New Jersey Long Term Care Education for Providers
Introduction to Optum

• United Behavioral Health (UBH) was officially formed on February 2, 1997, via the merger of U.S. Behavioral Health, Inc. (USBH) and United Behavioral Systems, Inc. (UBS).

• United Behavioral Health, operating under the brand Optum, is a wholly owned subsidiary of UnitedHealth Group. Optum is a health services business. You will see both UBH and Optum in our communications to you.

• UnitedHealthcare Community Plan of New Jersey has contracted with Optum to administer the behavioral health portion of New Jersey Long Term Care plan to include mental health and some substance abuse disorders. Effective July 1, 2014

We are dedicated to making the health system better for everyone. For the individuals we serve, you play a critical role in our commitment to helping people live their lives to the fullest.
Overview: NJ MLTSS Program

As of 7/1/2014 the State of NJ is combining the services provided under four waivers into one waiver, Managed Long Term Care Services and Supports (MLTSS). The benefits covered under this new waiver will move from Fee-for-Service Medicaid to Managed Care. The Managed Care Organizations (MCOs) will be responsible for reimbursement of these services effective 7/1/2014.

Authorizations provided under Fee-for-Service Medicaid will remain in effect during the Continuity of Care period. Assessments will be made by a Care Coordinator and that time a new authorization will be made to the provider.
### Services covered under MLTSS

<table>
<thead>
<tr>
<th>MLTSS Service</th>
<th>MLTSS Code</th>
<th>Modifier</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Family Care</td>
<td>S5140</td>
<td></td>
<td>Per Diem</td>
</tr>
<tr>
<td>Assisted Living ALR</td>
<td>T2031</td>
<td></td>
<td>Per Diem</td>
</tr>
<tr>
<td>Assisted Living ALP</td>
<td>T2031</td>
<td>U2</td>
<td>Per Diem</td>
</tr>
<tr>
<td>Assisted Living CPCH</td>
<td>T2031</td>
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<td>Per Diem</td>
</tr>
<tr>
<td>TBI Behavioral Management Individual</td>
<td>H004</td>
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<td>Per 15 Minute</td>
</tr>
<tr>
<td>TBI Behavioral Management Group</td>
<td>H004</td>
<td>HQ</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td>Caregiver/Participant Training</td>
<td>S511</td>
<td></td>
<td>Per Diem</td>
</tr>
<tr>
<td>Chore Services</td>
<td>S5120</td>
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<td>Per 15 Minute</td>
</tr>
<tr>
<td>Chore Services</td>
<td>S5121</td>
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<td>Per Diem</td>
</tr>
<tr>
<td>Cognitive Therapy Individual</td>
<td>T2013 HQ</td>
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<td>Per Hour</td>
</tr>
<tr>
<td>Cognitive Therapy Group</td>
<td>T2013 HQ</td>
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<td>Per Hour</td>
</tr>
<tr>
<td>Community Residential Svcs (low)</td>
<td>T2033</td>
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<td>Per Diem</td>
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<tr>
<td>Community Residential Svcs (medium)</td>
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<td>TF</td>
<td>Per Diem</td>
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<tr>
<td>Community Residential Svcs (high)</td>
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<td>Per Diem</td>
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<tr>
<td>Community Transition Svcs</td>
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<td>Per Service</td>
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<tr>
<td>Community Transition Svcs (administration)</td>
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<td>Home Based Supportive Care Individual</td>
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<tr>
<td>Home Based Supportive Care Group</td>
<td>S5130</td>
<td>HQ</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td>Home Delivered Meals</td>
<td>S5170</td>
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<td>Per meal</td>
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<tr>
<td>Medication Monitoring monthly</td>
<td>S5185</td>
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<td>Per month</td>
</tr>
<tr>
<td>Medication Monitoring initial setup</td>
<td>T1505</td>
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<td>Per Service</td>
</tr>
<tr>
<td>Occupational Therapy Individual Habilitation</td>
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<td>U2</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td>Occupational Therapy Group Habilitation</td>
<td>97535</td>
<td>U3</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td>Occupational Therapy Individual Rehabilitation</td>
<td>97535</td>
<td>U4</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td>Occupational Therapy Group Rehabilitation</td>
<td>97535</td>
<td>U5</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td>MLTSS Service</td>
<td>MLTSS Code</td>
<td>Modifier</td>
<td>Unit</td>
</tr>
<tr>
<td>---------------------------------------</td>
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<td>-------------------</td>
</tr>
<tr>
<td><strong>PERS monthly</strong></td>
<td>S5160</td>
<td></td>
<td>Per month</td>
</tr>
<tr>
<td><strong>PERS initial setup</strong></td>
<td>S5161</td>
<td></td>
<td>Per Service</td>
</tr>
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<td><strong>Personal Care Services Individual</strong></td>
<td>T1019</td>
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<td>Per 15 Minute</td>
</tr>
<tr>
<td><strong>Personal Care Services Group</strong></td>
<td>T1019</td>
<td>HQ</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td><strong>Personal Care Services Live-in</strong></td>
<td>T1020</td>
<td></td>
<td>Per Diem</td>
</tr>
<tr>
<td><strong>Physical Therapy Individual Habilitation</strong></td>
<td>97110</td>
<td>U2</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td><strong>Physical Therapy Group Habilitation</strong></td>
<td>97110</td>
<td>U3</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td><strong>Physical Therapy Individual Rehabilitation</strong></td>
<td>97110</td>
<td>U4</td>
<td>Per 15 Minute</td>
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<tr>
<td><strong>Physical Therapy Group Rehabilitation</strong></td>
<td>97110</td>
<td>U5</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td><strong>Private Duty Nursing over 21 RN</strong></td>
<td>T1002</td>
<td>UA</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td><strong>Private Duty Nursing over 21 LPN</strong></td>
<td>T1003</td>
<td>UA</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td><strong>Private Duty Nursing under 21 RN</strong></td>
<td>T1002</td>
<td>EP</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td><strong>Private Duty Nursing under 21 LPN</strong></td>
<td>T1003</td>
<td>EP</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td><strong>Residential Modifications</strong></td>
<td>S5165</td>
<td></td>
<td>Per Service</td>
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<tr>
<td><strong>Residential Modifications Evaluation</strong></td>
<td>T1028</td>
<td></td>
<td>Per Service</td>
</tr>
<tr>
<td><strong>Respite (non hospice) in the home</strong></td>
<td>T1005</td>
<td></td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td><strong>Respite (non hospice) in AL</strong></td>
<td>S5151</td>
<td></td>
<td>Per Diem</td>
</tr>
<tr>
<td><strong>Social Day Care</strong></td>
<td>S5102</td>
<td>U3</td>
<td>Per Diem</td>
</tr>
<tr>
<td><strong>Speech Therapy Individual Habilitation</strong></td>
<td>92507</td>
<td>U3</td>
<td>Per 15 Minute</td>
</tr>
<tr>
<td><strong>Speech Therapy Group Habilitation</strong></td>
<td>92508</td>
<td>U3</td>
<td>Per 15 Minute</td>
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<tr>
<td><strong>Speech Therapy Individual Rehabilitation</strong></td>
<td>92508</td>
<td>U4</td>
<td>Per 15 Minute</td>
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<tr>
<td><strong>Speech Therapy Group Rehabilitation</strong></td>
<td>92507</td>
<td>U4</td>
<td>Per 15 Minute</td>
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<tr>
<td><strong>Structured Day Program</strong></td>
<td>S5100</td>
<td></td>
<td>Per 15 Minute</td>
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<tr>
<td><strong>Supportive Day Services</strong></td>
<td>T2021</td>
<td></td>
<td>Per 15 Minute</td>
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<tr>
<td><strong>Vehicle Modifications</strong></td>
<td>T2039</td>
<td></td>
<td>Per Service</td>
</tr>
<tr>
<td><strong>Vehicle Modifications Evaluations</strong></td>
<td>T2039</td>
<td>U7</td>
<td>Per Service</td>
</tr>
</tbody>
</table>
Description of Units

- **Per Diem** – one unit equals once per day, only one unit can be billed per date of service.
- **Per Service** – one unit equals one service (i.e. one PERS instillation set up would be one unit of service).
- **Per Meal** – one meal equals one unit of service.
- **Per Month** – one unit equals one unit of service, only one unit can be billed per month.
- **Per Hour** – one unit equals one hour of service.
- **Per 15 Minutes** – one unit equals 15 minutes of service.
Providers in our Behavioral Health Network

Individual Practitioners

- Licensed to practice independently, without supervision or oversight as determined by state law. Possession of an independent license from the New Jersey state licensing board
  - Psychiatrist: MD, DO
  - Psychologist: PhD, PsyD, LP
  - Master Level: LCSW, LPC, LMFT
  - Nurse with prescriptive authority (NPP, APN)
  - Physicians Assistant (PA)

Groups

- Community Mental Health Centers, Federally Qualified Health Centers (CMHC/FQHC), and provider groups that employ licensed professional staff to render services under the agency.

Facilities

- General Hospitals with mental health and/or substance abuse services. Free standing mental health centers and free standing substance abuse centers
  - Acute Inpatient
  - Residential
  - Partial
  - Intensive Outpatient (IOP)
Member ID Card

Please note this image is for illustrative purposes only.
Covered Behavioral Services

- Behavioral Health Assessment
- Behavioral Health Counseling and Therapy (individual and group)
- Crisis Intervention
- Mental Health Partial Hospitalization
- Inpatient Psychiatric Hospitalization
- Medication Management Services
- Methadone & Suboxone Administration
- Psychological Testing
- Electro Convulsive Therapy (ECT)
- Mental Health Partial Outpatient Treatment
- Adult Mental Health Rehabilitation
# Prior Authorization Requirements

<table>
<thead>
<tr>
<th>No Authorization</th>
<th>Authorization Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>– Behavioral Health Assessment</td>
<td>– <strong>Mental Health</strong> Partial Hospitalization</td>
</tr>
<tr>
<td>– Behavioral Health Counseling and Therapy (individual and group)</td>
<td>– Inpatient Psychiatric Hospitalization</td>
</tr>
<tr>
<td>– Crisis Intervention</td>
<td>– Methadone &amp; Suboxone Administration</td>
</tr>
<tr>
<td>– Medication Management Services</td>
<td>– ECT</td>
</tr>
<tr>
<td></td>
<td>– Psychological Testing</td>
</tr>
<tr>
<td></td>
<td>– Adult Mental Health Rehabilitation (AMHR)</td>
</tr>
<tr>
<td></td>
<td>– Non Routine Behavioral Health Services . i.e. Psych. Testing</td>
</tr>
<tr>
<td></td>
<td><strong>Behavioral Health Prior Authorization:</strong> Phone #: 888-291-2506</td>
</tr>
</tbody>
</table>

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Utilization Management Statement

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

– Optum Level of Care Guidelines
– Optum Psychological and Neuropsychological Testing Guidelines
– Optum Coverage Determination Guidelines
– American Society of Addiction Medicine Criteria (ASAM)

Optum does not reward Medical Directors or licensed clinical staff for issuing denials of coverage or service
Continuity of Care for NJ MLTSS membership

- All State approved services will be authorized until the member is assessed by a UHC Community and State Health Plan Case Manager
- At that point, the UHC Community and State Health Plan Case Manager will create a new service plan with corresponding authorizations where necessary
- Existing services are authorized based on continuity of care provisions
- All requests prior to 7/1, or prior to member becoming eligible, are the responsibility of the State
- The State is providing prior authorization files which should allow us to identify current services
Provider Responsibilities

Provide services to members in a non-discriminatory manner

- Maintain availability for a routine level of need for services
- Maintain the level of staffing necessary to support ability to offer appointments within 14 calendar days or 10 business days of the request for services
- Provide After Hours coverage
- Support Members in ways that are culturally and linguistically appropriate

• Determine if members have benefits through other insurance coverage

• Advocate for members as needed

• Notify us at www.providerexpress.com within ten (10) calendar days whenever you make changes to your office location, billing address, phone number, Tax ID number, entity name, or active status (e.g., close your business or retire)

This includes roster management.
### Access to Care – Standards

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Outpatient – Mental Health</strong></td>
<td>Members will be offered an initial appointment within 10 calendar days</td>
<td></td>
</tr>
<tr>
<td><strong>Routine Outpatient – Substance Use Disorders</strong></td>
<td>Assessment within 10 days of initial contact. Treatment services are delivered within 14 days of assessment</td>
<td></td>
</tr>
<tr>
<td><strong>Urgent</strong></td>
<td>If not addressed in a timely way could escalate to an emergency situation</td>
<td>Referral within 24 hours. Services delivered within 48 hours of initial contact</td>
</tr>
<tr>
<td><strong>Life threatening emergencies</strong></td>
<td>Imminent risk of harm or death to self or others due to a medical or psychiatric condition</td>
<td>Referral is Immediate</td>
</tr>
</tbody>
</table>
General Documentation Standard

The following must be clearly documented in the members chart:

– Complete biopsychosocial assessment
– Substance abuse screening for consumers over the age of 11
– Full Axis I through V diagnosis
– Treatment plan with specific long term and short term goals
– Ongoing risk assessments

More information about documentation standards can be found in the Optum Provider Manual
Discharge Planning

• Effective discharge planning addresses how a member’s needs will be met during transition from one level of care to another or to a different treating clinician.

• Planning begins with the onset of care and should be documented and reviewed over the course of care.

• Discharge treatment planning will focus on achieving and maintaining a desirable level of functioning after the completion of the current episode of care.

• Discharge instructions should be specific, clearly documented and provided to the member prior to discharge. For discharge from an acute inpatient program, the member’s follow-up appointment will be scheduled prior to discharge for a date that is within seven days of the date of discharge.

• Throughout the treatment and discharge planning process, it is essential that members be educated regarding the importance of enlisting community support services, communicating treatment recommendations to all treating professionals, and adhering to follow-up care.
Cultural Competency

- Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals, that enables effective work in cross-cultural situations.

- 'Culture' refers to integrated patterns of human behavior within various racial, ethnic, religious or social groups, including:
  - Language
  - Thoughts
  - Communications
  - Actions
  - Customs
  - Beliefs
  - Values
  - Institutions

- 'Competence' implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.
Importance and Value of Cultural Competency

• A growing diversity impacts the field of behavioral health by increasing the need for services that are tailored to specific cultures

• Given the diverse ethnic population in the United States we must ensure that we provide culturally appropriate services

• We need to address how services are delivered and ensure that people are comfortable approaching us and using our services

• We must be able to address the stigma many individuals perceive towards mental illness and to encourage open discussion on mental health or substance abuse

• It is critical to emphasize the aspect of our programs and services that enable the clients or consumers to become self-sufficient and to embrace life completely
Claims Submission

• Providers must submit claims using the current CMS-1500 or UB04 with appropriate coding including, but not limited to, ICD-9, CPT, and HCPCS coding.

• Services rendered for outpatient partial care and Opioid Treatment services must be submitted on a CMS-1500 form.

• UnitedHealthcare requires that you initially submit your claim within your contracted deadline. The timely filing limit is contained within your provider agreement.

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

• Once claims are submitted, Electronic Payment & Statements (EPS) can also be accessed by requesting an ID and Log-In through www.providerexpress.com
Claims Submission Option 1 - Online

Entry through: **www.providerexpress.com**

- Secure HIPAA-compliant transaction features streamline the claim submission process
- Performs well on all connection speeds
- Submitting claims closely mirrors the process of manually completing a CMS-1500 form
- Allows claims to be paid quickly and accurately

You must be an Optum network clinician or group practice and have a registered user ID and password to gain access to the online claim submission function.

To utilize this service you must register as a new user on the portal.
Claims Submission Option 2 – EDI/ Electronically

- Electronic Data Interchange (EDI) is an exchange of information
- Performing claim submission electronically offers distinct benefits:
  - It's fast - eliminates mail and paper processing delays
  - It's convenient - easy set-up and intuitive process, even for those new to computers
  - It's secure - data security is higher than with paper-based claims
  - It's efficient - electronic processing helps catch and reduce pre-submission errors, so more claims auto-adjudicate
  - It's complete - you get feedback that your claim was received by the payer
  - It's cost-efficient - you eliminate mailing costs, the solutions are free or low-cost

- You may use any clearinghouse vendor to submit claims
- Payer ID for submitting claims to Optum is 87726
- Additional information regarding EDI is available on www.unitedhealthcareonline.com.
Claims Submission Option 3 - Hardcopy

- Use the CMS-1500 claim form
- Claim elements include but are not limited to diagnosis (DSM-IV-TR* or it’s successor), Member name, Member date of birth, Member identification number, dates of service, type and duration of service, name of clinician (i.e., individual who actually provided the service), provider credentials, tax ID and NPI numbers
- Paper claims submitted via U.S. Postal Service should be mailed to:

  • Mailing address:
    United Healthcare Community Plan of NJ
    PO Box 30760
    Salt Lake City, Utah 84130-0760
Claims Form – CMS 1500 Provider Section

Group NPI Submission

• **Box 24j:** Agencies submitting with a group NPI, should *not* place the name of the service provider in box 24j on the CMS1500

• **Box 33 and 33a:** Group agencies submitting with a group NPI should complete Box 33 and 33a
Claims Form – CMS 1500 Provider Section

Independently Licensed Provider NPI Submission

• **Box 24j**: Enter the **rendering** provider’s name (may be non-licensed) in the **shaded** portion, and the **NPI number of the independently licensed** supervising clinician in the **non-shaded** portion.
Independently Licensed Provider NPI Submission

**Box 31:** Enter the name and licensure of the independently licensed clinician who is supervising delivery of services or directly rendering the services; the name and license should be the same as it appears on the agency roster

**Only independently licensed clinicians should appear in Box 31**
Claims Form – CMS 1500 Provider Section

Independently Licensed Provider NPI Submission

• In addition to Box 24j and 31, also complete Box 33 and 33a when submitting with independently licensed provider NPI

• **Box 33**: Agency name, address, and phone number
• **Box 33a**: Agency NPI number
### Claims Form – UB04

#### Table Sample

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data 1</td>
<td>Data 2</td>
<td>Data 3</td>
</tr>
<tr>
<td>Data 4</td>
<td>Data 5</td>
<td>Data 6</td>
</tr>
</tbody>
</table>

#### Diagram Sample

![Diagram of claims form UB04](sample_image)
Claim Tips

To ensure clean claims remember:

- NPI numbers are always required for both rendering/billing provider on all claims
- A complete diagnosis is also required on all claims
  - Example: 295 Schizophrenic disorders is an incomplete diagnosis code as 5 digits are required

Claims filing deadline

- Providers should refer to their contract with Optum to identify the timely filing deadline that applies.

Claims Processing

- Clean claims, including adjustments, will be adjudicated within 30 days of receipt.

Balance Billing

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

• **Member Eligibility**
  – Provider is responsible to verify member eligibility

• **Coding Issues related to claims denials**
  – Coding issues including incomplete or missing diagnosis
  – Invalid or missing HCPC/CPT examples:
    • Submitting claims with codes that are not covered services
    • Required data elements missing, (i.e., number of units)

• **Provider information missing/incorrect**
  – Example: provider information has not been completely entered on the claim form or place of service

• **Prior Authorization Required**
  – No authorization received for those services for which an authorization is required
  – Units exceeded, example: authorization was given for 10 days, facility has billed for 11 inpatient days
Appeals

Provider Claim Dispute and Appeal

• Claims must be received within the timely filing requirements of your agreement through New Jersey Long Term Care with Optum. You may dispute a claims payment decision by requesting a claim review under Medicaid.

Provider Claims Dispute:

• Stated as “Administrative Appeals by Practitioner” on Provider Remit.

• If after a provider is not able to resolve a claim denial through Provider Service Center, the provider may challenge the claim denial or adjudication by filing a formal claim dispute.

• A claim dispute must be in writing and state with particularity the factual and legal basis and the relief requested, along with any supporting documents (e.g., claim, remit, medical review sheet, medical records, correspondence, etc.). Particularity usually means a chronology of pertinent events and a statement as to why the provider believes the action by UnitedHealthcare of NJ was incorrect.
Appeals

• Claims reconsideration through:


• Mailing address, fax and phone numbers

Appeals and Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512
Fax: 1-855-312-1470
Phone: 1-866-556-8166
Member Rights and Responsibilities

Members have the right to be treated with respect and recognition of his or her dignity, the right to personal privacy, and the right to receive care that is considerate and respectful of his or her personal values and belief system.

Members have the right to disability related access per the Americans with Disabilities Act.

You will find a complete copy of Member Rights and Responsibilities in the Network Manual.

These can also be found on the website: providerexpress.com

These rights and responsibilities are in keeping with industry standards. All members benefit from reviewing these standards in the treatment setting.

We request that you display the Rights and Responsibilities in your waiting room, or have some other means of documenting that these standards have been communicated to the members.
Critical Incident Reporting

• Providers must comply with the Critical Incident reporting
• Critical Incidents include, but are not limited to, the following when they occur in a NF/SCNF, inpatient Behavioral Health, home and community-based long-term care service delivery setting, community alternative residential settings, adult day care centers, other HCBS provider sites, and a Member’s home:
  – 1. Unexpected death of a Member;
  – 2. Missing person or unable to contact;
  – 3. Suspected or evidenced physical or mental abuse (including seclusion and restraints, both physical and chemical)
  – 4. Theft with law enforcement involvement;
  – 5. Law enforcement contact;
Critical Incident Reporting – cont.

– 6. Severe injury or fall resulting in the need for medical treatment;
– 7. Medical or psychiatric emergency, including suicide attempt;
– 8. Medication error;
– 9. Inappropriate or unprofessional conduct by a provider involving the Member;
– 10. Sexual abuse and/or suspected sexual abuse; and
– 11. Abuse and neglect, including self-neglect, and/or suspected abuse and neglect.
– 12. Incident likely to result in media attention
Critical Incident Reporting Form

This form must be received within **24 hours** of discovery of the incident.

Please complete this form and fax to the Quality Management Department along with any other supporting documentation to: **855-216-6408**

As applicable,
- APS 1-800-792-8820
- OOF 1-877-582-6995
- DCP©/ DC&P 1-877-652-2873

**SECTION 1: Member Information (complete all sections)**

<table>
<thead>
<tr>
<th>Subscriber ID#:</th>
<th>Member Name:</th>
<th>DOB:</th>
<th>Gender:</th>
<th>Member Address:</th>
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</thead>
<tbody>
<tr>
<td>Medicaid ID#:</td>
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<td></td>
</tr>
</tbody>
</table>

**Type of Services member receiving:**

If police report filed, when and by whom?

**UHC Care Coordinator for member:**

**SECTION 2: Critical Incident Information (complete all sections)**

<table>
<thead>
<tr>
<th>Date/Time Incident Occurred:</th>
<th>Date/Time Provider or UHC rep (CC etc) first learned of incident (discovery):</th>
</tr>
</thead>
</table>

**Date/Time Reported to UnitedHealthcare Clinical Quality Analyst:**

**Who first reported incident to provider or UHC rep:** □ member, □ POA/family, □ worker, Other__________

**Location of Incident:** □ Private home, Facility-based setting:
- Comprehensive Personal Care Home, □ Nursing Facility, □ Pediatric Day Care, □ Adult Day Health Service/Medical Day Center, □ Assisted Living Residence, □ Social Day Center, □ Group Home/Boarding Home, □ Community Residential Service Home, □ Other [name of facility], □ Community/General Public Area

**Provider Type:**

□ Community Living Facility Providers (Adult Facility Care, Assisted Living Services, Comprehensive Personal Care Home, Assisted Living Program, Community Residential Services)

□ Emergency Response System (PERS), In-Home Respite
- □ Home Health Providers Private Duty Nursing, Personal Care Assistant
- □ Individualized Service Providers (Residential Modification, Vehicle Modification, Non-Medical Transportation, Caregiver/Participant Training, Community Transition Services)
Member Website

www.liveandworkwell.com

liveandworkwell.com makes it simple for members to:

• Identify network clinicians and facilities
• Locate community resources
• Find articles on a variety of wellness and work topics
• Take self-assessments

The search engine allows members and providers to locate in-network providers for behavioral health and substance use disorder services.

Providers can be located geographically, by specialty, license type and expertise.

The website has an area designed to help members manage and take control of life challenges.
Optum Provider Website

www.providerexpress.com

• Our industry-leading Provider website includes both public and secure pages. Public pages include general updates and useful information. Secure pages are available only to network Providers and require registration. The password-protected “secure transactions” gives you access to Member and Provider specific information.

• Secure transactions include:
  – Check eligibility and authorization or notification of benefits requirements
  – Obtain initial authorization requests, if applicable
  – Create and maintain My Patients list
  – Submit professional claims and view claim status
  – Make claim adjustment requests
  – Register for Electronic Payments and Statements (EPS), including Electronic Funds Transfer (EFT)
  – Update your practice information
www.providerexpress.com

Public Pages include general updates and other useful information
- Download standard forms (Ex. Agency Roster Update form)
- Find staff contacts
- Review clinical guidelines
- Access current and archived issues of *Network Notes*, the provider newsletter

Secure pages are available only to network providers and require registration
- Providers will be able to update their practice information
  - To request a User-ID to the secure transactions on providerexpress.com: Select the “First-time User” link in the upper right hand corner of the providerexpress.com home page
  - Click the “Provider Express Support” icon to access our “Live Chat” feature or call (866) 209-9320 from 7 a.m. to 9 p.m. Central Time, Monday through Friday, excluding holidays
Joining Our Network - Clinicians

- The participation process begins with submission of the provider application
  - Clinicians contracting on an individual basis complete the CAQH universal application online at [www.caqh.org](http://www.caqh.org)
  - Providers complete Network Request form
  - Agencies pursuing group contracts complete the Optum Agency application

- Additional required application materials include
  - Signed Optum Provider Agreement with NJ Medicaid Addendum
  - Current State License(s)/ Certifications
  - Form W9- (if multiple tax ID numbers used, one W( must be submitted for each ID number)
  - Malpractice Questionnaire
  - Optum Disclosure of Ownership form
  - Other documents as applicable

- Approval by Optum Credentialing Committee Credentialing requirements can be found at [www.providerexpress.com](http://www.providerexpress.com) under “join our network.”

- Orientation to Optum clinical and administrative protocols via webinars or review of provider resources posted on [www.providerexpress.com](http://www.providerexpress.com).
Joining Our Network – CMHC/FQHC Agencies and Groups

Group Contracts

– For CMHC/FQHC agencies that employ licensed professional staff to render services under the umbrella of the agency, Optum will execute group contracts with the agency as the contracting entity.

– Agencies must submit the Optum agency application, indicating the services being provided and the licensed clinical professionals on the staff roster.

– The individual licensed clinicians on staff do not need to submit CAQH applications or be individually credentialed when they work for the agency under an Optum group contract.
Contact Information

• NJ Customer Service: 800-701-0710
• TTY: 800-701-0720, hearing impaired
• NJ MLTSS Information:  
  [http://www.state.nj.us/humanservices/dmahs/home/Essential_Elements_for_Providers_Participating_in_MLTSS.pdf](http://www.state.nj.us/humanservices/dmahs/home/Essential_Elements_for_Providers_Participating_in_MLTSS.pdf)
• Provider Service Line: 888-291-2506
• For specific contracting questions:  
  Susan Murphy, Network Manager 518-313-4771
  Email: Susan.A.Murphy@optum.com

Or for internet access:
  For claims status, member eligibility and benefits please go to:  
  • www.providerexpress.com
Susan A. Murphy@optum.com