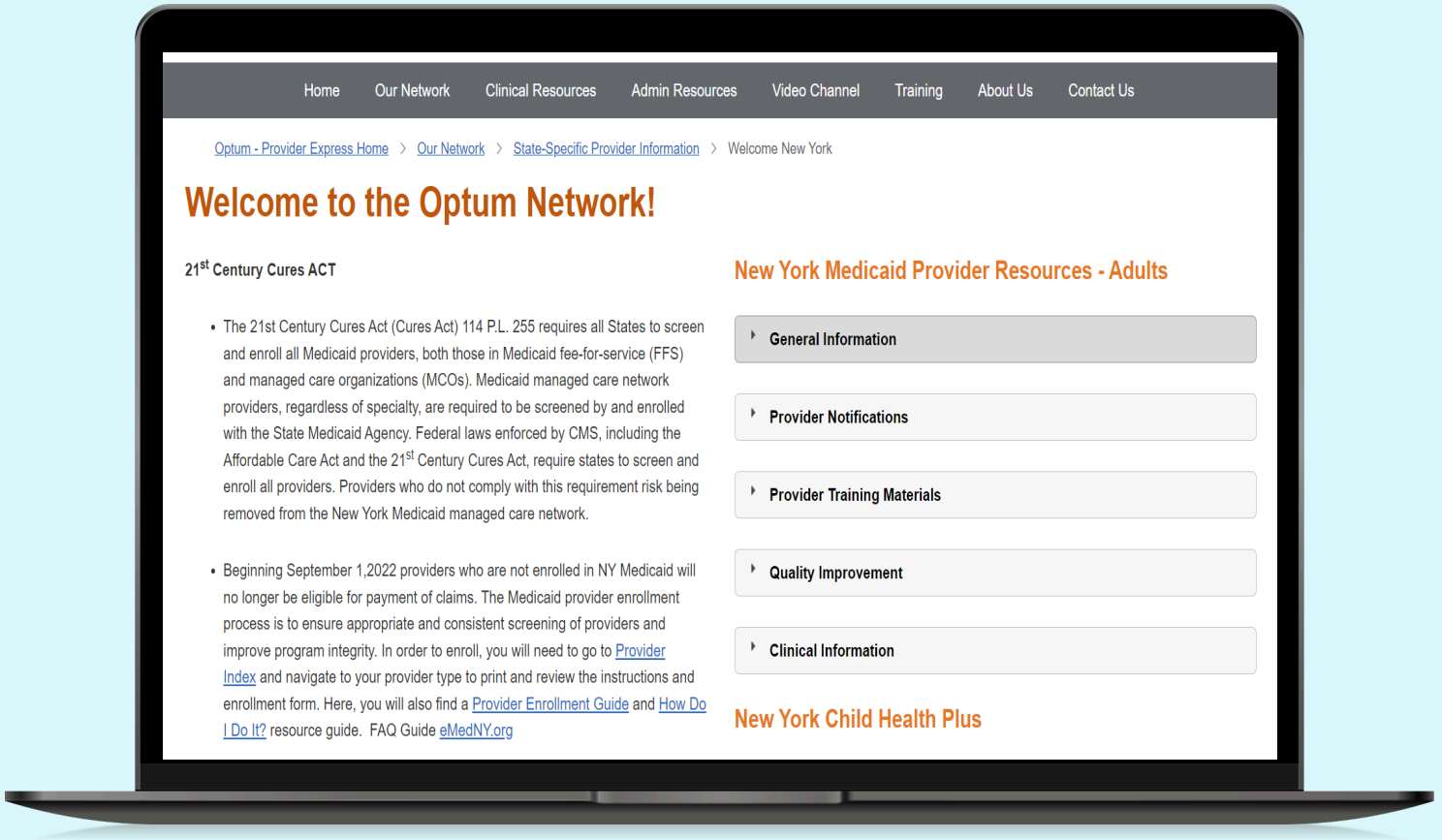


Public pages

Private pages (in-network providers only)

Navigate to NY Page via Our Network

providerexpress.com NY Page



NY State-specific Alerts and Information

Product-Specific Information- QRGs, provider notifications and training, Clinical Information

Links to Provider Manuals and Standard Clinical Criteria

liveandworkwell.com

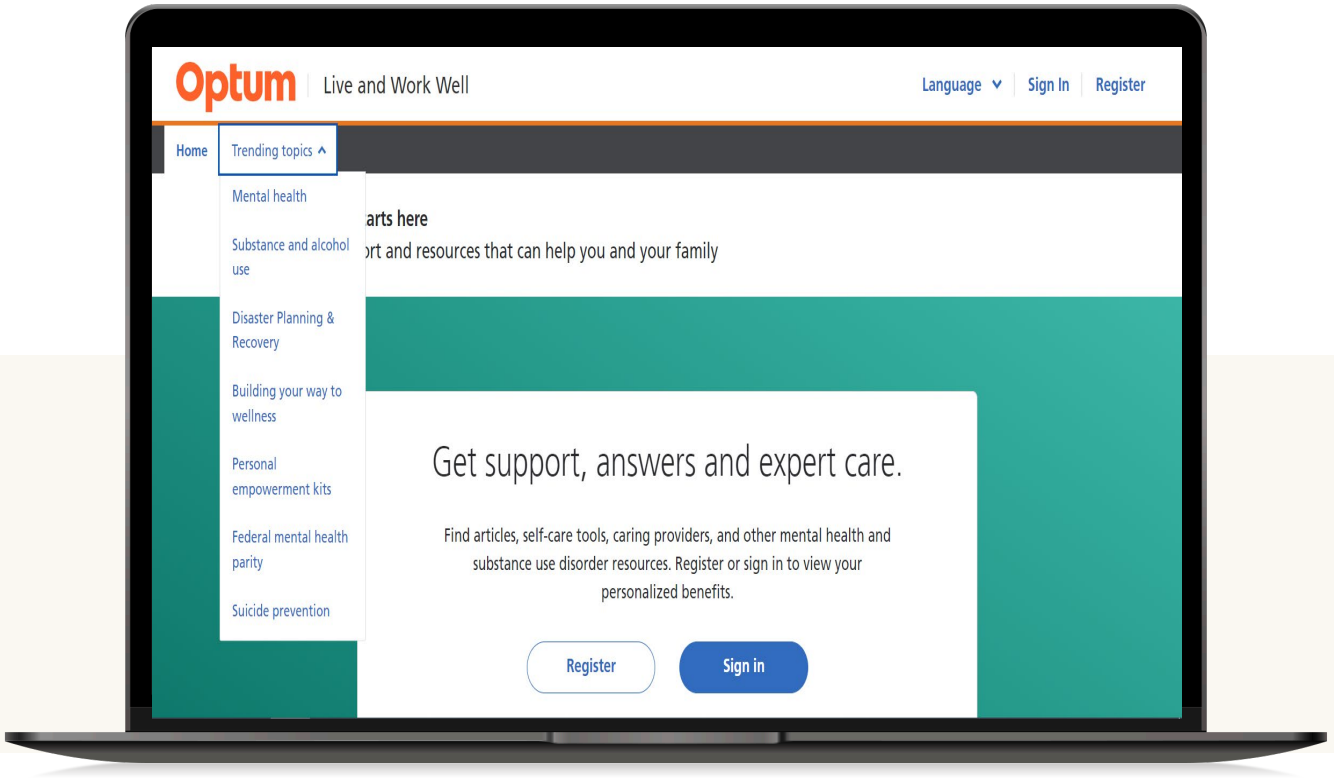
Member Resource:

- Videos, articles and resources
- NY-specific resource database
- Additional searchable databases to look up information/resources on childcare, eldercare, health conditions, alternative medicine, drug interactions and more

Public pages

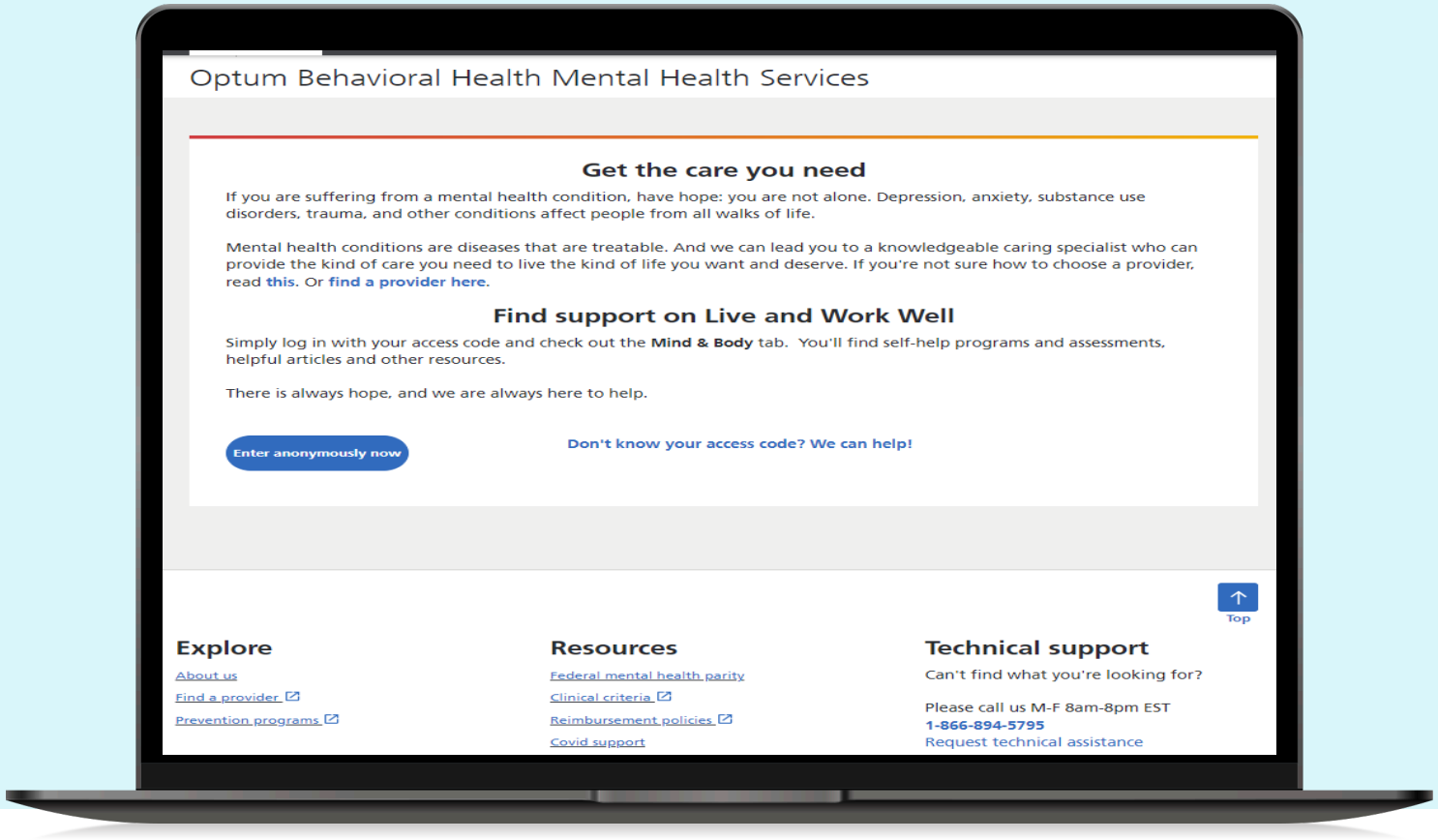
Secure pages

Register or Enter as Guest



United Behavioral Health and United Behavioral Health of New York, I.P.A., Inc. operating under the brand Optum

liveandworkwell.com Mental Health Services Page



- NY State-specific provider directory
- Search by Geography, Provider Type, Areas of Expertise
- Links to Self-help programs and assessments

uhcprovider.com

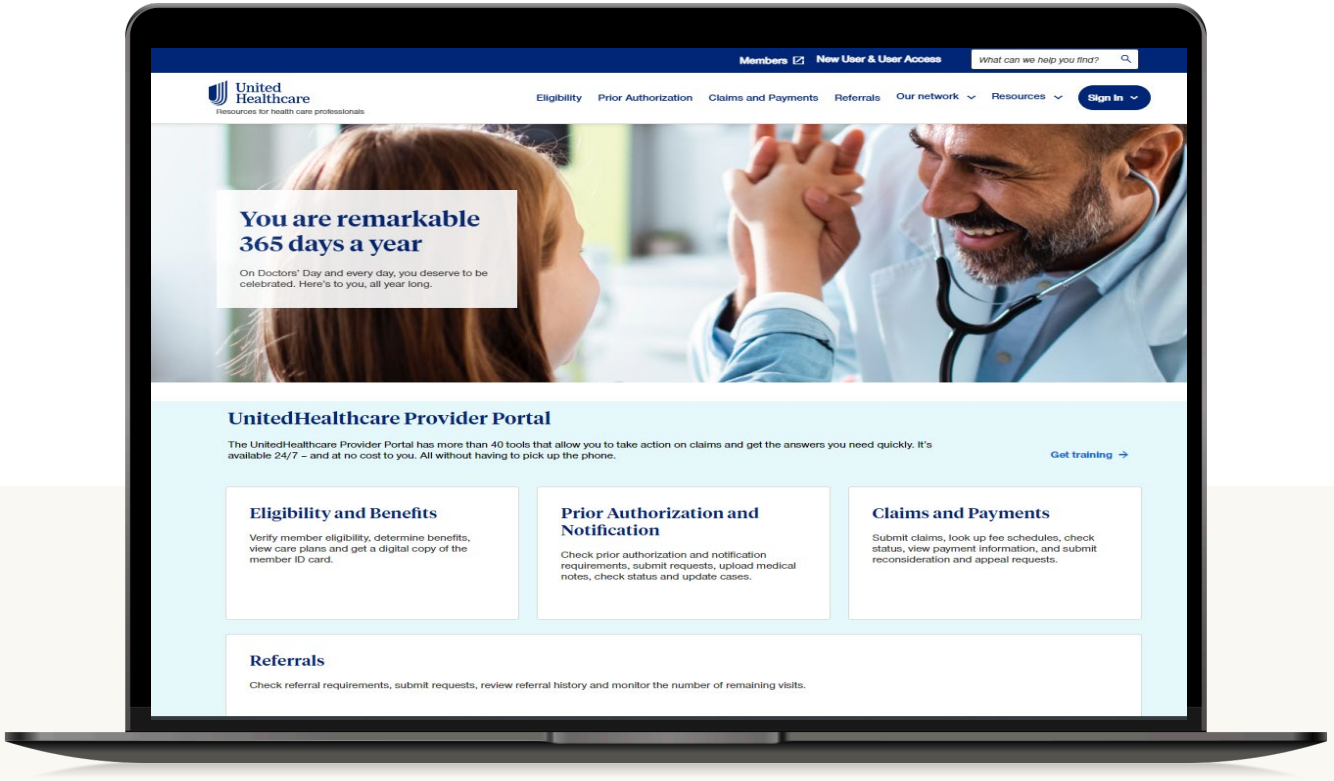
Member and Provider Resource:

- Find a provider
- Phone number and links to connect with UHC
- Preferred lab network
- Providers can update demographics and profiles
- Check member eligibility and benefits
- Submit prior authorization/notification
- Payment portals

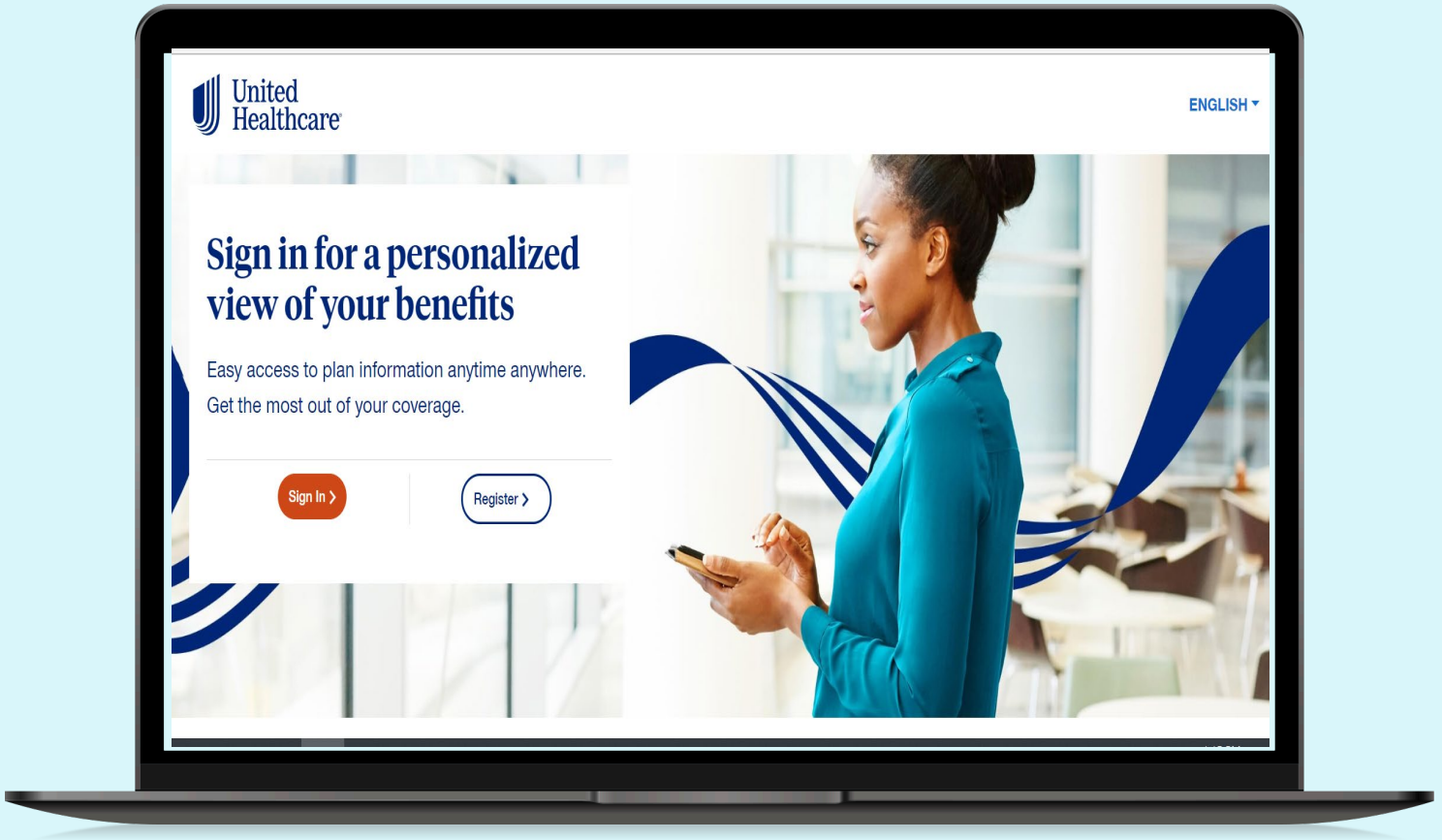
Member pages

Provider pages

Go paperless



uhcprovider.com Member Page



Personalized view of benefits

Find providers

Connect with UHC

uhccommunityplan.com

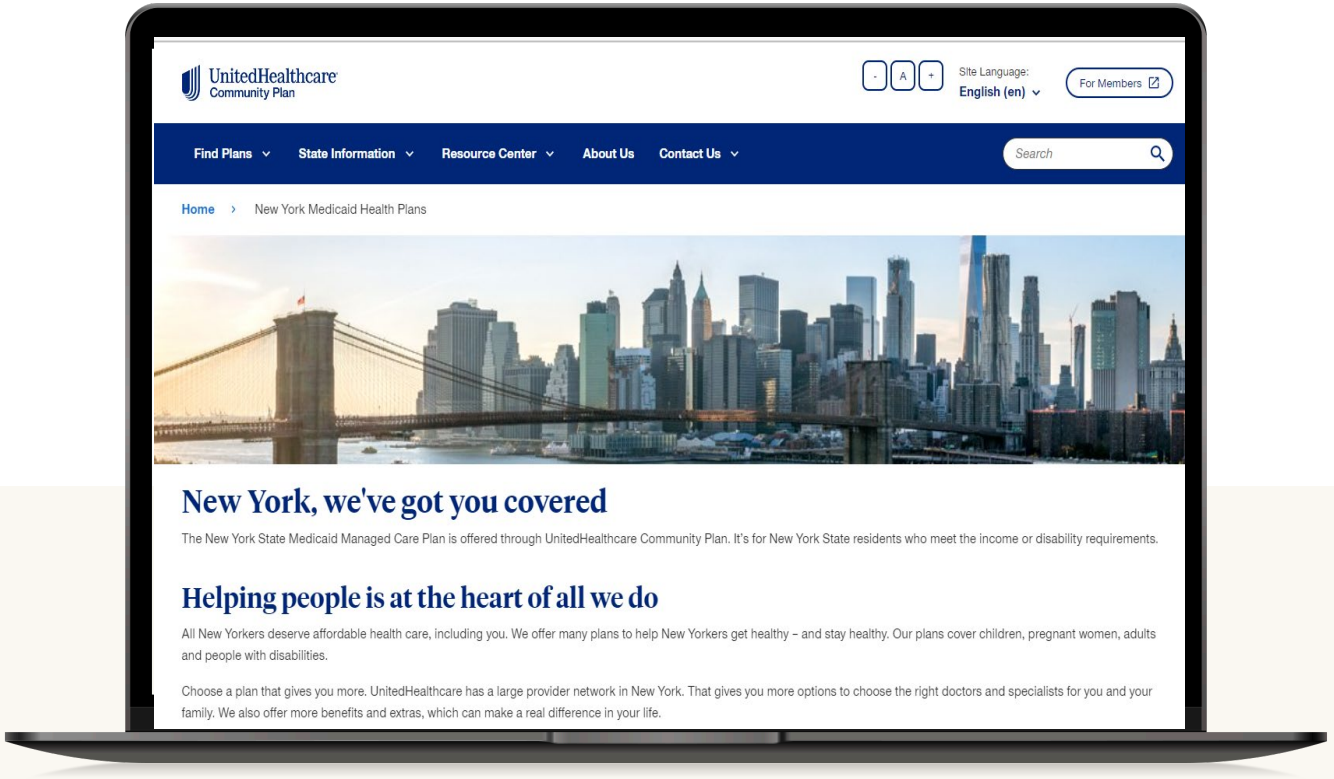
Member Resource:

- Select State Information to navigate to NY page
- Review all NY Community Plans (Medicaid, EPP, DSNP)
- Learn about all covered benefits: Mental health and substance use treatment, Care management, Diabetes supplies, Hearing services, Vision care
- Valuable information and tips to help those who care for people with both Medicaid and Medicare
- FAQs

Member pages

Provider pages

Go paperless



Managed Care Technical Assistance Center (MCTAC)

The Managed Care Technical Assistance Center (MCTAC) is a training, consultation, and educational resource for all mental health and substance use disorder providers in New York State.

What's available:

- ✓ Interactive Glossary of Terms
- ✓ Managed Care Language Guide
- ✓ Frequently Asked Questions
- ✓ MCO Plan Matrix
- ✓ Sample Instructional Claim Form
- ✓ Top Denials
- ✓ RCM Best Practices
- ✓ Best Billing and RCM Practices for working with MMCPs

MCTAC Home Page

ctacny.org

Center for Practice Innovations (CPI)

NYS requires OMH/OASAS licensed providers to take Uniform Network Provider Trainings with Center for Practice Innovations (CPI). Training can be found on the CPI website:

Center for Practice Innovations > Initiatives > UCNPT Uniform Clinical Network Provider Training > Overview

Training Topics Include:

- Motivational Interviewing
- Substance Use Disorders
- Suicide Prevention
- Person-centered Care
- Integrated Care (health and behavioral health conditions)
- Shared Decision Making
- Unique Needs of Children Involved in Child Welfare
- Unique Needs of Children with Serious Emotional Disturbances (SED)
- Unique Needs of Transition Age Youth (TAY)
- Unique SUD Needs of Adolescents
- Unique needs of Children 0-5
- Unique Needs of Medically Fragile Children
- CFTSS- Promoting Childhood Behavioral Health and Wellness: Early and Periodic Screening and Diagnostic Treatment (EPSDT)

New Users: Enrollment Form for CPI Trainings: Application to Join CPI's Learning Community (qualtrics.com)

Mandatory Annual Cultural Competency Training Requirements

Participating OMH/OASAS licensed/designated providers are expected to complete state required annual cultural competency training for all staff who have regular and substantial contact with members. Approved Cultural Competence Trainings Include:

NYS OMH

Center for Practice Innovation Platform:

- Network Provider Training Part 1: Cultural Competence
- Network Provider Training Part 2.1: Using the Cultural Formulation Interview

NYS OASAS

Center for Practice Innovation Platform:

- Network Provider Training Part 1: Cultural Competence
- Network Provider Training Part 2.1: Using the Cultural Formulation Interview

OASAS Training Catalog: Cultural Competency

webapps.oasas.ny.gov/training/index.cfm

For additional NYS Guidance:
omh.ny.gov/omhweb/bho/docs/cultural_competency_curriculum.pdf

Q&A