Provider Orientation: New York Medicaid and Wellness4Me
September & October 2015

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

- Joyce B. Wale, LCSW, Executive Director, Behavioral Health
- Lisa Camardo, Director of NY Behavioral Health Operations
- Lana Kats, MBA, Director of Network Management for NY Public Sector
- Adrene Cohen, RN, MA, MPA, FACHE, Northeast Regional Director, Accountable Care Programs and Health Homes
- Seth Mandel, MD, MBA, Behavioral Health Medical Director, Wellness4Me
- Peg Elmer, LCSW, Clinical Director, Wellness4Me
- Margaret Sullivan, RN, MSN, Clinical Director, Mainstream Medicaid
- Barbara Tedesco, MS, CRC, Recovery and Resiliency Manager
- Gayle Parker-Wright, LCSW-R, Network Trainer
- Eunice Hudson, Provider Education Specialist
- Allandro Pierre, MHA, Network Manager
- Missy Lerma, LCSW, Director of Network Management
Agenda

• Welcome and Introduction
• Overview of Optum and UnitedHealthcare Community Plan
• Health Homes
• Benefits
• Clinical Vision
• Clinical and Utilization Management Requirements
• Cultural Competency
• Quality Improvement
• Credentialing and Recredentialing
• Recovery and Resiliency
• Billing
• Provider Express and UnitedHealthcare Online
• Network Services
UnitedHealthcare Community Plan (Community Plan)

- Is the largest health benefits company dedicated to providing diversified solutions to states that care for the economically disadvantaged, the medically underserved and those without benefit of employer-funded health care coverage

- Participates in programs in 24 states plus Washington D.C. serving approximately 5 million beneficiaries of acute and long-term care Medicaid plans, the Children’s Health Insurance Program (CHIP), Special Needs Plans and other federal and state health care programs

- Health plans and care programs are uniquely designed to address the complex needs of the populations they serve, including the chronically ill, those with disabilities and people with higher risk medical, behavioral and social conditions
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 UBH, UBH I.P.A. and Optum in our communications to you

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.
Our United Culture

Our mission is to help people live healthier lives. Our role is to make health care work for everyone.


- Honor commitments
  Never compromise ethics

- Walk in the shoes of people we serve and those with whom we work

- Build trust through collaboration

- Invent the future, learn from the past

- Demonstrate excellence in everything we do
Managed care transition

• The NYS Office of Mental Health (OMH) is collaborating with the Department of Health (DOH) and Office of Alcoholism and Substance Abuse Services (OASAS) to implement the managed care transition in response to the recommendations and guiding principles set forth by the Medicaid Redesign Team (MRT) Behavioral Health (BH) Subcommittee

• The vision is to create a system that provides New Yorkers with fully integrated behavioral and physical health services offered within a comprehensive, accessible and recovery oriented system

  – For adults 21 and older, the integration of all Medicaid behavioral health (BH) and physical health (PH) benefits under managed care will go into effect **October 2015 in NYC** and on **July 2016 in the rest of New York State** and will be delivered through **two BH managed care models**
Managed care transition, continued

Managed care models:

• **Qualified Mainstream Managed Care Organizations (MCOs):** For all adults served in mainstream MCOs throughout the State, the qualified MCO will integrate all Medicaid State Plan covered services for mental illness, substance use disorders (SUDs), and physical health conditions

• **Health and Recovery Plans (HARPs):** HARPs will manage care for adults with significant behavioral health needs
  – They will facilitate the integration of physical health, mental health, and substance use services for individuals requiring specialized expertise, tools, and protocols which are not consistently found within most medical plans
  – In addition to the State Plan Medicaid services offered by mainstream MCOs, qualified HARPs will offer access to an enhanced benefit package comprised of **Home and Community Based services (HCBS)** designed to provide the individual with a specialized scope of support services not currently covered under the State Plan
Managed care transition, continued

The Managed Care System is being developed based on the Medicaid Redesign Team (MRT) guiding principles

• Person-Centered Care management
• Integration of physical and behavioral health services
• Recovery oriented services
• Patient/Consumer Choice
• Ensure adequate and comprehensive networks
• Tie payment to outcomes
• Track physical and behavioral health spending separately
• Reinvest savings to improve services for BH populations
• Address the unique needs of children, families & older adults
Wellness4Me (Health and Recovery Plan, HARP): phase 1

- **Starting October 1, 2015** both the Mainstream Medicaid and Wellness4Me Plan (HARP) benefits will be rolled out

- These products are for members who are 21 years and older residing in the 5 boroughs of New York City
  - It will be phased in over a 3 month period

- Home and Community Based Services (HCBS) for Wellness4Me members will begin **January 1, 2016**

- Membership by Borough / County
  - Bronx = Bronx County
  - Brooklyn = Kings County
  - Queens = Queens County
  - Manhattan = New York County
  - Staten Island = Richmond County
Wellness4Me Plan (HARP): phases 2 & 3

Phase 2

- **July 1, 2016**: includes all adults 21+ years old, in the rest of state
  - All New York State, eligible adults 21 and older, who meet the criteria can be enrolled in the Wellness4Me Plan

Phase 3

- **January 1, 2017**: all adults under 21 years old, adolescents and children in New York City (5 Boroughs), Nassau and Suffolk
- **July 1, 2017**: all adults under 21 years old, adolescents and children in the rest of state
Understanding Wellness4Me

- Wellness4Me is a new UnitedHealthcare Community Plan product for HARP-eligible members
- A member cannot be enrolled in the UnitedHealthcare Wellness4Me Plan and a Managed Medicaid Plan – The member must choose one plan
- The member must clinically qualify for Wellness4Me Plan based on the results of the New York State (NYS) Community Mental Health Assessment (needs assessment)
- NYS will “passively” enroll Community Plan members into the Wellness4Me Plan based on diagnosis and claims history
- Members can “opt out” of joining the Wellness4Me Plan and enroll in the Managed Medicaid plan within the first 90 days of enrollment
- Members can dis-enroll from either benefit within the first 90 days of enrollment – After 90 days, members must have a good reason to dis-enroll (e.g., moved out of the service area)
Wellness4Me Health Homes and Care Coordination

Adrene Cohen, RN, MA, MPA, FACHE, Northeast Regional Director, Accountable Care Programs and Health Homes
Wellness4Me Care Coordination and Health Homes

Wellness4Me Services

Integrate

Health Home

New York Health Home
Populations Health Homes serve

- Individuals who are experiencing a severe disability or mental illness
- High risk homeless
- Medication Assisted Therapy (MAT)
- Members seeking permanent housing and a sense of community
- Transition from jail/prison
- Court-ordered community dwellers
- Members with complex medical conditions such as obesity, diabetes, asthma, HIV, congestive heart failure, etc.
What is a Health Home?

The six (6) core Health Home functions mandated by the Patient Protection Act are:

<table>
<thead>
<tr>
<th>Operational Priorities</th>
<th>Medical</th>
<th>Behavioral</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition of care</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Care coordination</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Referral management</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Individual care</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Health promotion</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Care support for family/caregiver</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Overview of the process

Member Enrollment

- Assigned PCP
- HARP Care Coordinator
- Care Coordinator at Health Home

- Assigned BH Provider
- BH Care Coordinators
• Care Coordination will include:
  – Documentation of a Plan of Care by the behavioral and medical care team in one document
  – The Care Plan will indicate the activities and strategies to achieve stated care goals for the member
  – The interdisciplinary team that is created from the collaboration among providers facilitates the integration of care
Documentation will reside in a platform that is shared and provides reports

- The reports will facilitate tracking of
  - Referrals
  - Met/unmet goals
  - Appointments scheduled 90 days post hospitalization or emergency department visit
  - Hospitalizations or emergency department visits and 7 day follow-up
  - High-risk comorbid members for hospital avoidance
  - Alerts and other activities
Goals of Health Homes

• To use data to monitor member’s status
• To avoid service duplication
• To identify members who require care coordination or HARP services upon discharge
• To identify members who have not seen their PCP/Health Homes
• To create metrics that facilitate monitoring and evaluation
• To reduce cost
Program Managers are Registered Nurses

- Work on care transitions
- Work with Community Health Workers (CHWs) to engage members with a Health Home
- Train Health Homes/Coordination Management Agencies (CMAs) in care needs and provider contact
Wellness4Me, Mainstream Medicaid and Benefits
Lana Kats, MBA, Director of Network Management for NY Public Sector
## Covered Benefits for Wellness4Me and Mainstream Medicaid

<table>
<thead>
<tr>
<th>Services</th>
<th>Wellness4Me</th>
<th>Mainstream Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medically Supervised Outpatient Withdrawal (OASAS Services)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Outpatient Clinic and Opioid Treatment Program (OTP) Services (OASAS Services)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Outpatient Clinic Services (OMH Services)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Comprehensive Psychiatric Emergency Program</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Continuing Day Treatment</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Partial Hospitalization</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Personalized Recovery-Oriented Services (PROS)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Assertive Community Treatment (ACT)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Intensive Case Management/Supportive Case Management</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Inpatient Hospital Detoxification (OASAS Service)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Inpatient Medically Supervised Inpatient Detoxification (OASAS Service)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Inpatient Treatment (OASAS Service)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Rehabilitation Services for Residential SUD Treatment Supports (OASAS Service)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Inpatient Psychiatric Services (OMH Service)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>Covered</td>
<td>Covered</td>
</tr>
</tbody>
</table>
Membership cards: New York Medicaid, front of card
Membership cards: New York Medicaid, back of card

In an emergency go to nearest emergency room or call 911.

This card does not guarantee coverage. For coordination of care call your PCP. To verify benefits or to find a provider, visit the website myuhc.com/communityplan or call.

For Members: 800-493-4647
NurseLine: 877-597-7801

For Providers: uhccommunityplan.com 866-362-3368
Medical Claims: PO Box 5240, Kingston, NY, 12402-5240

Pharmacy Claims: OptumRX PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 877-305-8952
Wellness4Me Plan (HARP) vs. Behavioral Health Benefit

The Home and Community Based Services are ONLY available to members enrolled in Wellness4Me Plan (HARP).

HCBS will not start until 1/1/2016 to allow time for all HARP members to receive their full assessment and for Plans of Care to be documented.

<table>
<thead>
<tr>
<th>HCBS Services for Adults Meeting Targeting and Functional Needs</th>
<th>Wellness4Me</th>
<th>Mainstream Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Psychosocial Rehabilitation</td>
<td></td>
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</tr>
<tr>
<td>• Community Psychiatric Support and Treatment (CPST)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empowerment Services - Peer Supports</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Habilitation</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Habilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Residential Supports in Community Settings</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Family Support and Training</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Employment Supports</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Pre-vocational</td>
<td></td>
<td></td>
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<tr>
<td>• Transitional Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Intensive Supported Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• On-going Supported Employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education Support Services</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Respite</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Short-term Crisis Respite</td>
<td></td>
<td></td>
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<tr>
<td>• Intensive Crisis Respite</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Medical Transportation</td>
<td>Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
Membership cards: New York Wellness4Me, front of card
Membership cards: New York Wellness4Me, back of card

In an emergency go to nearest emergency room or call 911.  
Printed: 06/10/15

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Clinical Vision

Seth Mandel, MD, MBA, Behavioral Health Medical Director, Wellness4Me
Our Clinical Vision

**Care Advocacy**

The purpose of Care Advocacy is intervention on behalf of individuals living with a health issue. We improve the experience of individuals we serve, using a range of tools and resources. We are dedicated to recovery, resiliency, wellness and wellbeing provided at the highest quality and most cost-effective manner.

**Service System Solutions**

The purpose of Service System Management is to improve the structure of, access to and practice within systems of care. We build relationships within local communities to learn about and improve healthcare systems.

**Information Management and Technology**

The purpose of Information Management and Technology is to create a more engaging, effective and affordable healthcare experience and to empower individuals in their pursuit of well-being.
Our goals

<table>
<thead>
<tr>
<th>Recovery Focus</th>
<th>Improve Access to Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Apply recovery principles from first call through natural community supports</td>
<td>• Right care at the right time</td>
</tr>
<tr>
<td>• Support use recovery language and principles in every aspect of our work</td>
<td>• Eliminate silos through integrated person-centered care plans</td>
</tr>
<tr>
<td></td>
<td>• Broaden provider focus for integrating care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Integrate Physical and Behavioral Health</th>
<th>Reduce Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No wrong door access to care</td>
<td>• Reduce readmissions to inpatient</td>
</tr>
<tr>
<td>• Eliminate silos through integrated person-centered care plans</td>
<td>• Engage community based crisis stabilization and use of PCP services</td>
</tr>
<tr>
<td>• Broaden provider focus for integrating care</td>
<td>• Increase use of natural community supports</td>
</tr>
</tbody>
</table>

UnitedHealthcare®
Community Plan
Tools for system transformation

**Utilization Management**
- Review requests for service against LOCG’s / LOCADTR:
  - Prior Notification
  - Pre-Certification
  - Prior Authorization
  - Concurrent Review
  - Transition Planning for successful discharge

**Care Coordination**
- Follow-up support after discharge
- Risk assessment and safety planning
- Coordination with community resources
- Support member’s recovery goals
- Engagement of member, family, and other support systems in development of care plan

**Person-Centered Care**
- Align closely with Health Home and Accountable Care Teams
- Care plans include:
  - Strength-based assessment, including culture
  - Measurable/attainable/realtistic/timely objectives
  - Keeps the person in context of their environment and natural supports

**Quality Driven Outcomes**
- Team-Facing Measures:
  - Call quality
  - Inter-rater reliability measures
- Performance Improvement Projects
- Provider/Member - Facing Measures include HEDIS/NCQA
- HCBS
- Special Populations
Clinical and Utilization Management Requirements
Peg Elmer, LCSW, Clinical Director, Wellness4Me
Margaret Sullivan, RN, MSN, Clinical Director, Mainstream Medicaid
Frequently used acronyms

• ACT: Assertive Community Treatment
• CDT: Continuing Day Treatment
• SPOA: Single Point of Access
• PROS: Personalized Recovery Oriented Services
  – ISR: Initial Service Recommendation
  – IRP: Individualized Recovery Plan
  – IR: Intensive Rehabilitation
  – ORS: Ongoing Rehabilitation and Supports
  – CRS: Community Rehabilitation and Support
• OTP: Opioid Treatment Program
• LOCADTR: Level of Care for Alcohol & Drug Treatment Referral
Ambulatory behavioral health services

- Assertive Community Treatment (ACT)
- OMH Clinic services
- Continuing Day Treatment (CDT)
- Comprehensive Psychiatric Emergency Program (CPEP)
- Intensive Psychiatric Rehabilitation Treatment (IPRT)
- Partial Hospitalization
- Personalized Recovery Oriented Services (PROS)
- Transportation
- Crisis Intervention
## Authorization requirements: mental health

<table>
<thead>
<tr>
<th>Service</th>
<th>Prior Authorization</th>
<th>Concurrent Review Authorization</th>
<th>State: Additional Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient mental health office and clinic services including: initial</td>
<td>No</td>
<td>Yes</td>
<td>MMCOs/HARPs must pay for at least 30 visits per treatment episode without requiring authorization. MMCOs/HARPs must ensure that concurrent review activities do not violate parity law.</td>
</tr>
<tr>
<td>assessment; psychiatric assessment; psychosocial assessment; medication</td>
<td></td>
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<tr>
<td>treatment; and individual, family/collateral, and group psychotherapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological or neuropsychological testing</td>
<td>Yes</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Mental Health Continuing Day Treatment (CDT)</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mental Health intensive outpatient (note: NOT State Plan)</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Mental Health partial hospitalization</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Assertive Community Treatment (ACT)</td>
<td>Yes</td>
<td>Yes</td>
<td>New ACT referrals must be made through local Single Point Of Access (SPOA) agencies. Plans will collaborate with SPOA agencies around determinations of eligibility and appropriateness for ACT following forthcoming NYS guidelines.</td>
</tr>
</tbody>
</table>
# Authorization requirements: PROS

<table>
<thead>
<tr>
<th>Service</th>
<th>Prior Auth</th>
<th>Concurrent Review Authorization</th>
<th>State: Additional Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personalized Recovery Oriented Services (PROS) Pre-Admission Status</td>
<td>No</td>
<td>No</td>
<td>Begins with initial visit and ends when Initial Service Recommendation (ISR) is submitted to Plan. Providers bill the monthly Pre-Admission rate but add-ons are not allowed. Pre-Admission is open-ended with no time limit.</td>
</tr>
</tbody>
</table>
| PROS Admission: Individualized Recovery Planning                        | Yes        | No                              | Admission begins when ISR is approved by Plan. Initial Individualized Recovery Plan (IRP) must be developed within 60 days of the admission date. Upon admission, providers may offer additional services and bill add-on rates accordingly for:  
  - Clinical Treatment;  
  - Intensive Rehabilitation (IR); or  
  - Ongoing Rehabilitation and Supports (ORS). Prior authorization will ensure that individuals are not receiving duplicate services from other clinical or HCBS providers. |
<p>| PROS Active Rehabilitation                                             | Yes        | Yes                             | Begins when IRP is approved by Plan. Concurrent review and authorizations should occur at 3-month intervals for IR and ORS services and at 6-month intervals for Base/ Community Rehabilitation and Support (CRS) and Clinic Treatment services. |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Prior Authorization</th>
<th>Concurrent Review Authorization</th>
<th>State: Additional Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient office and clinic services provided by OASAS-certified</td>
<td>No</td>
<td>Yes</td>
<td>See OASAS guidance regarding use of LOCATDR tool to inform level of care determinations.</td>
</tr>
<tr>
<td>agencies including: initial assessment; psychiatric assessment;</td>
<td></td>
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<tr>
<td>psychosocial assessment; medication treatment; and individual, family</td>
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<tr>
<td>collateral, and group psychotherapy</td>
<td></td>
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<tr>
<td>Medically supervised outpatient substance withdrawal</td>
<td>No</td>
<td>Yes</td>
<td>Plans may require notification through a completed LOCADTR report for admissions to this</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>service within a reasonable time frame.</td>
</tr>
<tr>
<td>Opioid Treatment Program (OTP) services</td>
<td>No</td>
<td>Yes</td>
<td>Plans may require notification through a completed LOCADTR report for admissions to this</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>service within a reasonable time frame.</td>
</tr>
<tr>
<td>Substance Use Disorder intensive outpatient</td>
<td>No</td>
<td>Yes</td>
<td>Plans may require notification through a completed LOCADTR report for admissions to this</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>service within a reasonable time frame.</td>
</tr>
<tr>
<td>Substance Use Disorder day rehabilitation</td>
<td>No</td>
<td>Yes</td>
<td>Plans may require notification through a completed LOCADTR report for admissions to this</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>service within a reasonable time frame.</td>
</tr>
<tr>
<td>Stabilization and Rehabilitation services for residential SUD treatment</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>
Utilization management

**Prior Authorization**
- Inpatient Mental Health
- Inpatient SUD: Medically Managed Detox
- Inpatient Rehab
- Outpatient Mental Health: PHP, IOP, ECT, PROS, CDT, ACT, Psychological Testing
- SUD: Residential Rehab

**Concurrent Review**
- Inpatient: review is due on the last covered day
- Outpatient: updated clinical is due before the last covered day

**Discharge Review**
- Discharge date, medications and disposition
- Follow-up appointment within 7 days (inpatient level of care)
- Identification of biopsychosocial needs and follow-up (housing, medical, etc)

**Retrospective Review**
- Conducted for all covered levels of care for members who are eligible for benefits during the identified dates of service
- Must be requested within 120 days
Level of care guidelines

- Where can providers find level of care guidelines?

**Mental Health**

Provider Express:
- providerexpress.com
- Provider Manual
- Final LOCG’s pending NYS approval

**Substance Use Disorders**

Level of Care for Alcohol and Drug Treatment Referral (LOCADTR) NY LOCADTR 3
- [https://extapps.oasas.ny.gov](https://extapps.oasas.ny.gov)
Level of Care Guidelines (LOCG): provider resource

- Common Criteria for Guidelines- commitment of NYS and MCO’s to decrease provider burden
- Your homework assignment: review all relevant LOCGs
- LOCGs will be posted to Provider Express- visit this site frequently for updates and valuable information
- LOCGs are reviewed and updated annually
- Use it to train staff
- Many of these guidelines are pending review and approval by NYS
- Understanding how to use these guidelines as a clinical tool can greatly improve your managed care experience
Level of Care Determinations SUD: LOCADTR

• Designed for substance abuse treatment providers, the LOCADTR assists providers in making decisions about the appropriate level of care for a member.

• The LOCADTR is meant to ensure that all members in need of treatment for a substance use disorder have access to care and are placed in the least restrictive, but most appropriate level of care available.

• In addition to helping providers and members, the data collected by the tool will also be studied and analyzed to provide further insights into its effectiveness and allow for adjustments and updates to be made.

• Level of care is determined by a variety of factors, including:
  – Diagnostic information (for example, the number of DSM-5 criteria the member meets).
  – Assessment of the member’s need for crisis or detoxification services (for instance, determining possible medical complications from withdrawal).
  – Risk factors (such as the presence of severe medical and psychiatric conditions).
  – Resources available to the member (for example, a social or family network who are supportive of recovery goals).
Inpatient Substance Use Disorder (SUD) reviews

- Provider’s are required to submit clinical information via UnitedHealthcare Online Provider Portal
- Include a PDF file of the LOCADTR report with the clinical documentation
- Our Facility Based Care Advocates (FBC-A) will review clinical information and enter it in LOCADTR
- When the Level of Care is consistent with the provider report, services are authorized
- If the LOCADTR Level of Care is not consistent with the request, our FBC-A will call the provider to request additional clinical information
- Any overrides in LOCADTR require clinical justification: if you select an override you can anticipate a call from our FBC-A to substantiate the request
Override options

NEED TO OVERRIDE LOCADTR RECOMMENDATION

There is a need to override LOCADTR recommendation for the following reason:

- Not applicable
- The recommended level of care is not available.
- There are additional clinical factors documented below.
- There is an external mandate that is documented below.

- It is extremely important that providers document relevant information to substantiate an override
- Indicating that this level of care is not available within your service delivery system does not substantiate an override
Medical necessity

Care Advocates use the Level of Care Guidelines when making medical necessity determinations and as guidance when providing referral assistance.

**Generally accepted standards of practice**
- Based on credible scientific evidence
- Generally recognized by the relevant medical community
- Use evidenced-based outcomes to validate the practice

**Clinically appropriate**
- Type, frequency, extent, and duration of services
- Considered effective for the treatment of mental illness, substance use disorder, or associated symptoms

**Determinations of medical necessity**
- Informed by
  - Unique aspects of the case
  - Member’s benefit plan
- Available services
  - Ability of provider to meet the member’s immediate needs
  - Alternatives that exist in the service area

---

Optum

UnitedHealthcare Community Plan
What happens if medical necessity is not met?

- If a clinical review results in a disagreement about level of care there are a few options:
  - Peer Review
    - Full denial
    - Partial denial
  - Appeals

- When a determination is made that a level of care is not the right care at the right time we will:
  - Work closely with providers to identify a transition plan
  - Assist provider and members in finding services that meet the member’s needs
Evidence-Based Practices

Examples of Evidence-Based Practices (not an all inclusive list)

• Motivational Interviewing
• Person-Centered Care
• Trauma Informed Care
• Risk Assessment and Crisis Intervention
• Integrated Whole Health Model
• Critical Time Intervention
• Recovery and Resiliency
• Individualized Recovery Planning
• Cognitive Behavioral Therapy
• Dialectical Behavioral Therapy
Special populations

• Transition Age Youth (TAY)
  – Most vulnerable as they transition from child to adult system
  – Need to collaborate to identify and educate youth as they approach age 21
  – Identify youth that may qualify for Wellness4Me (HARP) and Health Homes

• Co-occurring Physical and Behavioral Health and/or SUD
  – Integrated models of care

• First episode psychosis
  – OnTrackNY - required tracking of first episode
  – Supportive Transition and Recovery Team (START)
  – NYS Qualified FEP Providers

• Opioid Dependence
  – Epidemic
  – Identifying, referring and linking members to appropriate SUD services
Wellness4Me: HCBS covered services

- Psychosocial Rehabilitation
- Community Psychiatric Support and Treatment (CPST)
- Habilitation/Residential Support Services
- Family Support and Training (FST)
- Short-Term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Empowerment Services – Peer Supports (OMH)
- Pre-Vocational Services
- Transitional Employment
- Intensive Supported Employment
- Ongoing Supported Employment
- Transportation
HCBS will be subject to utilization caps at the Member level that apply on a rolling basis (any 12 month period).

- Tier 1 HCBS: limited to $8,000
- Tier 1 and Tier 2 combined have an overall cap of $16,000

Utilization caps exclude crisis respite: short-term crisis respite and intensive crisis respite are each limited within their own individual caps to 7 days per episode and 21 days per year

**Tier 1**: Employment, education and peer support

**Tier 2**: Full array of HCBS
Individualized Service Planning

• Plans of Care
  – Master integrated document
  – Includes all services: providers, frequency and duration, contact information
  – Ideally POC will be completed by Health Home Care Coordinators
  – POC must be submitted to the Plan for approval
    • Confirming providers in network
    • Verifying members eligibility for the services listed
    • Evaluating POC for recovery goals that are person-centered and echo the members goals in their words
  – Our Care managers complete the POC when:
    • Member is not enrolled or is refusing Health Home care coordination or
    • Member is not Health Home eligible
    • We are committed to assist members with field based care advocates, peers, community health workers and housing specialists
Service specific plans

• The member's diagnosis or presenting issues warranting services
• The member's problems and strengths
• The member's service goals are consistent with the purpose and intent of the program
• Plan for the provision of additional services to support the recipient outside of the program
• Criteria for discharge planning
• Person-centered care planning is clear and includes
  – Consistent goals and objectives
  – Concrete and easy to understand information (who, what and when)
  – Evaluation of goal attainment
  – Proactive planning to prevent or de-escalate crisis
HCBS eligibility

NEW YORK STATE
Office of Mental Health
Office of Alcoholism and
Substance Abuse Services

Eligibility Assessment

SECTION A: IDENTIFICATION INFORMATION

<table>
<thead>
<tr>
<th>Name (First, Middle Initial, Last)</th>
<th>Health Home where person is enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>Is person on HCBS-eligible list?</td>
</tr>
<tr>
<td></td>
<td>On HARF list</td>
</tr>
<tr>
<td></td>
<td>Not on HARF list</td>
</tr>
</tbody>
</table>

What was individual's sex at birth?
(Provide birth certificate)
| Mark   | Female
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Other</td>
<td>Could not (would not) determine</td>
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Gender Identity
| Male   | Female
<table>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>Could not (would not) determine</td>
</tr>
</tbody>
</table>

Sexual Orientation
| Heterosexual or straight
| Bisexual, gay, or lesbian
| Bisexual
| Other
| Not sure
| Could not (would not) determine       |

Medicaid ID (CIN)

Health Home Local Case

What is person's religion?
| Roman Catholic
| Jewish
| Buddhist
| Muslim
| Other
| None

Date of Assessment

Residential/Living status at time of assessment
| Private home/apartment/condominium
| Own home
| Homeless - shelter
| Homeless - street
| Hospital facility/patient care unit
| OASAS-supervised community housing (or similar)
| OASAS-Sub community residence
| OASAS-Sub community residence program
| Other

Individual receives housing supports
| No   | Yes

Residential instability
| 2 or more moves in last 2 years (e.g., 2 or more moves, no permanent address, homeless, living in shelter)
| No   | Yes

Living Arrangement
| Alone
| With spouse (partner only)
| With spouse (partner and other)
| With child (not spouse, partner)
| With parent(s)/guardian(s)
| With roommate(s)
| With other relatives
| With non-relatives

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OPTUM

UnitedHealthcare Community Plan
HCBS eligibility, continued

![Community Mental Health Assessment Form](image-url)

### Section A: Identification Information

<table>
<thead>
<tr>
<th>Name (First, Middle Initial, Last)</th>
<th>Health Home where person is enrolled</th>
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<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Is person on HARP-eligible list?</th>
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<tr>
<td>Month: Day: Year</td>
<td>On HARP list?</td>
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<td>Not on HARP list</td>
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<th>What was individual's sex at birth? (as original birth certificate)</th>
<th>Medicaid ID (CMN)</th>
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<td>Male</td>
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<tr>
<td>Female</td>
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<td>Other</td>
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<th>Sexual Orientation</th>
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<td>Heterosexual or straight</td>
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<td>Homosexual, gay, or lesbian</td>
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<td>Bisexual</td>
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<td>Married</td>
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<td>Separated</td>
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<td>Divorced</td>
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<td>Partner/Significant Other</td>
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<td>Widowed</td>
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<th>Reason for Assessment</th>
<th>Person's expressed goals of care</th>
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<td>Not assessed</td>
<td>Identify primary goal</td>
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<td>Routine reassessment</td>
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<td>Return assessment</td>
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<tr>
<td>Significant change in status assessment</td>
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<tr>
<td>Care agreement</td>
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<tr>
<td>Other (e.g., relocation)</td>
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</table>

<table>
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<th>Medicaid ID (CMN)</th>
<th>Person's expressed goals of care</th>
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Form Version 1.4

UnitedHealthcare®
Community Plan

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Cultural Competency

Gayle Parker-Wright, LCSW-R, Network Trainer
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
- Competence means having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by members and their communities
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
Importance and value of cultural competence

- Given the diverse ethnic population in New York, providers must be prepared to provide culturally appropriate services
- Service settings and approaches should be culturally sensitive to engage individuals from diverse backgrounds to access services
- Promoting open discussions about mental health or substance abuse issues is an important step to reduce the stigma many individuals have
- Emphasizing individualized goals and self-sufficiency encourages members to live their lives to the fullest
Quality Improvement
Missy Lerma, LCSW, Director of Network Management
Quality improvement

Quality of care is measured and monitored throughout the organization.

Examples of how we measure quality:
– HEDIS® measures
– Complaints
– Sentinel Events
– Provider Satisfaction Surveys
– Member Satisfaction Surveys
– Coordination of Care
– Best Practice Guidelines
NCQA & HEDIS

• What is NCQA?

National Committee for Quality Assurance

• What is HEDIS?

Healthcare Effectiveness Data and Information Set

A tool used by more than 90% of America’s Health Plans to measure performance on important dimensions of care and service.
Examples of behavioral health HEDIS measures

- **FUH** – Follow-up After Hospitalization
- **AMM** – Antidepressant Medication Management
- **ADD** – Follow-up care for Children prescribed ADHD Medication
Member complaints

As an organization we investigate all member complaints (also known as grievances)

Complaints may be reported in different ways:

- Information is provided by the member and/or family member to the Health Plan or other internal department that reports cases
- Member direct report through calling the Health Plan Customer Service Department

Providers are part of the investigative process:

- Submit medical records for review
- Provide a response to an allegation
- Cooperate as necessary to resolve the investigation
Sentinel Events

What is a Sentinel Event?

Sentinel events are defined as a serious, unexpected occurrence involving a Member that is believed to represent a possible quality of care issue on the part of the practitioner/facility providing services, which has, or may have, deleterious effects on the Member, including death or serious disability, that occurs during the course of a Member receiving behavioral health treatment.

Reporting Sentinel Events to Quality:

• If you are aware of a sentinel event involving a Member, you must notify UnitedHealthcare Community Plan within one business day of the occurrence.

• Standardized reporting forms (located here on Provider Express) should be sent directly to the Quality Department through secure fax or email:
  • Fax: 844-342-7704 – Attn: Quality Department
  • Email: NYBH_QIDept@uhc.com

• Additional information about Sentinel Events can be found in the Behavioral Health Provider Manual.
An Appeal is any of the procedures that deal with the review of adverse determinations on the health care services a Member is entitled to receive or any amounts that the Member must pay for a covered service.

All Appeals should be submitted to:
UnitedHealthcare Community Plan Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364

For questions about Appeals, you may call 866-362-3368
Provider quality audits

• Provider audits are completed for a variety of reasons:

  – On-going monitoring of providers, including Home and Community Based Services providers
  – At the time of Credentialing and Recredentialing for providers without OMH/OASAS certification and without a national accreditation (for example, The Joint Commission or CARF)
  – Quality of Care (QOC) investigation
  – Investigation of member complaints regarding the physical environment of an office or agency
Provider quality audits, continued

**Elements reviewed during audits**
- Physical environment
- Policies and procedures
- Member treatment records
- Personnel files

**Scoring of Audits**
- 85% and higher is passing
- Scores between 80 – 84% require a Corrective Action Plan (CAP)
- Scores below 79% require a CAP and re-audit
Audit tools

• There are 8 audit tools for New York Medicaid:
  – Organizational Provider Site Audit Tool
  – Treatment Record Review Tool
  – HCBS Record Tool
  – Case Management Record Tool
  – Psychosocial Rehab Record Tool
  – Peer Support Record Tool
  – Clinician Site Audit Tool
  – Home Office Site Audit Tool

• The audit tools will be posted to providerexpress.com once they are finalized: from the home page, choose Our Network > Welcome to the Network > New York > Quality Improvement > Audit Tool Names
• Information regarding documentation standards for behavioral health providers can be located in 3 places:

  – The Optum Network Manual (located on providerexpress.com): from the home page, choose Clinical Resources > Guidelines/Policies & Manuals > Optum Network Manual > Treatment Record Documentation Requirements 
  – The New York Mainstream Medicaid and Wellness4Me Behavioral Health Provider Manual (Coming Soon, will be located on Provider Express: from the home page choose Our Network > Welcome to the Network > New York > NY Medicaid Behavioral Health Provider Manual)
  – The audit tools
Highlights of documentation standards

• Record must be legible
• All entries must be signed by the rendering provider
• Entries must include the start and stop time or length of time spent in the session (for timed sessions)
• A Psychiatric and medical history, including the presenting problem, is documented
• Risk assessments (initial and on-going), including safety planning when applicable are present
• A Substance abuse screening is completed
• For children and adolescents, a complete developmental history is documented
• Treatment planning documentation includes
  – Short- and long-term goals that are objective and measurable
  – Time frames for goal attainment
  – Updates to the plan when goals are achieved or new issues are identified
  – Modifications to goals if goals are not achieved

• For members that are prescribed medications documentation includes
  – The date of the prescription, along with dosage and frequency
  – Rationale for medication adjustments
  – Informed consent for medications
  – Education regarding the risks/benefits/side-effects/alternatives
• Coordination of care is completed (and documented) with Primary Care Physicians
• Coordination of care is completed (and documented) with other treating providers
• If the member refuses to allow coordination to occur, that is clearly documented in the treatment record
• Discharge planning should be on-going and a discharge summary is documented when services are completed
• Medical necessity for services that are rendered is clearly documented
Feedback to providers

- Feedback is provided verbally at the conclusion of the audit
- A written feedback letter is mailed within 30 days for routine audits; for Quality of Care audits, the feedback letter is mailed after the requesting committee reviews the audit results
- When a Corrective Action Plan is required, it must be submitted within 30 days of the request
- Re-audits are completed within 3-6 months of acceptance of the Corrective Action Plan
Credentialing and Recredentialing

Allandro Pierre, MHA, Network Manager
Network participation requirements

– 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
  • Agencies pursuing group contracts complete the Agency Application

– Additional required application materials include
  • Signed Agreement
  • Signed Disclosure of Ownership and Control Interest Statement
    – One per clinician pursuing individual contracting
    – One per agency if pursuing a group contract

– Pre-contractual site audits
  • Required for unaccredited agencies pursuing group contracts
  • May be waived if licensed by OMH/OASAS

– Approval by Optum Credentialing Committee
Group Contracts

- For provider group agencies that employ both licensed professional and unlicensed paraprofessional staff to render services under the umbrella of the agency, Optum will execute group contracts with the agency as the contracting entity.
- Group agencies must submit the Agency Application, including the services being provided and the licensed clinical professionals on the staff roster (when requested).
- The individual licensed clinicians on staff do not need to submit CAQH applications or be individually credentialed when they work for the agency under a group contract agreement.
The Credentialing Committee

• A standing committee comprised of:
  – Network clinicians (the majority of the Committee)
    • Not employees of Optum
    • Represent behavioral health disciplines including:
      – Psychiatrists
      – Nurses
      – Psychologists
      – Master’s Level clinicians
  – Licensed Optum staff (the minority of the Committee)
• Chaired by Optum Medical Director (licensed Psychiatrist)

• Decisions and actions of the Committee are:
  – Non-discriminatory
  – Guided by consideration of each applicant’s potential contribution to providing effective, efficient health care services for the individuals we serve
  – Based on Optum’s need for providers in the service area
Recredentialing

- Recredentialing is completed every 36 months (3 years)
  - This time line is established by NCQA
- Several months prior to the recredentialing date, a recredentialing packet will be sent to the provider
- Completion of the entire recredentialing packet is required for the recredentialing process to be completed
- Site audits will be completed for organizational providers as indicated by Optum policy
- Failure to complete the recredentialing paperwork or participate in the recredentialing site audit (when applicable) will impact the provider’s status in the network
- Completion of the recredentialing process takes time, it is important to submit required documentation as soon as possible
Recovery and Resiliency and Peer Support Services
Barbara Tedesco, MS, CRC, Recovery and Resiliency Manager
## Origins of recovery: It’s mainstream now

<table>
<thead>
<tr>
<th></th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>1900’s:</strong> Institutionalization - shackles, restraint to early origins of rehabilitation</td>
<td><strong>1970’s:</strong> Organized groups fighting for patients’ rights. Community support services</td>
<td><strong>2000’s:</strong> President’s New Freedom Commission validates the concept of recovery; IOM Quality Chasm: mental health is key to overall health</td>
</tr>
<tr>
<td><strong>1940’s:</strong> Earliest psychosocial rehabilitation programs</td>
<td><strong>1980’s:</strong> Consumers self-help/advocacy groups &amp; peer-run services</td>
<td><strong>2010’s:</strong> Moving from recovery as an add-on for outliers to core</td>
</tr>
<tr>
<td><strong>1950’s:</strong> Medication, shock therapy</td>
<td><strong>1990’s:</strong> Surgeon General’s report: peer services, support mainstream</td>
<td></td>
</tr>
<tr>
<td><strong>1960’s:</strong> Radical/anti-psychiatry movement/de-institutionalization</td>
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</tr>
</tbody>
</table>
Origins of addiction recovery

Pre-1900-1960

1800’s: Native American movements
1840’s: Temperance movements
1935: Alcoholics Anonymous
1948 (again in 1963): Narcotics Anonymous

1970-1990

1970’s: Medication supported treatment (methadone)
1980’s: Dual diagnosis supports; recovery from addiction becomes fashionable
1990’s: Recovery advocacy movement: involvement in policy and program development; conversation begins of validating recovery support services

2000’s - present

2000’s: President’s New Freedom Commission validates the concept of recovery;
IOM Quality Chasm: mental health is key to overall health
2010’s: Moving from recovery as an add-on for outliers to core
New SAMHSA definition

<table>
<thead>
<tr>
<th>Working Definition of Recovery</th>
<th>A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.</th>
</tr>
</thead>
</table>

**Principles of Recovery**

- Person-driven
- Occurs via many pathways
- Holistic
- Supported by peers
- Supported through relationships
- Culturally-based and influenced
- Supported by addressing trauma
- Involves individual, family, and community strengths and responsibility
- Based on respect
- Emerges from hope

**Four major domains that support recovery:**

- **Health**: Overcoming or managing one's disease(s) as well as living in a physically and emotionally healthy way
- **Home**: A stable and safe place to live
- **Purpose**: Meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income, and resources to participate in society
- **Community**: Relationships and social networks that provide support, friendship, love, and hope
## Shifting the paradigm

<table>
<thead>
<tr>
<th>Illness/Deficit Focused</th>
<th>Recovery/Person-Centered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mastery of the professional treating deficits – compliance of individual</td>
<td>Partnership emphasizing collaboration, strengths, and empowerment leading to resilience</td>
</tr>
<tr>
<td>Services begin with illness assessment and work toward illness reduction goals</td>
<td>Services begin with engagement and work toward quality of life goals</td>
</tr>
<tr>
<td>Recovery from the illness sometimes results after illness and behaviors are managed</td>
<td>Personal recovery is central from beginning to end</td>
</tr>
<tr>
<td>Motivation for change is externally driven</td>
<td>Motivation for change based on personal hope and individuals’ own goals</td>
</tr>
<tr>
<td>Medication compliance is key</td>
<td>Medication is one tool based on informed choice</td>
</tr>
<tr>
<td>Use techniques that promote illness control and reduction of risk</td>
<td>Use techniques that promote personal growth and self-responsibility</td>
</tr>
<tr>
<td>Services are forever and embedded in MH system</td>
<td>Emphasis on personal life management and the use of natural community resources</td>
</tr>
</tbody>
</table>
## Resilience

### Definition of Resilience

“The capacity of a system, enterprise, or a person to maintain its core purpose and integrity in the face of dramatically changed circumstance.”

### Good News

- “New research suggests that there are concrete things we can do to bolster resilience”
- “Resilience appears to be a common phenomenon of basic human adaptation systems”
- “Patterns of resilience depend upon habits of the mind that we can cultivate”

### Facilitators of Resilience

- Trauma informed practices: What happened to you vs. what is wrong with you
- Build optimism, accentuate strengths
- Strong support system, including self-help
- Cultural identity and pride
- Hope
- Creativity and powers of persuasion
- Mindfulness
- Inspire and be inspired

Proactive approach to crisis planning

Planning for a crisis is best done before the crisis

– Psychiatric Advance Directives
– Wellness and Recovery Plans (WRAP)
– Mental Health First Aid: http://www.mentalhealthfirstaid.org/cs/

Additional Resources

• http://www.power2u.org/consumerrun-statewide.html
• http://www.cdsdirectory.org/
• http://www.iccd.org/search_form.php

Warm Lines:

• Parachute NYC includes a peer operated Support Line 646–741–HOPE
  – All services are confidential and there is no need for a referral
  – Live answer available from 4:00 p.m. - 12:00 a.m. Eastern time
Peer support specialists

| Certified Peer Specialist | • Person who acknowledges “lived experience” and maintains strong recovery strategies  
|                          | • Uses recovery strategies and formal training for the benefit of others  
|                          | • May offer emotional support, share knowledge, teach skills toward meaningful life goals |
| Effectiveness            | • Engaging and retaining people in MH and SU services  
|                          | • Supporting people in taking active role in treatment  
|                          | • Lowering re-hospitalization rates/reducing ER services |
| Effectiveness            | • Increasing overall satisfaction with services  
|                          | • Reducing symptoms and/or substance use  
|                          | • Improvements in practical outcomes (employment, housing, etc.) |
| Why                     | • Supported by New Freedom Commission, SAMHSA, Crossing the Quality Chasm, etc  
|                         | • Evidence-based practice  
|                         | • It works |
Billing and Claims
Eunice Hudson, Provider Education Specialist
Links to resource documents

- HARP Mainstream Billing and Coding Manual

- HCBS Manual

- Fee Schedule and Rate Codes
  https://www.omh.ny.gov/omhweb/bho/phase2.html
Billing requirements

Requirements

- 837i claim form (institutional) electronic form
- UB-04 (institutional) paper form
- Medicaid fee-for-service rate code
- Value code “24”
- Valid procedure code(s)
- Procedure code modifiers (as needed)
- Units of service

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

Recent trainings:
- Integrated Managed Care Billing Guidance (guidance on how to submit clean claims)
- HCBS Service Cluster Webinar Series

Also available:
- Interactive glossary of terms
- Managed Care Language Guide
- Frequently Asked Questions
- MCO Plan Comparison Matrix

Website: http://mctac.org
Mainstream Medicaid

New Carved-In Services
Assertive Community Treatment (ACT) services

• Billed once per month
• Use one rate code for the month’s services
• Use the last day of the month in which the services were rendered as the date of service
• Use of rate code, procedure code and modifier combinations are required
• Use of rate code, procedure code and modifier combinations

- OMH Clinics, both hospital-based and free-standing, have been billing Fee-For-Service (FFS) under the Ambulatory Patient Group (APG) rate setting methodology, using rate code, procedure code, and modifier code combinations, since October 1, 2010
- For non-SSI recipients enrolled in managed care, OMH Clinics have been billing Medicaid plans for those same rate code, procedure code, and modifier code combinations, and receiving the government rate (APG rate) for those services, since September 1, 2012
- As of the effective date of the behavioral health managed care carve-in and the creation of the HARPs, we will cover OMH clinic services for all enrollees and mirror the APG rates as we do now for the non-SSI population
Recipient only:

- Billed on a daily basis
- Three tiers
  - 1-40 hours
  - 41-64 hours
  - 65+ hours
- Two types of visits
  - Full and Half day
- Combination of rate code, procedure code and modifier code(s)

Collateral, group collateral, preadmission and crisis visits:

- Billed separately from the regular CDT visits
Additional services

Comprehensive Psychiatric Emergency Program (CPEP)
- Billed on a daily basis
- Combination of rate code, procedure code and modifier code(s)
  - Brief Emergency Visit
  - Full Emergency Visit
  - Crisis Outreach Services
  - Interim Crisis Service
  - Extended Observation Bed

Intensive Psychiatric Rehabilitation Treatment (IPRT)
- Billed on a daily basis
- Combination of rate code, procedure code and modifier code(s)
- Reimbursement is provided for service duration of at least one hour and not more than five hours per recipient, per day
Partial Hospitalization
• Billed on a daily basis
• Combination of rate code, procedure code and modifier code(s) is dependent on the number of hours of service a day
• Reimbursement is provided for service duration of at least four hours and not more than seven hours per recipient, per day

Personalized Recovery Oriented Services (PROS)
• Reimbursed on a monthly case payment basis
• Use the last day of the month as the date of service
• Use of rate code, procedure code and modifier combinations
• All the line level dates of service must also be the last day of the month
Claim 1 – Rate code 4521 in the header (field 39 on UB-04) plus H2019U2 and 13-27 units at the line level (fields 44 and 46)
Claim 1 – Value Code 24 and Rate code 4521 in the header (field 39 on UB-04) plus H2019U2 and 13-27 units at the line level (fields 44 and 46)
Medically Necessary Transportation for Behavioral Health Services:

- Medically necessary transportation for behavioral health will be a carved-out service
- Bill directly to the state by the transportation provider

Non-Medical Transportation (only for Wellness4Me Members and individuals in HIV Special Needs Programs (SNPs) meeting the eligibility criteria based on the plan of care)

- Bill directly to the state by the transportation provider
Crisis intervention

- Provided off-site
- Fee includes transportation, do not bill separately
- Two separate types of sessions
  - Per hour
    - Billed daily in one hour units with a limit 4 units (4 hours) per day
    - Requires the participation of at least 2 staff (one can be non-licensed)
  - Per diem
    - Billed daily with a max unit of 1 (5+ hours)
    - Requires the participation of at least 2 staff
Office of Alcoholism and Substance Abuse Services (OASAS)

Substance Use Disorder Services & Billing
Billing requirements

OASAS claims are reimbursed based on APG methodology

- UB-04 claim form; 837i
- Value code
- Rate code
- Revenue codes
- CPT/HCPCS codes
- Procedure modifiers
- Date of service
- Service units
- OASAS Credentialed Alcoholism and Substance Abuse Counselor (CASAC) ID Number
OASAS: Important modifier reminders

- The HF modifier is requested for all OASAS claim types
  - The modifier does not impact pricing but will support data collection
- OTP programs will continue to use the KP modifier for the first medication administration visit of the service week
OASAS: outpatient rate codes, freestanding facilities

Rate codes are assigned based upon certification/program type and Setting (hospital vs. freestanding)

Title 14 NYCRR Part 822 Community/Freestanding
(Article 32 only)
- Chemical Dependence Outpatient Clinic program – rate code 1540
- Chemical Dependence Outpatient Rehabilitation Program – rate code 1573
- Opiate treatment program – rate code 1564

Medical Services
Title 14 NYCRR Part 822 Community/Freestanding
(Article 32 only)
- Chemical Dependence Outpatient Program – rate code 1468
- Chemical Dependence Outpatient Rehabilitation Program – rate code 1570
- Opiate Treatment Program – rate code 1471
OASAS: outpatient rate codes, hospital-based

Title 14 NYCRR Part 822 Hospital Based OASAS Certified Outpatient (Article 28 and Article 32)

- Chemical Dependence Outpatient Clinic program – rate code 1528
- Chemical Dependence Outpatient Rehabilitation Program – rate code 1561
- Opiate treatment program – rate code 1567

Medical Services
Title 14 NYCRR Part 822 Hospital Based OASAS Certified Outpatient (Article 28 /Article 32)

- Chemical Dependence Outpatient Program – rate code 1552
- Chemical Dependence Outpatient Rehabilitation Program – rate code 1558
- Opiate Treatment Program – rate code 1555
### NYS Allowable Billing Combinations of OMH/OASAS State Plan Services and HCBS

<table>
<thead>
<tr>
<th>HCBS/State Plan Services</th>
<th>OMH Clinic/OLP</th>
<th>OASAS Clinic</th>
<th>OASAS Opioid Treatment Program</th>
<th>OMH ACT</th>
<th>OMH PROS</th>
<th>OMH IPRT/CDT</th>
<th>OMH Partial Hospital</th>
<th>OASAS Outpatient Rehab</th>
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<tr>
<td>PSR</td>
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<tr>
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<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Quick reminders

- Use value code 24
- One rate code per claim
- Include units as applicable
- There cannot be a hyphen in your Tax Identification Number (TIN)
- NPI numbers are required
- A complete diagnosis is required
- Verify member eligibility
- Obtain prior authorization for those services that require it
- Home and Community Based Services require authorization except
  - Short term crisis respite up to 72 hours
  - Staff transportation
Submission of Claims
Clean claim

A claim with no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents timely payments from being made on the claim is considered a clean claim.

- All required fields are
  - Complete
  - Legible

All claim submissions must include:
- Member’s name, Medicaid identification number and date of birth
- Provider’s Federal Tax I.D. number (TIN)
- National Provider Identifier (NPI)
- A complete diagnosis (ICD-10-CM)

Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at [cms.gov](http://cms.gov)
Claims submission deadline

- Providers must initially submit claims within one hundred and twenty (120) days after the date of the service
- Paper clean claims will be paid within 45 days of receipt
- Electronic clean claims will be paid within 30 days of receipt
- If a provider wants to appeal a claim payment or denial, the appeal must be submitted within 90 days (pending confirmation) after receipt of the Provider Remittance Advice (PRA)
Claims submission option 1: EDI/Electronically

- Electronic Data Interchange (EDI) is an electronic-based exchange of information
- Performing claim submission electronically offers distinct benefits
  - It’s fast – eliminates mail and paper processing delays
  - 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 is 87726
- Additional information regarding EDI is available on UHCCommunityplan.com
Claims submission option 2: hardcopy

Paper claims submitted via U.S. Postal Service should be mailed to:

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

Appeals submitted via U.S. Postal Service should be mailed to:

United Healthcare Community Plan, Appeals
P.O. Box 31364
Salt Lake City, UT 84131-0364
Electronic Payments & Statements (EPS)

• Faster Payments, better cash flow
• Less work, more time
• No need to change your current posting process
  • For more information call 866-842-3278, option 5
  • Or visit https://www.unitedhealthcareonline.com
Provider portals

Provider Express - providerexpress.com

Our industry-leading provider website includes both public and secure pages for behavioral health providers. Public pages include general updates and useful information. Secure pages require registration and are available only to network providers. The password-protected “secure transactions” provides New York Medicaid providers access to provider-specific information.
Provider portals

Public Pages include general updates and other useful information:

• Download standard forms (i.e. provider demographic updates, psych testing forms)
• Find network contacts
• Review clinical guidelines
• Access archived issues of Network Notes, the provider newsletter
• Level of Care Guidelines
• Training/Webinar offerings
Secure pages are available only to Optum in-network providers and require registration.

Providers will be able to update their practice information using the “My Practice Info” feature.

To request a User ID, select the “First-time User” link in the upper right corner of the home page.

If you need assistance or have questions about the registration process, call the Provider Express Support Center at **866-209-9320** (toll-free) from 7 a.m. to 9 p.m. Central time, or chat with a tech support representative online.
Provider Express – Home Page

It's coming up fast, are you up to speed?

Transactions
- Eligibility & Benefits
- Auth Request & ReviewOnline
- Auth Inquiry
- Claim Entry
- Claim Inquiry
- My Provider Express
- My Practice Info
Provider Express Home Page – Log In

It's coming up fast, are you up to speed?

Transactions
- Eligibility & Benefits
- Auth Request & Review Online
- Auth Inquiry
- Claim Entry
- Claim Inquiry
- My Provider Express
- My Practice Info
Provider Express – Tech Support Live Chat feature

If you are contracted in the Optum/OHES-CA network, you can use the registration process to create your account within Provider Express.

Register

The following information is required to register:

Providers (individually-contracted clinicians):
1. Provider First Name
2. Provider Last Name
3. Tax ID
4. NPI (Type I - Individual)
5. Last 4 digits of Provider’s SSN

Groups/Practices (contracted for outpatient, professional services):
1. Group/Practice Name
2. Tax ID
3. NPI (Type II - Organization)

Facilities (contracted for inpatient, IOP and other facility-related services):
1. Facility Name
2. Federal Tax ID
3. NPI (Type II - Organization)

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My Practice Info – Review Clinician Profile

• My Practice Info allows users to view demographic and other information on their practice
  – Much of the information can be updated via an online request, rather than making a telephone call
• Users can click on the pencil icons to make updates
• Users can click on the Tax ID in the “Practice Addresses by Tax ID” section, to view and make any changes to address information
My Practice Info – Review Clinician Profile

**My Practice Info - Review Clinician Profile**

- **Clinician Name:** John Doe
- **NPI:** not on file
- **Taxonomy code:** MD - Medical Doctor
- **Language(s):** ENGLISH
- **Clinician Email Address:** email@email.com
- **Gender:** M
- **Medicaid Number:**
- **Medicare Number:**
- **Expertise:**

**Ethnicity:**
- **Tax Id(s):**

**Practice Addresses by Tax ID**

Please select a Tax ID:

<table>
<thead>
<tr>
<th>Tax ID</th>
<th>Practice Name</th>
<th>Primary Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>909999999</td>
<td>Doe, John A</td>
<td>123 Anywhere Street</td>
</tr>
</tbody>
</table>

*Someday USA 55555

*If you need to change your tax identification number, add a new practice under a different tax identification number, inform us of your move to another state, or inform us of a new practice in another state, please complete the Clinician Add/Change Application and fax or mail it to the Network Manager for your state.

**Credentialed Address**

Our records indicate that you would like correspondence related to your credentialing sent to the address shown below. Click on the address below. Changing your credentialing address will not change primary practice address information. Please click on the Tax ID in the section above.

Please note: P.O. Boxes cannot be used unless you are able to attest that certified mail can be signed for at that address.

Please click on your Credentialed Address to update.

123 Anywhere Street
Someday USA 55555
The Clinician Addresses page allows users to view and update current address information on file for the practice/TIN.

My Practice Info - Clinician Addresses

Click an address to edit. Please make all of your updates (including adding new or deleting addresses) before clicking the Submit All Changes button below. Changes will be reflected on your profile within 3 to 5 business days after the submission of your request.

Tax ID: 999999999 - Doe, John A.

<table>
<thead>
<tr>
<th>Delete</th>
<th>Address</th>
<th>Primary</th>
<th>Mailing</th>
<th>Remit</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>123 Anywhere Street</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Somewhere USA 55555</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accepting?</th>
<th>Phone</th>
<th>Secured Fax</th>
<th>Address Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>555-555-5555</td>
<td>656-555-5555</td>
<td>None Listed</td>
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</tbody>
</table>

1099 Address

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>123 Anywhere Street</td>
<td>(555)555-5555</td>
</tr>
<tr>
<td>Somewhere USA 55555</td>
<td></td>
</tr>
</tbody>
</table>

Submit All Changes

Remember to click the “Submit All Changes” button when you are done making your updates.
My Practice Info – Group Login

- Group logins will see a difference in the My Practice Info page due to how they are set up in the internal system.
- Clicking on the “View Address Info” button will display the locations page specific to that group.

![Image of Practice Information Page]

Our records indicate that Diamond Grove Center has the following contact information.

<table>
<thead>
<tr>
<th>Contact Name</th>
<th>Contact Phone Number</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Last Name</td>
<td>555-555-5555</td>
<td>update</td>
</tr>
</tbody>
</table>

Our records indicate that the following list of providers are in the practice. To update the list of providers below, please contact your Provider Network Manager.

<table>
<thead>
<tr>
<th>Providers</th>
<th>NPI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name, Provider</td>
<td>1234567890</td>
</tr>
</tbody>
</table>
My Practice Info – Practice Locations for Group Logins

- The Practice Locations page for group logins also looks different from individual logins.
- Users can click on the “update” or “delete” links to the right of any address, and/or can click on the Add New Location button at the bottom.
- With any of these updates, if there are individually-contracted providers for that group, there are options to choose which provider(s) the update/delete/add affects.

### My Practice Info - Practice Locations

Our records indicate that Diamond Grove Center has the following locations. To add a new location, click Add New Location. Any requested changes will be reflected in 3 to 5 business days from the time of request.

<table>
<thead>
<tr>
<th>Address</th>
<th>Address Type</th>
<th>Phone</th>
<th>Secured Fax</th>
<th>Conditions of Address</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>123 Anywhere Street</td>
<td>Remit, Practice, Primary</td>
<td>(555)555-5555</td>
<td>None Listed</td>
<td></td>
<td>update</td>
</tr>
</tbody>
</table>

Add New Location
Example from DSM-5

Diagnostic Label and Criteria: APA/DSM
• Obsessive-Compulsive Disorder
• Criteria outlined A-D with specifiers to include in documentation

Diagnostic Billing Codes: WHO/ICD
• 300.3
  • ICD-9-CM
  • Use through dates of service 9/30/15
• (F42)
  • ICD-10-CM
  • Use beginning dates of service 10/1/15 and later

The International Classification of Disease (ICD) is maintained by the World Health Organization (WHO). It is used to track and trend morbidity and mortality world-wide. The DSM, published by the APA, has historically mapped to the ICD-CM codes used in the U.S. for billing.

The current edition, DSM-5, maps conditions to both the ICD-9-CM and ICD-10-CM codes.

Special Call-Out
DSM-5 has had some coding updates, these are available online from the APA: www.psychiatry.org/dsm5 > DSM-5 Coding Update
Timeline and Dates of Service

This is a “flip-of-the-switch” change for our industry.
The legislation requires full and immediate transition to ICD-10 for billing for all Dates of Service October 1, 2015 and later. There is no transitional grace period for ICD-10.

What about services spanning the transition date?

• A single claim cannot include both ICD-9 and ICD-10 code sets
• The Outpatient Date of Service (DOS) or Inpatient date of discharge determines which ICD code set (ICD-9-CM or ICD-10-CM) should be used
  • Neither the date of claim submission nor the date of receipt matter in terms of ICD code set selection
Date of Service (DOS) key to ICD code set selection

Outpatient Services

Client A
- Seen for services on 9/3, 9/10, 9/17 and 9/24: All DOS may be filed on a single claim using ICD-9-CM codes

Client B
- Seen for services on 10/1, 10/8, 10/15 and 10/22: All DOS may be filed on a single claim using ICD-10-CM

Client C
- Seen for services on 9/17, 9/24, 10/1 and 10/8: The September DOS may be filed on a single claim using ICD-9-CM, and the October DOS will need to be submitted on a second separate claim using ICD-10-CM
Inpatient and Residential Services
For services spanning September into October 2015, the Date of Discharge determines which ICD code set to apply. Regardless of admission date:

- Client discharges on or before 9/30/15: bill using ICD-9-CM
- Client discharges on or after 10/1/15: bill using ICD-10-CM

Electronic Data Interchange (EDI) / 837 submissions:
You can submit a batch of claims/encounters within a file that contain both ICD-9 and ICD-10 transactions but each claim or encounter is limited to either ICD-9-CM or ICD-10-CM.

Regardless of your method of claim submission you must indicate whether the specific claim filed is using ICD-9-CM or ICD-10-CM codes.

Only one code set (ICD-9 or -10) may be used on a single claim.
Resource Links

Provider Express

ICD-10 and DSM-5 Resources
ICD-10 Transition Webinar

American Psychiatric Association (DSM-5)

APA Practice: DSM-5
APA Coding Update: March 2014
APA DSM-5 Implementation and Support
APA Understanding ICD-10-CM and DSM-5: A Quick Guide (Feb 2014)

It's coming up fast, are you up to speed?
Home page, post login
Check eligibility and benefits

---

### Patient Eligibility

**Patient Search**

- **Search by:**
  - Enrollee#, DOB Search
  - Enrollee#, Name Search
  - Alpha Search
  - Swipe/Scan Health Care ID Card

* Indicates Required Field
* Subscriber information required to complete a Family Search

- **Enrollee Number**
- **Date of Birth (mm/dd/yyyy)**
- **Enrollee Number**
- **Date of Birth (mm/dd/yyyy)**

*Search for:* Family Information
*Individual Information*

*Date to check:* 07/30/2013

**Related Links**

- Consumer Driven Health Plans
- HIPAA 5010 and ICD-10
- Herceptin Policy Notice
- I Speak Cards (interpretive services in CA)
- Integrated Card
- Issue: Family Deductibles of $10,000 or More
- Medical Policies
- Network Contacts
- Patient Eligibility
- Patient Eligibility and Benefits Quick Reference
- Prescription Drug List
- Products and Services
- Reimbursement Policies
- Swipe Health Care ID Cards Quick Reference
- Tutorial

By using this search function you represent to us that you have obtained authorization from the patient whose name is being searched, to view his or her personal information in connection with the provision of medical services.
Check eligibility and benefits, continued

Patient Eligibility

<table>
<thead>
<tr>
<th>Eligibility Details</th>
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<td>Patient Details</td>
<td>Primary Care Physician Details</td>
</tr>
<tr>
<td>Name</td>
<td>Provider Name:</td>
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<tr>
<td>Date of Birth</td>
<td>Provider Number:</td>
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<td>Address</td>
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<tr>
<td></td>
<td>End Date:</td>
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</table>

Coordination of Benefits

Carrier Name: UnitedHealthcare Primary

Lab Information

<table>
<thead>
<tr>
<th>Lab Name</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
</table>

Radiology Information

<table>
<thead>
<tr>
<th>Radiology Name</th>
<th>Start Date</th>
<th>End Date</th>
</tr>
</thead>
</table>

HEDIS/EPSDT

Refer to Community Plan Reports

Eligibility details tab
**Notifications/Prior Authorizations**

**Notification/Prior Authorization Submission**

*Note: Unitedhealthcare Online now supports most notifications/prior authorizations online. For further information on Advance, Admission and other notification/prior authorization requirements, visit the [Advance & Admission Notification](#) page or consult the notification/prior authorization list in the Provider Notification/Prior Authorization Guide. For further assistance, please call the number on the back of the member's health care ID Card.*

*Note: Submit radiology notifications via [Radiology Notification Submission & Status](#).*

*Note: Swipe/Scan ID card option may not work for all members. Please select a different search type if you have difficulty with the Swipe/Scan ID card feature.*

*Note: Submit Medicare Specialty Drug authorizations via [Specialty Drug Prior Authorization Submission & Status (Medicare Part B)](#).*

---

**Notification/Prior Authorization Type**

- **Admitting/Attending Physician**
  - Inpatient/Outpatient Facility
  - Outpatient Other/Office/DME/HHC

**Search for:**

- Admitting/Attending Physician
- Facility (e.g. hospitals and skilled nursing facilities)

**Corporate Tax ID Owner:**

**Physician/Provider Tax ID:**

**Physician/Provider Name:**

**Physician/Provider Address:**

**Search**
Electronic Payments & Statement

Electronic Payments & Statements (EPS)

Note: If you receive a pop-up blocker message from your internet browser, you will need to disable this feature in order to continue to use Electronic Payments and Statements. Go to “Related Links” on the right side of this page and select “How to turn off pop-up blockers” for instructions.

Electronic Payments & Statements (EPS)
- Eliminate paper checks and receive electronic claims payments
- View and print multiple EOBs

*Indicates Required Field
*Corporate Tax ID Owner: [Select a Corporate Tax ID Owner]

Single Explanation of Benefit (EOB) Search

*Indicates Required Field
Search by:
- Status and Date
- Payment Number

*Corporate Tax ID Owner: [Select a Corporate Tax ID Owner]
*Physician/Provider Tax ID: [Select a Tax ID]
*Status: [All]

EOB Start Date: (mm/dd/yyyy)
EOB End Date: (mm/dd/yyyy)

Note: EOB Date is the date that appears on the EOB/check. If you are unsure of the EOB date, enter a range starting from when the claim was submitted through 4 weeks past that date.

Related Links
- Administrative Guides
- EPS Enrollment Form
- EPS FAQs
- EPS NPI Addendum Form
- EPS Program Overview
- EPS User Guide
- Electronic Payments & EOB Quick Reference
- HIPAA 5010 and ICD-10
- How to Secure an 835
- How to turn off pop-up blockers
- Medicare Non-contracted Provider Appeal & Dispute Rights
- National Provider Identifier EPS FAQs
- UnitedHealthcare Community Plan Electronic Payments (EFT)
- Welcome to EPS Demo
Live and Work Well
Live and Work Well, continued

Clinician Vetted Education, Programs and Tools:

- Cognitive behavioral therapy based programs on depression, anxiety, stress, drinking, drug use
- Articles, newsletters, multimedia and guides
- Health calculators
- Mental health screeners
- eCards
- Forums
- Webinars
- NY-specific resource database
- Additional searchable databases to lookup information/resources on childcare, eldercare, health conditions, alternative medicine, drug interactions and more!
Personal Empowerment Kits

No matter where you are on your journey to well-being, it’s important that you build your resiliency. You might be prescribed medication that will help you, but you need to do more to achieve your long-term recovery and well-being. These toolkits offer a range of different tools you can use depending on your personal preferences. Do you like the idea of using a game to build resiliency? How about a graphic novel approach? Perhaps you prefer journaling or meditation? How about tracking your journey to long-term recovery and well-being?

You’ll find all that and more in these toolkits:

- Addiction Recovery Tools
- Family Recovery and Resiliency Tools
- Recovery, Resiliency and Empowerment Tools
- Smartphone Apps for Substance Use Disorder Treatment/Recovery
- Tools You Can Use

Planning resources: https://www.liveandworkwell.com/public/
Network Services

Lana Kats, MBA, Director of Network Management for NY Public Sector
New York Medicaid Network Services team

- Lana Kats
  Network Director

- Allandro Pierre
  Network Manager

- Afrika Zyonne-Kumani
  Network Manager

- Jenny Morfin
  Network Manager

- Eunice Hudson
  Provider Education Specialist

- Gayle Parker-Wright
  Network Trainer

- Vacant
  Community Liaison

- Vacant
  Community Liaison

- Vacant
  Provider Relations Representative
Appointment availability standards

Time frames represent requirements based on the date of the appointment request.

- **MH Outpatient Clinic/PROS Clinic**
  - Urgent Care: within 24 hours
  - Non Urgent MH/SUD: within 1 week
  - Follow-up to emergency or hospital discharge: within 5 days
  - Follow-up to jail/prison discharge: within 5 days

- **ACT**
  - Urgent Care: within 24 hours for Assisted Outpatient Treatment (AOT)
  - Follow-up to emergency or hospital discharge: within 5 days

- **PROS**
  - Non Urgent MH/SUD: within 2 weeks
  - Follow-up to emergency or hospital discharge: within 5 days
Appointment availability standards, continued

Time frames represent requirements based on the date of the appointment request.

- **Continuing Day Treatment**
  - Behavioral Health Specialist: 2 to 4 weeks

- **Intensive Psychiatric Rehabilitation Treatment (IPRT)**
  - Behavioral Health Specialist: 2 to 4 weeks

- **Partial Hospitalization:**
  - Follow-up to emergency or hospital discharge: within 5 days

- **OASAS Outpatient Clinic**
  - Urgent Care: within 24 hours
  - Non Urgent MH/SUD: within 1 week
  - Follow-up to emergency or hospital discharge: within 5 days
Appointment availability standards, continued

Time frames represent requirements based on the date of the appointment request.

- MH Outpatient Clinic/PROS Clinic
  - Urgent Care: within 24 hours
  - Non Urgent MH/SUD: within 1 week
  - Follow-up to emergency or hospital discharge: within 5 days
  - Follow-up to jail/prison discharge: within 5 days

- Detoxification
  - Emergency: upon presentation

- Substance Use Disorder Inpatient Rehabilitation
  - Emergency: upon presentation
  - Urgent MH/SUD: within 24 hours

- Opioid Treatment Program
  - Urgent MH/SUD: within 24 hours
Appointment availability standards, continued

Time frames represent requirements based on the date of the appointment request.

- **Crisis Intervention/Respite**
  - Emergency: immediately
  - Urgent MH/SUD: within 24 hours for short term respite
  - Follow-up to emergency or hospital discharge: immediately

- **Rehabilitation services for residential SUD treatment supports**
  - Behavioral Health Specialist: 2 to 4 weeks
  - Follow-up to emergency or hospital discharge: within 5 days

- **Comprehensive Psychiatric Emergency Program (CPEP)**
  - Emergency: upon presentation

- **Inpatient Psychiatric Services**
  - Emergency: upon presentation
Appointment availability standards, continued

Time frames represent requirements based on the date of the appointment request.

• Rehabilitation and Habilitation
  − Non Urgent MH/SUD: within 2 weeks
  − Follow-up to emergency or hospital discharge: within 5 days

• Educational and Employment Support Services
  − Non Urgent MH/SUD: within 2 weeks

• Peer Supports Services (PSS)
  − Urgent Care: within 24 hours
  − Non Urgent MH/SUD: within 1 week*
  − Follow-up to emergency or hospital discharge: within 5 days

*Unless appointment is pursuant to emergency or hospital discharge, in which case the standard is within 5 days; or if PSS are needed more urgently for symptom management, the standard is within 24 hours
Appointment availability standards, continued

Time frames represent requirements based on the date of the appointment request.

- **Psychosocial Rehabilitation**
  - Non Urgent MH/SUD: within 2 weeks

- **Community Psychiatric Support and Training**
  - Non Urgent MH/SUD: within 2 weeks

- **Family Support and Training**
  - Non Urgent MH/SUD: within 2 weeks

- **Educational and Employment Support Services**
  - Non Urgent MH/SUD: within 2 weeks

*Unless appointment is pursuant to an emergency or hospital discharge or release from incarceration, in which case the standard is within 5 days of request*
# Provider Service Quick Guide

**Mainstream Medicaid & Wellness4Me**

## Call Center for UnitedHealthcare
1-866-362-3368

### Websites & What's Available
- [providerexpress.com](http://providerexpress.com)
  - Demographic Updates
  - Guidelines and Policies
  - Best Practice Guidelines
  - Level of Care Guidelines
  - Recovery & Resiliency Toolkit
  - Network Manual
  - Trainings and Webinars
  - Sentinel Events Reporting Form

- [uhccommunityplan.com](http://uhccommunityplan.com)
  - A website for Health Care Professionals, Community Organizations and Members
  - For providers, links will direct you to important information in your state
  - Directs you to our secure provider site UnitedHealthcare Online®

- [unitedhealthcareonline.com](http://unitedhealthcareonline.com)
  - Check member eligibility
  - Check claim status & payments
  - Claims Reconsideration
  - Electronic Data Interchange (EDI) information
  - Tools & Resources
  - Tutorials

### Claims Submission
- **Paper Claim submission:**
  - Optum Behavioral Health
  - P.O. Box 30760
  - Salt Lake City, UT 84130-0760

  Claims must be submitted within 120 days from the date of service

- **EDI**
  - Payer ID: 67726
  - EDI Support: 800-210-8315 or email ac edi ops@uhc.com
| --- | --- |
| **Appeals** | UnitedHealthcare Community Plan, Appeals  
P.O. Box 31364  
Salt Lake City, UT 84131 |
| **Care Advocacy** | 1-866-362-3388 |
| **Best Practice Guidelines** | We have adopted Best Practice Guidelines, which were developed by nationally recognized organizations. Provider Express > Guidelines/Policies & Manuals > Best Practice Guidelines |
| **Utilization Management Guidelines** | Additional details about utilization management guidelines are located in the New York Medicaid Behavioral Health Manual. **Prior Authorization is not required for:**  
  - Outpatient mental health and substance use clinic services  
  - Initial medically necessary emergency and post-stabilization services, including emergency behavioral health care  
  - Urgent care  
  - Crisis stabilization, including mental health  
  - Post-stabilization care services  
  - Personalized Recovery Oriented Services (PROS) pre-admission status  
  - Opioid Treatment Program (OTP)  
  - Substance use disorder intensive outpatient  
  - Substance use disorder day rehabilitation  
  - Medically supervised outpatient substance withdrawal  

**Prior Authorization is required for:**  
  - Facility-based care  
  - Non-routine outpatient care including but not limited to, psychological testing and extended sessions of 53 minutes or more  
  - Home and Community Based Services (HCBS)  
  - Personalized Recovery Oriented Services (PROS) admission (60 days) & active rehabilitation status  
  - Continuing Day Treatment (CDT)  
  - Mental Health Intensive Outpatient Program (MH IOP)  
  - Assertive Community Treatment (ACT)  
  - Partial Hospitalization  
  - Residential substance use treatment |
| **Medical Transportation** | UnitedHealthcare Community Plan Transportation Reservation line: 1-866-913-2497  
UnitedHealthcare Community Plan Ride Assistance (Where’s my ride): 1-866-913-2498 |
Future training opportunities and communications

• Webinars of this presentation will be available throughout September and October
• Targeted HCBS Provider training (prior to 1/1/16 go-live date)
• Additional billing training (pending state approval of the billing manual)

We look forward to feedback from you to help us identify potential future training topics

Provider Alerts will be used to inform providers about future trainings, changes to processes, and posting of information to Provider Express
Contact us

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Thank you for attending today
Questions