

2019

UnitedHealthcare Community Plan
of Washington
Behavioral Health Manual



Washington Integrated
Managed Care
UnitedHealthcare Community
Plan

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Introduction

Welcome!

We are pleased to have you working with us to serve the individuals covered under Washington Medicaid. We are focused on creating and maintaining a structure that helps people live their lives to the fullest. At a time of great need and change within the health care system, we are energized and prepared to meet and exceed the expectations of consumers, customers and partners like you.

Our relationship with you is foundational to the recovery and well-being of the individuals and families we serve. We are driven by a compassion that we know you share. As we work together, you will find that we seek and pursue opportunities to collaborate with you to set the standard for industry innovation and performance.

We encourage you to make use of Provider Express, our industry-leading website, (providerexpress.com) where you can get news, access resources and, in a secure environment, make demographic changes at the time and pace you most prefer. We continuously expand our online functionality to better support your day-to-day operations. Visit us often!

Important Notice

This manual does not replace the primary national [Network Manual](#). Rather, this manual supplements the Network Manual by focusing on the core service array, roles and responsibilities, as well as process and procedures specific to the State of Washington Medicaid programs. UnitedHealthcare provides this manual as a more focused resource for clinicians specifically serving the Washington Medicaid membership. In addition, some sections of the primary Network Manual are included in this manual for your convenience. The [National Manual](#) can be found on Provider Express (Quick Links > Guidelines/Policies & Manuals > Network Manual > [National Network Manual](#)).

Governing Law

This manual shall be governed by, and construed in accordance with, applicable federal, state and local laws. To the extent that the provisions of this manual conflict with the terms and conditions outlined in your Agreement, the subject matter shall first be read together to the extent possible; otherwise and to the extent permitted by, in accordance with, and subject to applicable law, statutes or regulations, the Agreement shall govern.

Clinical Overview

Effective January 1, 2019, UnitedHealthcare Community Plan (The Plan) will manage mental health and substance use disorder services to help adults and children enrolled in Washington Medicaid access the most effective treatment for their needs.

UnitedHealthcare is working closely with the state of Washington, consumers, family members, providers and community stakeholders to develop, implement and maintain a utilization management program for Washington Medicaid to monitor the appropriate utilization of covered services and to:

Simplify the administrative processes for providers, enabling them to devote more staff time to treating Members

- Encourage Members to access services at the time they first recognize symptoms in themselves or in a family member
- Ensure that all services provided are medically necessary, are focused on measurable outcomes, and are supporting the Member's recovery and/or the family's resiliency

Our focus is on improving access to treatment, expanding the array of covered services and improving the quality of care and treatment outcomes. Our goal is to enhance the statewide behavioral health system and make it easier for people to access care. In addition to adding more behavioral health care providers and programs, UnitedHealthcare plans to increase services available in rural areas to ensure that Members are able to get the care they need in their community.

UnitedHealthcare is committed to recovery, resiliency and person-centered care. This includes assisting and supporting people in learning to manage their behavioral health and wellness challenges. Our practices are anchored in the belief that people with mental illness are able to live, work and participate productively in their communities despite their behavioral health challenges, and are resilient and able to rebound from trauma, stigma and other stresses.

We look forward to an active partnership as we all work together to improve the lives of Members in Washington.

Washington Medicaid Benefits

UnitedHealthcare Community Plan of Washington administers behavioral health integrated managed care benefits for Washington Medicaid (Apple Health) Members. All Medicaid Members shall be provided care in the same manner, on the same basis, and in accordance with the same standards offered to all other Members in your care.

Clinical Incident Reporting

Critical Incidents are traumatic. When one of our members experiences a Critical Incident, UnitedHealthcare is responsible for following up to ensure they have the care they need.

Critical Incidents are reported to the Healthcare Authority (HCA) by UnitedHealthcare through semi-annual reporting as well as 24-hr notification to the HCA Incident Reporting System.

In order to provide follow-up, it is important that our external provider network reports Critical incidents to UnitedHealthcare as soon as the incident has been identified.

Critical Incident Reporting Criteria:

- A major injury or major trauma that has the potential to cause prolonged disability or death of a member that occurs in a facility that provides behavioral health services
- An unexpected death of a member that occurs in a facility that provides behavioral health services
- Violent acts allegedly committed by a member to include:
 - Arson
 - Assault resulting in serious bodily harm
 - Homicide or attempted homicide by abuse
 - Drive by shooting
 - Extortion
 - Kidnapping
 - Rape, sexual assault or indecent liberties
 - Robbery
 - Vehicular homicide
 - Attempted suicide & all completed suicides
 - Homicide or attempted homicide by a member
 - Abuse, neglect or exploitation of a member (APS/CPS reporting)
- Unauthorized leave of a mentally ill offender or a sexual or violent offender from a mental health facility, secure Community Transition Facilities (i.e. Evaluation and Treatment Centers, Crisis Stabilization Units, Secure Detox Units, and Triage Facilities) that accept involuntary admissions
- Any event involving a member that has attracted or is likely to attract media attention as it relates to the criteria stated above

NOTE: The Health Care Authority has recently announced that child abuse cases are no longer required to be reported to the Medicaid MCOs such as United Healthcare through the Critical Incident process, but rather are reported directly to the Children's Administration/CPS as part of mandatory reporting requirements. The intent is to reduce the burden of reporting and eliminate duplicative reporting as much as possible. However if the incident also falls under one of the additional critical incident reporting criteria outlined here, it must be reported through United Healthcare's critical incident process.

If you have any questions please contact us at wa_criticalinc@uhc.com or fax to 1-844-680-9871.

What a Critical Incident is NOT

- Threatening suicide or suicidal ideation (thinking about it)
- Routine car accidents not resulting in a serious injury
- Accidents-minor not resulting a serious injury
- The unexpected death or serious injury of an enrollee
- A credible threat to enrollee safety
- Any allegation of financial exploitation of an enrollee

How to report a Critical Incident

As soon as you are notified of the critical incident, ensure member safety first, then report.

Some critical incidents require notification to HCA w/in 1 business day of United Healthcare notification, so it is important that you report to United Healthcare as soon as possible

Email the completed Critical Incident form to United Healthcare at:

wa_criticalinc@uhc.com or fax to 1-844-680-9871

If secure email is not available, you can fax the form to 1-844-680-9871

Obtaining Authorizations

Phone:

UnitedHealthcare Call Center: 1-877-542-9231

IP & Res reviews 24/7

Non-Routine Outpatient: Call during business hours

Fax:

1-844-747-9828

Web Portal:

providerexpress.com

Frequently used non-routine services where an authorization can be requested online include: Psychological Testing, Transcranial Magnetic Stimulation (TMS), GFS funded treatment, and [ABA/Autism](#)

For other non-routine services, call the number on the back of the Member's ID card to request authorization.

GFS: Covered Services *as covered per benefit package

- Services Include:
- Residential Room & Board
- Personal Care
- Supported Employment
- Engagement & Referral
- Alcohol & Drug School
- Opiate Dependency/HIV Services
- Community Outreach
- Sobering Services
- Acute Withdrawal Management
- Therapeutic Interventions for Children
- Housing Support Services
- Family Hardship Services
- Recovery Support Services
- Jail Services
- Expanded Community Services
- PACT
- Interim Services
- Childcare Services

The following Reference Guide should be used for covered Behavioral Health Provider Services which are available and accessible to all Medicaid Members:

<p style="text-align: center;">SERVICE TYPE AND DESCRIPTION</p>	<p style="text-align: center;">PRIOR AUTHORIZATION REQUIRED? *LENGTH OF AUTHORIZATION</p>
<p>ACUTE INPATIENT CARE – MENTAL HEALTH AND SUD Acute Psychiatric Inpatient; Evaluation and Treatment Acute Psychiatric admission to Behavioral Health Unit or Freestanding Hospital Inpatient Acute Withdrawal (Detoxification) ASAM 4.0</p> <p>MEMBERS ADMITTED ON AN ITA ARE REVIEWED FOR CHANGE IN LEGAL STATUS, CONFIRMATION OF ACTIVE TREATMENT AND TRANSITION OF CARE NEEDS.</p>	<p>No. Emergent Acute admissions require notification only within 24 hours followed by concurrent review.</p> <p>Voluntary Admission requires initial review within 24 hours of admission.</p> <p>Coordinate with Whole Person Care/Health Home Care coordinator.</p> <p><i>*Initial: 3-5 days</i></p>
<p>WITHDRAWAL MANAGEMENT (IN A RESIDENTIAL SETTING)</p> <ul style="list-style-type: none"> • ASAM 3.7 • ASAM 3.2 <p>MEMBERS ADMITTED ON AN ITA ARE REVIEWED FOR CHANGE IN LEGAL STATUS, CONFIRMATION OF ACTIVE TREATMENT AND TRANSITION OF CARE NEEDS.</p>	<p>No, if <u>Emergent</u> –requires notification only within 24 hours followed by concurrent review.</p> <p>Yes, if <u>planned</u> – requires pre-service review and concurrent review.</p> <p><i>*3-4 days</i></p>
<p>CRISIS STABILIZATION IN A RESIDENTIAL TREATMENT SETTING</p>	<p>No, if <u>Emergent</u> –requires notification only within 24 hours followed by concurrent review.</p> <p>Yes, if <u>planned</u> – requires pre-service review and concurrent review.</p> <p><i>*Initial: 3-5 days</i></p>
<p>RESIDENTIAL TREATMENT – MENTAL HEALTH AND SUBSTANCE USE DISORDER</p> <ul style="list-style-type: none"> • ASAM 3.5 • ASAM 3.3 • ASAM 3.1 	<p>Yes, if <u>planned</u> – requires pre-service review and concurrent review.</p> <p><i>*Initial 14 days: Short Term non-hospital residential: ASAM 3.5 code H0018</i></p> <p><i>Initial 30 Days: Long Term non-hospital: ASAM 3.1 code H0019</i></p>

SERVICE TYPE AND DESCRIPTION	PRIOR AUTHORIZATION REQUIRED? *LENGTH OF AUTHORIZATION
PARTIAL HOSPITALIZATION/DAY TREATMENT <ul style="list-style-type: none"> ASAM 2.5 	Yes. <i>*Initial: 4 days</i>
INTENSIVE OUTPATIENT PROGRAMS/ SERVICES <ul style="list-style-type: none"> ASAM 2.1 	No , for Code: 96153 Yes , if non network provider requests. <i>Initial: Less than or equal to 12 visits based on Authorization / Notification Rules and Outlier Monitoring</i>
MEDICATION EVALUATION AND MANAGEMENT	No , not for in network providers. Yes , if non network provider requests.
MEDICATION ASSISTED THERAPY	No , not for in network providers. Yes , if non network provider requests.
INITIAL ASSESSMENT (MH AND SUD/ASAM) AND OUTPATIENT PSYCHOTHERAPY SERVICES	No , not for in network providers. Yes , if non network provider requests. Outlier monitoring with concurrent and post-service medical necessity reviews.
HIGH INTENSITY OUTPATIENT/COMMUNITY BASED SERVICES (WISE/PACT)	Yes: MH IOP S9480 WISE requires Notification only
APPLIED BEHAVIOR ANALYSIS	Yes. Pre-Service Authorization is required for ABA Therapy and Continued Treatment Authorization every 6 months.
ELECTROCONVULSIVE THERAPY (ECT)	Yes. Pre-Service Authorization Required for Initiation, Continuation and Maintenance treatment. *6-12 initial visits
TRANS MAGNETIC STIMULATION	Yes. Pre-Service Authorization Required for Initial or Acute treatment.
PSYCHOLOGICAL TESTING	No prior authorization required for <u>first 2 units of service</u> per client per lifetime. Yes , Prior Authorization required for additional units of service.
NEUROPSYCHOLOGICAL TESTING	No prior authorization required.

SERVICE TYPE AND DESCRIPTION	PRIOR AUTHORIZATION REQUIRED? *LENGTH OF AUTHORIZATION
TELEHEALTH/TELEPSYCH (VIRTUAL VISITS)	No , not for in network providers. Yes , if non network provider requests.
“WRAP-AROUND SERVICES” – STATE GENERAL FUND SERVICES	No . Payment limited to GFS allocated amount identified in Provider contract.
CLUBHOUSE	No . Payment limited to GFS allocations and agreement in Provider Contract
RESPITE CARE	No . Payment limited to GFS allocations and agreement in Provider Contract

“Notification Only”

Emergent, unplanned admissions to acute inpatient BH facilities (such as E & T or acute inpatient detoxification) do not require prior authorization but do require notification of the admission by means of electronic file, fax or phone call within 24 hours of that admission. Clinical information shall be provided for medical necessity determination, known as concurrent review, following this notification. This can apply to lower level services as well.

The Bree Collaborative

In 2011, Dr. Robert Bree established a collaborative forum comprised of public and private stakeholders. The group combines efforts and expertise to identify and recommend evidence-based strategies, which improve quality of care, improved health outcomes through the delivery of integrated health care. Behavioral health care integrated into primary care is one of the leading focuses of the Bree Collaborative, which has been not only efficient in the delivery of best practice treatment, it has also been shown to be a cost-effective model of care.

Use of evidence-based, existing models of assessment and eight elements are incorporated to define a minimum standard to promote integrated care in the Bree Collaborative Model. Washington State has adopted the elements of best practice by incorporating the eight elements of the Bree Collaborative as an initiative to bridge evidence-based management that allows all health care providers the basis to achieve integrated care services. Use of the following *eight elements*, with specified criteria, allow the patient to be the full focus of care delivery, promote care that becomes standard, by encompassing the full perspective of integration of medical and behavioral wellbeing.

1. Integrated Care Team
2. Patient Access to Behavioral Health as a Routine Part of Care

3. Accessibility and Sharing of Patient Information
4. Practice Access to Psychiatric Services
5. Operational Systems and Workflows to Support Population-Based Care
6. Evidence-Based Treatments
7. Patient Involvement in Care
8. Data for Quality Improvement

For additional criteria to engage the Bree Collaborative please resource the full document: [DR. ROBERT BREE COLLABORATIVE \(March, 2017\)](#)

GAIN-SS

The Global Assessment of Individual Needs-Short Screener (GAIN-SS) is an evidence-based, five-minute screening tool for general populations to identify clients who have one or more behavioral health disorders.

Overview: The 5-minute GAIN-Short Screener (GAIN-SS) is designed primarily for 3 things:

1. It serves as a screener in general populations to quickly and accurately identify clients (also known as patients, respondents, or research participants) whom the full 1.5 to 2-hour GAIN-Initial would identify as having 1 or more behavioral health disorders (e.g., internalizing or externalizing psychiatric disorders, substance use disorders, or crime/violence problems), which would suggest the need for referral to some part of the behavioral health treatment system. It also rules out those who would not be identified as having behavioral health disorders;
2. It serves as an easy-to-use quality assurance tool across diverse field-assessment systems for staff with minimal training or direct supervision;
3. It serves as a periodic measure of change over time in behavioral health.

GAIN-SS Forms are available by clicking the following links:

[GAIN-SS target data elements setup form](#) (14-479)

[GAIN-SS target data elements admission and assessment form](#) (04-416)

GAIN-SS copyright © Chestnut Health Systems. For more information on the instrument, please visit <http://www.gaincc.org> or contact the GAIN Project Coordination Team at (309) 451-7900 or GAINInfo@chestnut.org

[Washington State Health Care Authority](#) links for billers, provider and partners

Screening, brief intervention, and referral to treatment (SBIRT)

Screening, brief intervention, and referral to treatment (SBIRT) is a model for early intervention and treatment for people with — or at risk of developing — substance use disorders. Providers must be certified in the SBIRT model to implement this approach and offer SBIRT services. SBIRT is a universal public health approach to integrate behavioral and primary health care. It is a way to increase awareness that substance abuse is preventable and that treatment works. SBIRT can be provided in a wide variety of medical and community healthcare settings and provides universal screening for substance use.

- Detects risky or hazardous substance use that may lead to abuse or dependence.
- Offers early intervention and timely referral and treatment for people who have substance use disorders.

How do I become SBIRT Certified, so I can Bill for Services?

Completion of the six-module [Screening, Brief Intervention, and Referral to Treatment in Washington State](#) course will meet the Health Care Authority's (HCA) four-hour training requirements to be certified to submit billing and provide — or supervise individuals providing — SBIRT services.

Claims Billing Information for SBIRT Services

Use CPT codes: **99408 & 99409**

Accepted ICD-10 Diagnosis Codes:

Z71.41 (Alcohol abuse counseling and surveillance of alcoholic)

Z71.51 (Drug abuse counseling and surveillance of drug abuser)

WA-HCA additional resources [SBIRT implementation guide](#)

Evidence-Based Practice Codes

What are Evidence-Based Practice (EBP) codes and how are they used?

EBP codes are specially designated identifiers on a claim or encounter that are used to report specific research, or evidence-based practices for children's public mental health care provided by licensed or certified mental health providers to children 18 and under in Washington State. EBP encounter data is used for reporting to the legislature and other reporting requirements related to the provision of mental health services to children.

How should providers report EBPs under IMC?

The rules for coding and submitting EBPs under IMC are slightly different:

- The EBP code must be reported as a nine-digit number beginning with '860'. The next three digits must represent the appropriate EBP code as outlined in the Evidence-Based Practices Reporting Guide. The last three digits must be reported as '000'.

Example: 860163000 should be used when reporting Child-Parent Psychotherapy

- Report one EBP code per encounter in the 2300 REF02 Prior Authorization field of the standard 837 file submission.
- The REF01 field should contain the 'G1' qualifier (prior authorization).
- The REF02 field should contain the nine-digit EBP code.

Example: REF*G1*860163000

Please review the [Evidence-Based and Research-Based Practices](#) page on the Washington State Department of Social and Health Services site for reporting guides and other resource information.

WISe (Wraparound with Intensive Services)

Wraparound with Intensive Services (WISe) is designed to provide comprehensive behavioral health services and supports to Medicaid eligible individuals, who are up to 21 years of age with complex behavioral health needs, and their families. The goal of WISe is for eligible youth to live and thrive in their homes and communities, as well as to avoid or reduce costly and disruptive out-of-home placements while receiving behavioral health treatment services.

WISe team members demonstrate a high level of flexibility and accessibility by working at times and locations that ensure meaningful participation of family members, youth and natural supports, including evenings and weekends. WISe also provides access to crisis response 24 hours a day, seven days a week, by individuals who know the youth and family's needs and circumstances, as well as their current crisis plan. The service array includes intensive care coordination, intensive treatment and support services, and mobile crisis outreach services, provided in home and community settings, based on the individual's needs and a plan developed using a wraparound process by a Child and Family Team (CFT). Behavioral health services and supports will be available that are sufficient in intensity and scope, including those based on available evidence of effectiveness, and individualized to each youth and their family's unique needs. Care is integrated in a way that ensures youth are served in the most natural, least restrictive environment. The intended outcomes are individualized to the goals identified and prioritized by each youth and family. They often include: increased safety, stabilization, school success, and community integration; and support to ensure that youth and families can live successfully in their homes and communities and make positive and informed decisions regarding their care and lives, with an avoidance of hospitalizations and out-of-home placements.

Anyone can make a referral for a WISE screen, including the youth and family. All Medicaid-eligible youth, up to age 21, who might benefit from WISE should be referred for a WISE Screen.

All referrals for a WISE screen to the Managed Care Entity (MCE), any MCE provider or other WISE referral contact, should result in a WISE screening, regardless of referral source. A WISE screen must be offered within 10 business days of receiving a referral and be completed by a CANS-certified screener. When youth meets the CANS algorithm, is covered by Medicaid and agrees to be in the program, please fax notifications with enrollment date. Notifications forms must also be faxed to UHC for adverse determinations and termination of services.

Adherence to the WISE manual, which provides guidelines to ensure consistency in the goals, principles, and the delivery of the program across the state, is required. The WISE [Program, Policy and Procedure Manual](#) can be found on the HCA website.

Please refer to the section in the manual which outlines the infrastructure and requirements an agency must have in place to be eligible for consideration as a WISE provider. Agencies must meet all applicable federal standards related to the provision of behavioral health services covered under Medicaid. Agencies interested in becoming a WISE provider must hold a current Behavioral Health Agency License, issued by the Department of Health. Agencies must also have a contract with a Managed Care Entity. Additionally, agencies must be certified, or have sub-contracts or Memorandums of Understanding to provide all of the following services:

- Individual treatment services
- Family therapy services
- Case management services
- Psychiatric medication services
- Crisis mental health services—Outreach services
- Recovery support—Wraparound facilitation services
- Recovery support—Peer support services

Agencies interested in becoming a WISE provider must meet standards related to:

- Access
- Practice model
- Service array
- Staffing
- Community oversight and cross-system collaboration
- Documentation

For service array and coding, follow the [Service Encounter Reporting Instructions \(SERI\)](#).

The Practice Model, based on the wraparound approach, is to be followed when providing services, and include the following phases:

- Engagement
- Assessing
- Teaming
- Service Planning and Implementation
- Monitoring and Adapting
- Transition

Additionally, participation in the state sponsored trainings and coaching sessions offered through the WISE Workforce Collaborative are a requirement of WISE agency staff. When onboarding new WISE practitioners, agencies must document completion of the following set of trainings: all WISE agencies are required to have lead staff participate in WISE coaching sessions. Regions will partner with the WISE Workforce Collaborative, which will serve, under the direction of the Division of Behavioral Health and Recovery (DBHR), as their primary resource for ongoing technical assistance related to training and coaching for WISE practitioners

Behavioral Health Specialists

- Advanced registered nurse practitioner, including psychiatric advanced registered nurse practitioner and psychiatric mental health and board- certified nurse practitioners
- Agency affiliated counselor
- Certified adviser
- Certified counselor
- Chemical dependency professional
- Chemical dependency professional - trainee (CDPT)
- Hypnotherapist
- Licensed marriage and family therapist
- Licensed marriage and family therapist – associate (LMFTA)
- Licensed mental health counselor
- Licensed mental health counselor – associate (LMHCA)
- Licensed practical nurse (LPN)
- Physician (MD)
- Physician Assistant (PA)
- Registered Nurse (RN)
- Psychiatrist (MD)

- Psychologist (PhD)
- Licensed social worker associate, advanced (LSWAA)
- Licensed social worker associate, independent clinical (LSWAIC)
- Licensed social worker, advanced (LASW)
- Licensed, Independent Clinical Social worker (LICSW)
- Sex offender Treatment Provider
- Affiliate sex offender treatment provider
- DBHR-Certified Peer Counselor

Emergency services may be rendered without the requirement of prior authorization. Payment cannot be denied for treatment of what constitutes an emergency behavioral health condition on the basis of a behavioral health diagnosis or symptoms.

Description of Behavioral Health Services

All providers should be familiar with the Washington State Behavioral Health Care Authority (HCA) Service Definitions Manual, maintained by the [Washington Health Care Authority \(HCA\)](#). The summary below serves as a quick reference guide. The current version of the Apple Health (Medicaid) manual WAC index and other resource material can be found on the [HCA website](#).

Service	Description
Behavioral Health Home	A Health Home is not a place. It is a set of free services to support the Members who have chronic condition(s) and would like the support of a care coordinator. Email: healthhomes@hca.wa.gov
Chemical Dependency Services	Includes an array of individual-centered outpatient, intensive outpatient and residential services consistent with the individual's assessed treatment needs, with a rehabilitation and recovery focus designed to promote skills for coping with and managing substance use symptoms and behaviors
Crisis Services	Crisis services are provided to an individual who is experiencing a psychiatric crisis, and are designed to interrupt and/or ameliorate a crisis experience via a preliminary assessment, immediate crisis resolution & de-escalation, and referral & linkage to appropriate community services to avoid more restrictive levels of treatment

Service	Description
Family Treatment	Family members can talk with a behavioral health care professional about emotional problems they may be having and learn coping skills the family can use to manage them
Group Treatment Services	A group of people with similar emotional issues meet with a behavioral health care professional; the group members share experiences and practice coping skills in order to learn how to manage issues as independently as possible
Individual Treatment Services	Individuals can talk with a behavioral health care professional about emotional issues they may be having and learn coping skills to manage them
Inpatient/Hospital-based Care	The need for one or more nights in a hospital for emergency treatment which cannot otherwise be treated in the community by a provider
Outpatient Therapy	Individual, family, group psychotherapy and mental health assessment, evaluation and testing
Assertive Community Treatment (PACT)	Interventions that address the functional problems of individuals who have the most complex and/or pervasive conditions associated with a serious mental illness or co-occurring addictions disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the individual's ability to cope and relate to others and enhancing the highest level of functioning in the community
Peer Support	Provided by a Peer Support Specialist (who received behavioral health services themselves) to help individuals learn to manage difficulties in their lives
Psychological/ Neuropsychological Testing	Individuals complete written, visual or verbal tests that are administered by a psychologist measuring thinking and emotional abilities
Wraparound with Intensive Service (WISe)	Wraparound with Intensive Services, or WISe, is a new approach to helping Medicaid-eligible children, youth, and their families with intensive mental health care. Services are available in home and community settings and offer a system of care based on the individualized need of the child or youth

For services requiring an authorization, if we deem the service medically necessary, the service authorization will begin on the date of the request for the service.

Medication Management Services

Psychiatrists, prescribing APRNs and Medical Psychologists are not required to obtain prior authorization for the initial consultation, routine medication management sessions and other routine outpatient services, such as: 90791, 90792, 90833, 90834 and evaluation & management (E&M) codes as applicable.

Inpatient Services

Emergency services may be rendered without the requirement of prior authorization. Payment cannot be denied for treatment of what constitutes an emergency behavioral health condition on the basis of a behavioral health diagnosis or symptoms.

We require notification of inpatient emergency admissions within 24 hours of admission. We reserve the right to deny a claim for payment based solely on lack of notification.

We are staffed with independently licensed staff 24 hours a day/7 days per week (including weekends and holidays) to respond to authorization requests.

Residential Services

Authorization for both Substance Abuse Residential Treatment and Psychiatric Residential Treatment Facilities needs to be requested prior to the Member's admission to those levels of care when possible. If prior notification cannot occur, notification of admission is required within one (1) business day (Monday – Friday) of admission.

Psychological Testing

Psychological testing must be pre-authorized. Psychological testing is considered after a standard evaluation (CPT code 90791 or 90792 including clinical interview, direct observation and collateral input, as indicated) has been completed and one of the following circumstances exists:

- There are significant diagnostic questions remaining that can only be clarified through testing
- There are questions about the appropriate treatment course for a patient, or a patient has not responded to standard treatment with no clear explanation, and testing would have a timely effect on the treatment plan
- There is reason to suspect, based on the initial assessment, the presence of cognitive, intellectual and/or neurological deficits or impairments that may affect functioning or interfere with the patient's ability to participate in or benefit from treatment, and testing will verify the presence or absence of such deficits or dysfunction

Generally, psychological testing solely for purposes of education or school evaluations, learning disorders, legal and/or administrative requirements is not covered. Also not covered are tests performed routinely as part of an assessment. We recommend that you contact UnitedHealthcare Provider Services Line at 1-866- 675-1607 to determine authorization requirements and procedures.

For information regarding test administration please refer to the [Psychological/Neuropsychological Testing Guidelines](#) located on Provider Express. This guide also addresses other procedures related to testing and report writing. You can also contact the Care Advocacy Center at 1-866-675-1607 for assistance with any questions.

Care Advocacy

The Behavioral Health Care Advocacy Center (CAC) focuses on activities that impact Medicaid Members' stabilization and recovery and promote active participation in their care. This approach consists of targeted interventions intended to facilitate Member services, identify Members who may be at risk, and to assist you in the coordination and delivery of care to Members. This approach supports a collaborative relationship between you and the Care Advocate. Care Advocacy activity may include:

- Emphasizing the integration of medical and behavioral care by promoting communication among all treating providers involved in Members' care
- Ensuring that Members being discharged from facility-based care have appropriate discharge plans, that they understand them and that they are able to access and afford the recommended services
- Proactively reaching out to providers to discuss Members' care when an individual has been identified as being at-risk
- Offering clinical consultations with medical staff
- Reaching out to Members in some circumstances to educate, evaluate risk, and offer assistance
- Supporting Members to actively participate in treatment and follow-up care
- Referencing web-based and written information regarding behavioral health conditions for Members and treating providers designed to support informed decision making

Care Advocate Availability

The UnitedHealthcare Care Advocacy Center in Washington is open for standard business operations Monday through Friday from 8 a.m. to 5 p.m. Central Standard Time. In addition, we are staffed 24 hours a day/7 days per week (including weekends and holidays) to discuss urgent and emergent situations (such as potential inpatient admissions), to handle Members in crisis, or any other questions about the care advocacy process.

Eligibility Inquiry

The services a Member receives are subject to the terms and conditions of The Plan. It is important that you inquire about what services are covered and the Member's enrollment status before providing services.

Utilization Management Begins at Intake

UnitedHealthcare believes that a “no wrong door” approach is the best way to ensure that Members or their families can access services at the time they first recognize symptoms. Therefore, we have intake policies that facilitate immediate access to treatment:

A Member can contact a network provider's office and request an appointment

- A family member can contact a network provider's office and request an appointment for a Member

The Member Service Line, 1-866-675-1607, is available 24 hours a day, 365 days a year, and provides a Member or family member immediate contact with someone who can help identify a network provider most appropriate to the Member's needs and preferences. If requested, we will contact the provider on the Member's behalf and finalize arrangements to help the Member get to the provider's office or access emergency/crisis services.

Peer Services and Supports

This is a form of community support service in which a Certified Peer Specialist utilizes their training, lived experience and experiential knowledge to assist the Member/Member's parent or legal guardian with achieving the recovery and resiliency goals. Assistance can take a variety of forms such as providing information about services or self-care, supporting the development of skills, and facilitating access to services and resources.

These services may be delivered while the Member is receiving behavioral health treatment, in advance of the start of behavioral health treatment in order to facilitate engagement in care, or as part of the Member's transition from other services.

The services help the Member/Member's parent or legal guardian become more socially connected and increase engagement in treatment and empowerment.

Assisting with Recovery

We encourage you to assist Members with their recovery by providing information about their condition, its treatment, and self-care resources. Members have the right to information that will support decision-making, promote participation in treatment, enhance self-management, and support broader recovery goals.

We encourage you to discuss all treatment options and the associated risks and benefits and solicit Members' input about their treatment preferences. Nothing in this manual is intended to interfere with your relationship with Members.

Assessment

Thorough clinical assessments are required, and should be included in the clinical record. The initial diagnostic assessment includes a biopsychosocial history that provides information on previous medical and behavioral health conditions, interventions, outcomes, and lists current and previous medical and behavioral health providers. The mental status exam includes an evaluation of suicidal or homicidal risk. A substance use screening should occur for Members over the age of 12 years, noting any substances abused and treatment interventions. Other areas to be covered in the assessment are developmental history, education, legal issues, and social support. Cultural and spiritual considerations should be covered. A note should also be made of any community resources accessed by the Member. A culmination of these assessment aspects, including negative findings, will yield a DSM-5 diagnosis (ICD-10 is used for billing purposes).

Treatment, Recovery & Resiliency and Discharge Planning

The treatment plan stems from the Member's condition, and is used to document realistic and measurable treatment goals as well as the evidence-based treatments that will be used to achieve the goals of treatment. Effective treatment planning should take into account significant variables such as age, level of development and the history of treatment. Other variables to consider are whether the proposed services are covered in The Plan and are available in the community.

Finally, you should also consider whether community resources such as support groups, consumer-run services, and preventive health programs can augment treatment.

The provider should also take into account the Member's expressed or documented preferences in a psychiatric advance directive or crisis plan. For some Members, treatment is part of a broader recovery & resiliency effort, so the recovery & resiliency goals documented in a recovery plan should also be considered.

A change in the Member's condition should prompt a reassessment of the treatment plan and selection of level of care. When the condition has improved, the reassessment determines whether a less restrictive level of care may be adequate to treat the condition, or whether the Member no longer requires treatment. When a Member's condition has not improved or has worsened, the reassessment determines whether the diagnosis is accurate, the treatment plan requires modification or a change in the level of care.

Effective discharge planning enables the Member's safe and timely transition from one level of care to another, and documents the services they will receive post-discharge. Discharge planning begins at the onset of treatment when the provider anticipates the discharge date and forms an initial impression of the Member's post-discharge needs. The initial discharge plan may evolve in response to changes in the Member's condition and preferences.

The final discharge plan documents the:

- Anticipated discharge date
- Proposed post-discharge services
- Plan to coordinate discharge with the provider at the next level of care (when indicated)
- Plan to reduce the risk of relapse
- Agreement by the Member with discharge plan

As the Member transitions from one level of care to another, we expect that the first appointment at the next level of care will be scheduled according to the Member's needs. The first post-discharge appointment following inpatient care should occur no later than seven (7) days from the date of discharge. This timeframe is in accordance with the Health Effectiveness Data and Information Set (HEDIS®) standard for follow-up treatment after discharge from inpatient care.

UnitedHealthcare Behavioral Health Care Advocates and Field Care Advocates monitor discharge planning and are available to assist with identifying and facilitating access to treatment services and community resources. UnitedHealthcare expects that the provider will collaborate with the Member during treatment, recovery and discharge planning whenever possible.

Coordination of Care

Communication with Primary Physicians and Other Health Care Professionals

To coordinate and manage care between behavioral health and medical professionals, we require that you seek to obtain the Member's consent to exchange appropriate treatment information with medical care professionals (e.g., primary physicians, medical specialists) and/or other behavioral health providers (e.g., psychiatrists, therapists). We require that coordination and communication take place at: the time of intake, during treatment, the time of discharge or termination of care, between levels of care and at any other point in treatment that may be appropriate. Coordination of services improves the quality of care to Members in several ways:

- It allows behavioral health and medical providers to create a comprehensive care plan
- It allows a primary care physician to know that his or her patient followed through on a behavioral health referral

- It minimizes potential adverse medication interactions for Members who are being treated with psychotropic and non-psychotropic medication
- It allows for better management of treatment and follow-up for Members with coexisting behavioral and medical disorders
- It promotes a safe and effective transition from one level of care to another
- It can reduce the risk of relapse

To facilitate effective communication between treatment professionals involved in a Member's care, UnitedHealthcare requires network providers to coordinate services with the Member's primary care physician (PCP) at a minimum, by applying the following standards for care coordination:

- During the diagnostic assessment session, request the Member's written consent to exchange information with all appropriate treatment professionals
- After the initial assessment, provide other treating professionals with the following information within two weeks:
 - Summary of Member's evaluation
 - Diagnosis
 - Treatment plan summary (including any medications prescribed)
 - Primary clinician treating the Member

Attempt to obtain all relevant clinical information that other treating providers may have pertaining to the Member's mental health or substance use problems

- Update other behavioral health and/or medical clinicians when there is a change in the Member's condition or medication(s)
 - When serious medical conditions warrant closer coordination
 - At the completion of treatment, send a copy of the discharge summary to the other treating professionals

Some Members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. UnitedHealthcare, as well as accrediting organizations, expects you to make a "good faith" effort at communicating with other behavioral health providers and any medical care providers who are treating the Member as part of an overall approach to coordinating care.

Management of Outpatient Services

Outpatient Management

The goal of our outpatient management program is to reduce administrative burden through the use of Practice Management and the Algorithms for Effective Reporting and Treatment (ALERT) Program. For services that are in-scope, the precertification requirements have been removed. The in-scope Services include:

- Individual/Group/Family Therapy
- Psychosocial Rehabilitation
- Community Psychiatric Support & Treatment
- Homebuilders
- Multi-Systemic Therapy
- Functional Family Therapy
- Outpatient Addiction Services (ASAM Level 1)

The ALERT Program uses claims data and service combinations to identify Members who have a frequency or duration that is higher than expected. When this occurs, a licensed care advocate will contact the provider telephonically to:

- Review eligibility for the service(s)
- Review the treatment plan/plan of care
- Review the case against applicable medical necessity guidelines There are three potential outcomes of this review:
 - Close case (Member is eligible, treatment plan/plan of care is appropriate, care is medically necessary)
 - Modification to plan (e.g., current care is not evidence based but there is agreement to correct)
 - Referral to Peer Review (e.g., Member appears ineligible for service; treatment does not appear to be evidence based; duration/frequency of care does not appear to be medically necessary)

Quality Improvement

We are committed to the highest quality of care provided in a manner consistent with the dignity and rights of Members and to meeting or exceeding customer expectations. Our Quality Improvement (QI) Program is outlined in the UnitedHealthcare Washington Administrative Guide. In addition to the activities previously outlined, the QI Program monitors: accessibility; quality of care; appropriateness, effectiveness and timeliness of treatment; and Member satisfaction. The QI Program is comprehensive and incorporates the review and evaluation of all aspects of behavioral health care. If you have any feedback regarding QI projects and processes, please contact Network Management.

Compliance with the QI Program is required in accordance with your Agreement, including cooperation with UnitedHealthcare and customers in our efforts to adhere to all applicable laws, regulations and accreditation standards.

The key components of the QI Program required of you as a participating provider include, but are not limited to:

- Ensuring that care is appropriately coordinated and managed between you and the Member's primary care physician (PCP) and other treating clinicians and/or facilities

- Cooperation with on-site audits and requests for treatment records
- Cooperation with the Member complaint process (e.g., supplying information necessary to assess and respond to a complaint)
- Responding to inquiries by our Quality staff
- Participation in Quality initiatives related to enhancing clinical care or service for Members
- Assisting us in maintaining various accreditations as appropriate and as requested
- Submission of information related to our review of potential quality of care concerns
- Helping to ensure Members receive rapid follow-up upon discharge from an inpatient level of care

Some of the activities that may involve you are described in more detail below.

Member Satisfaction Surveys

On at least an annual basis as required by contract, we conduct a behavioral health Member Satisfaction Survey of a representative sample of Members receiving behavioral health services within the network. The results of the survey are reviewed. Action plans are developed to address opportunities for improvement. Both the survey results and action plans are shared as necessary and appropriate.

Provider Satisfaction Surveys

We regularly conduct a satisfaction survey of a representative sample of clinicians delivering behavioral health services to Members. This survey obtains data on clinician satisfaction with our services including Care Advocacy, Network Services and claims administration.

The results of the survey are compared to previous years for tracking and trending. Action plans are developed to address opportunities for improvement. Both the survey results and action plans are shared as necessary and appropriate.

Practice Guidelines

We have adopted clinical guidelines from nationally recognized behavioral health organizations and groups. The Best Practice Guidelines and Level of Care Guidelines are available through Provider Express: Home page > Quick Links > Guidelines/Policies & Manuals > [Best Practice Guidelines and Level of Care Guidelines](#). Your feedback is encouraged on all guidelines and any suggestions on new guidelines to be considered for adoption are welcome. If you would like a paper copy of these guidelines please contact Network Management.

The ASAM Criteria, developed by the American Society of Addiction Medicine (ASAM), address wide-range clinical criteria and behavioral health service levels for

substance-related and addictive disorders. Under our Provider Agreements, residential care is defined as ASAM level of care 3.5 (see [Benchmark Levels of Care for Adolescents and Adults table](#)). Your Agreement sets forth the levels of care for which you are contracted and may not cover all ASAM-defined levels of care. Links to [information regarding The ASAM Criteria](#), can be found under “Optum Level of Care Guidelines” on Provider Express.

Complaint Investigation

Providers may file a complaint by contacting the Provider Services Line at 1-866-675-1607. The complaint or dispute will be documented and resolved; resolution will be communicated to the provider. Please refer to the UnitedHealthcare Washington Administrative Guide for additional information about the complaint process.

Treatment Plan Documentation, Performance Improvement & Program Evaluation, & Quality Audits

The Treatment Plan Documentation Requirements are outlined in the [Network Manual](#). In addition to the requirements outlined in the manual, the following requirements are specific to Washington Medicaid.

Patient record reviews to ensure the treatment plans are consistent with WAC 388-877-0620 and 388-877A-0135. Patient record reviews to ensure services are appropriate based on diagnosis, the treatment plan is based on the patient’s needs and progress notes support the each service:

- Timeliness of service
- Cultural, ethnic, linguistic, disability or age related needs are addressed
- Coordination with primary care
- Provider adherence to practice guidelines, as relevant
- Provider processes for reporting, Tracking and resolving complaints/Grievances
- Provider compliance with reporting and managing critical incidents
- Information security

Program of Assertive Community Treatment (PACT)

WA-PACT Policy and Procedure Requirement: The PACT team shall maintain written Culturally and Linguistically Appropriate Services (CLAS) policies and procedures incorporating the as outlined:

The PACT team shall have a performance improvement and program evaluation plan, which shall include the following:

A statement of the program's objectives. The objectives shall relate directly to the program's consumers or target population.

- Measurable criteria shall be applied in determining whether or not the stated objectives are achieved.
- Methods for documenting achievements related to the program's stated objectives.

Methods for assessing the effective use of staff and resources toward the attainment of the objectives.

In addition to the performance improvement and program evaluation plan, the PACT team shall have a system for regular review that is designed to evaluate the appropriateness of admissions to the program, treatment or service plans, discharge practices, and other factors that may contribute to the effective use of the program's resources.

- For additional guidelines and information please review the [Washington State Program of Assertive Community Treatment \(PACT\) Program Standards](#)

Behavioral Health Administrative Service Organization (BH-ASO)

What is a BH-ASO?

The Health Care Authority (HCA) is transforming health care by focusing on the whole person and ensuring care is coordinated and delivered where and when a person needs it. By January 2020, all regions of the state will transition to an integrated system for physical health, mental health, and substance use disorder services in the Washington Apple Health (Medicaid) program.

In this integrated managed care program, most services for Apple Health clients are provided through managed care organizations. However, some services in the community, such as services for individuals experiencing a mental health crisis, must be available to all individuals, regardless of their insurance status or income level.

For this reason, HCA will contract with a Behavioral Health Administrative Service Organization (BH-ASO) to provide these services within a region.

What services will the BH-ASO provide to anyone in the region, regardless of insurance status?

Certain services must be available to anyone regardless of their insurance status or income level. The following services may be provided by the BH-ASO to anyone in the region who is experiencing a mental health or substance use disorder crisis:

- A 24/7/365 regional crisis hotline for mental health and substance use disorder crises

- Mental health crisis services, including the dispatch of mobile crisis outreach teams, staffed by mental health professionals and certified peer counselors
- Short-term substance use disorder crisis services for people intoxicated or incapacitated in public
- Application of mental health and substance use disorder involuntary commitment statutes, available 24/7/365 to conduct Involuntary Treatment Act assessments and file detention petition

Contact your Regional BH-ASO:

King County BH-ASO - Crisis Connections: 1-866-427-4747 or 206-461-3222

North Sound BH-ASO - Community Crisis Line: 1-800-584-3578 and 1-800-747-8654

Pierce - Beacon Health Options: 1-800-576-7764, TTY 711

Spokane County BH-ASO: Regional Behavioral Health: 1-877-266-1818

Greater Columbia BH-ASO: 1-888-544-9986

South West WA - Beacon Health Options - 1-800-626-8137, TTY 866-835-2755

Patient Review and Coordination (PRC) Program for Prescribers

All prescribers have the option to refer a Member to a PRC. The patient may be assigned to a specific provider(s) that is either chosen by the client or assigned by the program. PRC clients can be assigned to one or any combination of the following provider types:

Primary care provider

- Pharmacy
- Hospital for non-emergency care
- Narcotic prescriber

The goal of the program is to improve the state’s ability to identify and inhibit the diversion of controlled substances and drugs of concern in an efficient and cost-effective manner that shall not impede the appropriate utilization of these drugs for legitimate medical purposes.

For additional information please consult the [Patient Review and Coordination \(PRC\)](#) page on the WA HCA website.

Confidentiality

Providers must comply with all requirements related to protection of Personal Health information, including but not limited to requirements set forth in Chapter 42 of the Code of Federal Regulations (CFR) Section 431.306 (42 CFR §431.306) regarding Release of Information. Additionally, Providers who are contracted to service Members

for Substance Use Disorder (SUD) must obtain a Release of Information (ROI) before any SUD treatment is disclosed to any party regarding treatment of the Member.

This [Authorization for Release of Information](#) is the provider's responsibility to obtain and maintain in the Member's Electronic Medical Record.

Network Requirements

Network providers are required to support Members in ways that are culturally and linguistically appropriate, and to advocate for the Member as needed.

Network providers are required to notify us at providerexpress.com within ten (10) calendar days whenever you make changes to your practice including office location, weekend or evening availability, billing address, phone number, Tax ID number, entity name, or active status (e.g., close your business or retire).

Providers are prohibited from balance billing any Member for any reason for covered services.

UnitedHealthcare requires that providers not employ or contract with any employee, subcontractor or agency that has been debarred or suspended by the federal or state government, or otherwise excluded from participation in the Medicare or Medicaid program.

Credentialing

Initial credentialing of a provider is completed within 60 days of receipt of a completed credentialing application. A completed credentialing application includes all necessary documentation, attachments, and a signed Agreement.

Physician Addictionologists must be certified by the American Society of Addictions Medicine (ASAM) or the American Board of Addiction Medicine (ABAM) or have added qualifications in Addiction Psychiatry through the American Board of Psychiatry and Neurology (ABPN).

Network Training Requirements

Providers are required to participate in a comprehensive provider training and support program to gain appropriate knowledge, skills, and expertise to comply with the requirements.

The annual training program will address the following areas:

- Orientation to UnitedHealthcare
 - Credentialing and Recredentialing
 - Provider Website Orientation
 - Member Eligibility Verification
 - Claims and Billing Guidelines

- Clinical Model
 - Crisis Management
 - Treatment Planning
 - Use of Evidence-Based Practices
 - Care Coordination
- Cultural competency
 - Cultural competency in healthcare is the ability of providers to understand social, ethnic, religious, and linguistic characteristics of a population and use this understanding to improve the quality of care providers deliver. Oscar Health is committed to ensuring that our Members are treated with dignity and respect and that their cultural needs are considered when interacting with providers.
 - Join us for FREE online provider education accessible through Link. Go to UHCprovider.com, log into Link with your Optum ID, click on the UHC On Air app, and go to the Washington channel to find the required Cultural Competency Program.
 - It is a mandatory requirement that all Washington IMC Providers participate and attest to Cultural Competency Training.
- Documentation requirements
- Utilization requirements

Additional Trainings:

WISe Training

eLearning modules walk you through WISe in Washington.

- WISe training module 1 – Overview (15:56) and handout
- WISe training module 2 – Principles (16:15) and handout
- WISe training module 3 – Phases, Part A (18:49) and handout
- WISe training module 4 – Phases, Part B (23:37) and handout
- WISe training module 5 – Team meetings (13:10) and handout
- WISe training module 6 – Crisis (11:50) and handout

Access to Care

On-Call and After-Hours Coverage

You must provide or arrange for the provision of assistance to Members in emergency situations 24 hours a day, seven days a week. You should inform Members about your hours of operation and how to reach you after-hours in case of an emergency. Each Member's treatment plan must also include a crisis plan that informs the Member what to do in the case of an emergency. In addition, any after-hours message or answering service must provide instructions to the Members regarding what to do in an emergency situation. When you are not available, coverage for emergencies should be arranged with another participating provider.

Access to Outpatient Mental Health and Substance Use Disorder Services

To ensure that all Members have access to appropriate treatment as needed, we develop, and maintain a provider network with adequate types and numbers of providers. We require that network providers adhere to specific access standards, which are outlined as follows:

- Emergent, crisis or emergency behavioral health services must be available at all times and an appointment shall be arranged within one (1) hour of the request
- Urgent Care must be available within twenty-four (24) hours of the request
- Routine, non-urgent appointments shall be arranged within fourteen (14) days of referral
- An outpatient appointment for behavioral health or substance abuse must be offered within seven (7) days of an acute inpatient discharge

UnitedHealthcare expects that Members will generally have no more than a 45 minute wait time for their appointment in your office; this includes time spent in the waiting room and consultation room.

If the provider is delayed Members should be notified immediately. If the wait is anticipated to be longer than 90 minutes, Members should be offered a new appointment time. In addition, any rescheduling of an appointment must occur in a manner that is appropriate for the Member's health care needs and ensures continuity of care consistent with good professional practice.

Members who walk-in seeking an appointment and do not have an urgent need should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.

UnitedHealthcare will monitor compliance with appointment access standards and the provision of after-hours coverage through monitoring of Member complaints and telephonic assessment of appointment availability.

If you are unable to take a referral, immediately direct the Member to contact us at 866 675-1607 so that they can obtain a new referral.

Geographic Access Standards

UnitedHealthcare is expected to meet certain geographic access standards; these standards must be met for 90% of the membership we serve.

Provider	Urban	Rural
Psychiatrists	15 Miles	30 Miles
Behavioral Health Specialists	15 Miles	30 Miles
	Statewide Access Requirement	
Psychiatric Residential Treatment Facilities (PRTFs)	200 Miles	
	Adults	Adolescents
ASAM Level III.3/5 Clinically Managed High Intensity Residential	30 Miles	60 Miles
ASAM Level III.7 Medically Monitored Intensive Residential Co-Occurring Treatment	60 Miles	N/A
ASAM Level.III7D Medically Monitored Residential Detoxification	60 Miles	N/A


Billing and Claims

Claims and Encounters must be billed according to the Health Care Authority (HCA) Integrated Managed Care [Service Encounter Reporting Instructions](#) (SERI).

Billing Guidelines

- Keep your NPI handy.
 - You will need to bill your registered NPI on your claims
 - The NPI you need to bill is the servicing provider ID assigned to you, as an individual
 - The NPI is placed in box 24J of your HCFA claim form.
- Billing Limitations (it is important that providers acquaint themselves with the current billing restrictions):
 - Some of the services are not able to be billed on the same day as other Covered Services
 - Most codes have a daily or annual limit to the amount of services that may be provided
- Reminder: ICD-10 codes became effective on 10/1/2015. Claims billed with ICD-9 codes will be rejected
- Report the provider doing the service, using that provider's registered NPI in box 24J of the HCFA form.
 - Include your Tax ID number, Service Location (where service was rendered) and Billing Information

Example below:



24. A.	DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES			E.	F.	G.	H.	I.	J.	
	From	To	MM	DD	YY	MM			DD	YY	EMG							CPT/HCPCS
1																		NPI
2																		NPI
3																		NPI
4																		NPI
5																		NPI
6																		NPI

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? <small>(If gov't. claims, see back)</small>	28. TOTAL CHARGE	29. AMOUNT PAID	30. Plevd for NUCC Use
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/> YES <input type="checkbox"/> NO	\$	\$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS <small>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</small>			32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ()		
SIGNED _____ DATE _____			a. NPI	b. _____	a. NPI	b. _____	

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

All claim submissions must include:

- Member name, Medicaid identification number and date of birth
- Provider's Federal Tax I.D. number
- National Provider Identifier (NPI) (unique NPI's for rostered clinicians)
- Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at www.cms.gov

Claims Submission

Claims may be submitted in different ways:

- Online (UHCprovider.com)
- Electronic Data Interchange (EDI) using any clearinghouse
 - Payer ID is 87726
 - More information is available on UHCprovider.com
- U.S. Mail

UnitedHealthcare Community Plan of Washington
 P.O. Box 31341
 Salt Lake City, UT 84131-0341

Contact / Resource Information

Partnership Access Line (PAL)

The Partnership Access Line (PAL) is a telephone-based child mental health consultation system, funded by the state legislature, being implemented in Washington State. PAL employs child psychiatrists, child psychologists, and social workers, affiliated with Seattle Children's Hospital, to deliver its consultation services. The PAL team is available to any primary care provider throughout Washington State.

PCPs may call 1-866-599-7257 between the hours of 8:00 a.m. and 5:00 p.m. for any type of child mental health issue that arises with any child, not just UnitedHealthcare members. Additional information regarding PAL may be found at:

[Seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line](https://seattlechildrens.org/healthcare-professionals/access-services/partnership-access-line)

Network Management

Behavioral health providers can reach their Network Management support in the following ways:

Toll-free line:	1-866-675-1607
Fax:	1-855-833-3724
Email:	WAIMC@optum.com

Washington Recovery Help Line:

Phone: 1-866-789-1511

Website: warecoveryhelpline.org

Technical Support for Provider Express

For questions about using this site, issues with requesting a user ID and password, or for technical issues, call the **Provider Express Support Center** at **1-866-209-9320** (toll-free) from 7:00 a.m. to 9:00 p.m. Central Time.