Provider Orientation:

Neighborhood Health Plan of Rhode Island
Thank you so much for joining today!

We will be getting started momentarily.
Welcome to Optum

Webinar Topics

1. Introduction to Optum and Neighborhood of Rhode Island
2. Covered Members and Eligibility
3. Covered Services and Authorizations
4. Network
5. Clinical Overview
6. Claims / Billing
7. Contacting Optum
8. Online Resources
About Neighborhood

• Founded with the support of Rhode Island’s Community Health Centers and began serving members in 1994
• More than 200,000 members (one in five Rhode Islanders)
• Over 500 diverse employees including nurses, social workers, customer service
• First community health center based health plan in the country to be rated “Excellent” by the National Committee for Quality Assurance for 18 consecutive years
Who is Optum?

Optum is a leading health services organization dedicated to making the system work better for everyone.

Our core values:

Integrity | Compassion | Relationships | Innovation | Performance
UnitedHealth Group structure

UnitedHealth Group®

OPTUM®

Making the health system work better for everyone

Information and technology-enabled health services:

- Technology solutions
- Pharmacy solutions
- Intelligence and decision support tools
- Health management and interventions
- Administrative and financial services

Helping people live healthier lives

Health care coverage and benefits:

- Employer & Individual
- Medicare & Retirement
- Community & State
- Global
Covered Members and Eligibility
Covered Members

- Neighborhood Health Plan of Rhode Island was contracted with Optum to manage the behavioral Health and Substance Abuse benefits for the following membership groups:

  - Commercial

  - Medicare/Medicaid (Integrity)

  - Medicaid for adults and children
Member Identification Card - Integrity (front)

Member Name: Cardholder Name
Member ID: Cardholder ID#
Health Plan (80840): 7104829339
Effective Date: Coverage Start Date

PCP Name: PCP Name
PCP Phone: PCP Phone

MEMBER CANNOT BE CHARGED
Copays: PCP/Specialist: $0  ER: $0  Rx: $0

H9576  001
In an emergency, call 911 and ask for help or go directly to the nearest hospital emergency room.

**Member Services:** 1-844-812-6896 (TTY 711)
**24-Hour Nurse Advice:** 1-844-617-0563
**Behavioral Health:** 1-401-443-5995 (TTY 711)
**Pharmacy Help Desk:** 1-866-693-4620

**Website:** www.nhpri.org/INTEGRITY

**Send Claims To:** Neighborhood Health Plan of Rhode Island
P.O. Box 28259
Providence, RI 02908

**Provider Inquiry:** 1-800-963-1001
Member ID #: 107765511
Plan: MED

Member: JOHN Q SAMPLE

PCP Name: KELVIN D GILLMAN
PCP Site: Children's Healthcare
PCP Phone #: (401) 383-6776

Copays:
Office Visit: $0
Pharmacy/RX: $0
ER: $0

ACCESS

www.nhpri.org
Member Identification Card - Medicaid (back)

Members: Bring this ID card whenever you go to the doctor or the pharmacy.

- **Member Services:** 1-401-459-6020 • 1-800-459-6019 (TTY/TDD: 711)
- **24-Hour Nurse Advice Line:** 1-844-617-0563
- **Mental Health and Substance Use:** 1-401-443-5997
- **In an emergency,** call 911 and ask for help or go directly to the nearest hospital emergency room.
- **Providers:** To verify eligibility/benefits go to: connect.navinet.net
- **Durable Medical Equipment:** 1-866-205-2122
- **Rx BIN/Rx PCN/Rx Group:** 004336/ADV/RX6437
- **Pharmacy Help Desk:** 1-800-364-6331
Member ID#: 13503758600
Plan: 20003-01
Member: JOHN Q SAMPLE
PCP: LISA M MENARD-MANLOVE
PCP Site: Wood River HC
PCP Phone#: (401) 539-2461
Rx BIN / PCN / Group:
004336 / ADV / RX2323

*PCP/*Specialist: 20%/20%
*Pharmacy: $15/$40/$75/20%
*Urgent Care/*ER: 20%/20%
*Deductibles apply:
$5,600/$11,200

Commercial • www.nhpri.org
Bring this ID card whenever you go to the doctor or the pharmacy.
Member Services: 1-855-321-9244 (TTY/TDD: 711)
24-Hour Nurse Advice Line: 1-844-617-0563
Mental Health and Substance Use: 1-833-470-0578
In an emergency, call 911 and ask for help or go directly to the nearest hospital emergency room.
• Providers: To verify eligibility/benefits go to: connect.navinet.net
• Durable Medical Equipment: 1-866-205-2122
• Pharmacy Help Desk: 1-800-364-6331
This card is for identification only and does not certify coverage.
Member eligibility can be confirmed in 2 ways:

1. Calling into 800 #

<table>
<thead>
<tr>
<th>Product</th>
<th>NHP of RI</th>
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<tbody>
<tr>
<td>INTEGRITY</td>
<td>1-401-443-5995</td>
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<tr>
<td>Medicaid</td>
<td>1-401-443-5997</td>
</tr>
<tr>
<td>Commercial</td>
<td>1-833-470-0578</td>
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</tbody>
</table>

2. Utilizing Provider Express
Eligibility & Benefits – Provider Express…Where to Start

Eligibility & Benefits allow users to search for a Member’s eligibility by using My Patients list, Member ID Search or the Name/DOB Search.

The My Patients list is also built using this transaction.
Eligibility & Benefits – Three Search Options

Eligibility & Benefits

Step 1: Member Search

- Member ID Search
- Name/DOB Search
- My Patients Search
Eligibility & Benefits – *Member Search*

Provider Express offers three methods for searching eligibility:

1. Member ID
2. Name/DOB
3. My Patients (a list you build yourself)
Eligibility & Benefits – *Member ID Search*

Using the Member ID Search tab, the user must provide required information indicated with an asterisk.

The Date to Check Eligibility will default to the current date, but this may be altered up to a year in the past.

When all the required information is provided, click the **Search** button to begin the Member search.
Eligibility & Benefits – *Eligibility Information*

Regardless of the search method, if a matching Member record is found, the eligibility information will display:

- Here you will find the group number, relationship, the most recent effective date of coverage, and the termination date (if applicable)

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**Eligibility and Benefits - Eligibility Information**

*Eligibility Information for Member XXXXX7890 for 03/01/2016*

For benefit information, click on the member's name.

Due to recent Parity changes, please carefully review the member's benefit information to ensure authorization is required, before submitting an authorization request.

Members Covered Under Group: 99999

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Relationship</th>
<th>State</th>
<th>Member ID</th>
<th>Effective Date</th>
<th>Termination Date</th>
<th>Demographic Info</th>
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<tbody>
<tr>
<td>MEMBER NAME</td>
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<td>XXXXX7890</td>
<td>07/01/2014</td>
<td>Still Active</td>
<td>View Info</td>
</tr>
</tbody>
</table>

Add to My Patients  | Search Again
Eligibility & Benefits – Viewing Demographic Information

Clicking on the **View Info** button will bring up a display of demographic information that is available for that Member.

### Eligibility and Benefits - Eligibility Information

**Eligibility Information for Member XXXXX7890 for 03/01/2016**

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<td>Still Active</td>
<td>![View Info]</td>
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</tbody>
</table>

Add to My Patients  
Search Again
Eligibility & Benefits – *Benefits Information*

From the Eligibility Information page, you can click on the Member’s name (which is an underlined link) to get to the benefits page.

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**Eligibility and Benefits - Eligibility Information**

*Eligibility Information for Member XXXX7890 for 03/01/2016*

For benefit information, click on the member’s name.

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<td>XXXX7890</td>
<td>07/01/2014</td>
<td>Still Active</td>
<td>View Info</td>
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</table>

**Add to My Patients**

**Search Again**
The benefit information page displays eligibility information, along with year-to-date accumulators for both deductible and out-of-pocket (if applicable) and benefit details.

The Benefit Category drop-down list supports look up of other benefits such as deductibles, copays, etc.
Covered Services and Authorizations
Understanding covered benefits

Coverage Determination Guidelines standardize the interpretation and application of terms of the Member's Benefit Plan including terms of coverage, exclusions and limitations.

Coverage Determination Guidelines can be found on Provider Express.

Optum Members have a variety of benefits available to them.

Check a Member's benefits and eligibility on Provider Express through secure Transactions.
## Covered Services - Higher Levels

### Commercial
- Inpatient Mental Health and Substance Use inclusive of:
  - Residential Services Mental Health and Substance Use (does not include MHPRR)
  - Inpatient Substance Use Detox
  - Electroconvulsive therapy
- Partial Hospitalization Mental Health and Substance Use

### Integrity
- Inpatient Mental Health and Substance Use inclusive of:
  - Residential Services Mental Health and Substance Use (does not include MHPRR)
  - Inpatient Substance Use Detox
  - Electroconvulsive therapy
- Partial Hospitalization Mental Health and Substance Use

### Medicaid
- Inpatient Mental Health and Substance Use inclusive of:
  - Residential Services Mental Health and Substance Use (does not include MHPRR)
  - Inpatient Substance Use Detox
  - Electroconvulsive therapy
- Partial Hospitalization Mental Health and Substance Use
## Covered Services - Outpatient Levels

<table>
<thead>
<tr>
<th>Commercial</th>
<th>Integrity</th>
<th>Medicaid</th>
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<tbody>
<tr>
<td>- Intensive Outpatient Services</td>
<td>- Intensive Outpatient Services</td>
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<td>- Autism Services</td>
<td>- Standard therapeutic services</td>
<td>- Standard therapeutic services</td>
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<td>- Standard therapeutic services</td>
<td>- Crisis Stabilization</td>
<td>- Crisis Stabilization</td>
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<td>- Crisis Stabilization</td>
<td>- Electroconvulsive therapy</td>
<td>- Electroconvulsive therapy</td>
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<tr>
<td>- Electroconvulsive therapy</td>
<td>- Psychological testing</td>
<td>- Psychological testing</td>
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<td>- Psychological testing</td>
<td>- Transcranial magnetic stimulation</td>
<td>- Transcranial magnetic stimulation</td>
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<td>- Transcranial magnetic stimulation</td>
<td>- Medication Assisted Therapy</td>
<td>- Medication Assisted Therapy</td>
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<td>- Medication Assisted Therapy</td>
<td>- Enhanced Outpatient Services</td>
<td>- Enhanced Outpatient Services</td>
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<tr>
<td>- Community Based Detox</td>
<td>- Integrated Health Homes</td>
<td>- Integrated Health Homes</td>
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<tr>
<td>- Enhanced Outpatient Services</td>
<td>- Peer Supports</td>
<td>- Peer Supports</td>
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<td>- Day/Evening Treatment</td>
<td>- Assertive Community Treatment</td>
<td>- Assertive Community Treatment</td>
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<td>- OTP Health Homes</td>
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<td>- Clubhouse</td>
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<td>- Community Based Detox</td>
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<td></td>
<td>- Mental Health Psychiatric Rehabilitative Residence MHPRR*</td>
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<td>- Sober Living</td>
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<td>- Day/Evening treatment</td>
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<td>- Home based Therapeutic Services</td>
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<td>- OTP Health Homes</td>
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<td>- Personal Assistance Services and Supports (PASS)</td>
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<td>- Community Based Detox</td>
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<td></td>
<td>- Mental Health Psychiatric Rehabilitative Residence MHPRR*</td>
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<td>- Sober Living/Halfway House</td>
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Authorization/Notification Requirements - Higher Levels of Care

**Commercial**
- Inpatient Mental Health and Substance Use inclusive of:
  - Residential Services Mental Health and Substance Use
  - Inpatient Substance Use Detox
  - Electroconvulsive therapy
- Partial Hospitalization Mental Health and Substance Use

**Integrity**
- Inpatient Mental Health and Substance Use inclusive of:
  - Residential Services Mental Health and Substance Use
  - Inpatient Substance Use Detox
  - Electroconvulsive therapy
- Partial Hospitalization Mental Health and Substance Use

**Medicaid**
- Inpatient Mental Health and Substance Use inclusive of:
  - Residential Services Mental Health and Substance Use
  - Inpatient Substance Use Detox
  - Electroconvulsive therapy
- Partial Hospitalization Mental Health and Substance Use
Authorization Requirements - Outpatient Levels

**Commercial**
- Intensive Outpatient Services
- Autism Services
- Crisis Stabilization Unit/Observation
- Electroconvulsive therapy
- Psychological testing
- Transcranial magnetic stimulation

**Integrity**
- Assertive Community Treatment*
- OTP Health Homes*
- Mental Health Psychiatric Rehabilitative Residence MHPRR*
- Integrated Health Homes*

**Medicaid**
- Intensive Outpatient Services
- Crisis Stabilization Unit/Observation
- Electroconvulsive therapy
- Psychological testing
- Transcranial magnetic stimulation
- Integrated Health Homes*
- Assertive Community Treatment*
- OTP Health Homes*
- Mental Health Psychiatric Rehabilitative Residence MHPRR*
- Community Based Detox
- Day/Evening Treatment

*Authorization must be obtained from Department of Behavioral Healthcare and Developmental Disabilities and Hospitals
Important authorization information

Routine outpatient services do **not** require prior authorization. The following frequently-used procedure codes are considered routine services:

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<thead>
<tr>
<th>90791</th>
<th>90832</th>
<th>90834</th>
<th>90846</th>
<th>90847</th>
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<td>90849</td>
<td>90853</td>
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Non-routine services **do** require an authorization for Commercial and Medicaid

Use providerexpress.com to request authorization for the following:
- Psychological Testing
- Transcranial Magnetic Stimulation (TMS)
- Applied Behavior Analysis

**Login to Provider Express:** Auth Request >> click appropriate link
**OR without logging in:** Clinical Resources >> Forms >> Clinical Forms

Please call the number on the back of the Member’s ID card to authorize all other non-routine services
Once you have obtained authorization for clinical services, you have the capability in the secure Transactions on Provider Express to:

- Look up authorizations, even if the authorization was not generated through Provider Express
- View authorization details
Transition of Care Benefits

Neighborhood Health Plan of Rhode Island is working with Beacon to obtain a file of authorized services:

• Inpatient Services extending beyond January 1, 2019 will have an authorization entered into Optum’s clinical system to support clinical reviews and claims payment for dates of service greater than January 1, 2019

• Outpatient services that require authorization will be entered into Optum’s clinical system to support clinical reviews and claims payments
Network
Types of Providers in the Behavioral Health Network

Licensed Mental Health Professionals
- Psychiatrist
- Advanced Psychiatric Nurse Practitioner
- Doctor of Osteopathic Medicine
- Licensed Behavior Analyst (Commercial ABA Network)
- Medical Doctor
- Physician Assistant
- Licensed Psychologist
- Licensed Independent Clinical Social Worker
- Licensed Clinical Mental Health Counselor
- Licensed Addiction Counselor
- Licensed Marriage and Family Therapist
- Licensed Chemical Dependency Professional
- Licensed Chemical Dependency Clinical Supervisor

Other Types of Providers
- Peer Support Specialist (Medicaid)
- Case Manager (Medicaid)
Types of Organizations in the Behavioral Health Network

- Federally Qualified Health Centers (FQHCs)
- Agencies and CMHC (Community Mental Health Centers)
- Groups
- Free Standing Psychiatric Facilities
Provider Responsibilities

• Render services to Members in a non-discriminatory manner:
  – Maintain availability for a routine level of need for services
  – Offer routine non-urgent appointments within 10 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 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
Join 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 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
  − State required credentialing documents (attestation forms, licensures)

• Approval by Optum Credentialing Committee Credentialing requirements can be found at providerexpress.com under “Join Our Network”

• Orientation to Optum clinical and administrative protocols via webinars or review of provider resources posted on providerexpress.com
Join Our Network, (continued)

FQHCs, Agencies and Groups:

- For 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.
Recredentialing

- Recredentialing is completed every 36 months (3 years):
  - Time line is established by NCQA

- Several months prior to the recredentialing date, a recredentialing packet will be sent to the primary address on file for the provider

- Completion of the entire recredentialing packet is required for the recredentialing process to be completed

- Site audits will be completed for organizational providers as indicated by Optum policy

- Failure to complete the recredentialing paperwork or participate in the recredentialing site audit (when applicable) will impact the provider’s status in the network
Supervisory Protocol Addendum

The Supervisory Protocol addendum allows for non-credentialed clinicians to render services while under the supervision of an independently licensed clinician:

- Clinicians rendering psychotherapy services must have a minimum of a master’s degree
- All services that are rendered must be within the scope of the clinician’s training
- Supervision must:
  - Occur regularly on a one-to-one basis
  - Be documented
- Protocol is reflective of requirements outlined by the State for OTP HH, IHH and ACT oversight
Attestation for Integrity

Welcome to the Optum Network!

Rhode Island Provider Resources

Optum Network Manual
- Network Manual

Level of Care Guidelines
- LOC Guidelines

Best Practice Guidelines
- BP Guidelines

Algorithms for Effective Reporting and Treatment (ALERI)
- Intro to ALERT
- ALERT Resources

Coordination of Care (COC)
- COC Flyer
- COC Checklist

Rhode Island Medicaid-Specific Resources

General Information

Neighborhood Health Plan of Rhode Island

NHP of RI training information

We are providing links to support required training for providers serving Neighborhood Health Plan of Rhode Island (NHP of RI) INTEGRITY members.

Click here for to learn about training and attestation requirements and to access links to training provided by NHP of RI.

After completing the trainings, you will be asked to attest to having completed those and, at that time, will also be asked to attest to information related to these topics:
- Standards of Conduct, Compliance Policies, and Compliance Information
- Fraud, Waste and Abuse Training
- Reporting Fraud, Waste, Abuse and Compliance Issues
- OIG and GSA Exclusion Screening

Additional information and forms are available, including psych/neuropsych testing guidelines, credentialing plans, and Disability Solutions Manual, on the Provider Express Guidelines/Policies & Manuals and Optum Forms pages.
Attestation for Integrity (continued)

Rhode Island Neighborhood Health Plan Provider Training

Medicare Training and Attestation Information

Attestation Requirements

In order to serve Neighborhood Health Plan of Rhode Island (NHP) Members, you and/or your organization must complete the following attestations:

1. Standards of Conduct, Compliance Policies, and Compliance Information
2. Fraud, Waste and Abuse Training
3. Reporting Fraud, Waste, Abuse and Compliance Issues
4. OIG and GSA Exclusion Screening
5. Completion of Neighborhood Health Plan of Rhode Island's INTEGRITY Medicare Medicaid Plan (MMP) Training

Training Links for NHP INTEGRITY MMP

NHP and Optum must ensure that First Tier, Downstream and Related Entitles (FDRs) and Affiliates that we contract with are in compliance with applicable state and federal regulations and meet Neighborhood's requirements for training. The required trainings are as follows:

1. Introduction to INTEGRITY
2. Enrollee Rights and Protections
3. Culture Competence, Disability Literacy and the ADA
4. Model of Care, Assessment and Care Planning
5. Putting Cultural and Disability Competence into Practice
6. Integration of Behavioral Health and Long Term Services and Supports

Action Steps to Complete All Requirements

1. Complete each of the 6 NHP INTEGRITY MMP trainings
2. Complete all required attestations here (coming soon)

Rhode Island Neighborhood Health Plan Provider Training

Register Now

After completing registration, you will receive emailed instructions for joining the meeting

November Webinars
- Wednesday, November 14, 2018 - 8:30 a.m., EST
- Friday, November 16, 2018 11:00 a.m., EST
- Tuesday, November 27, 2018 8:30 a.m., EST
- Thursday, November 29, 2018 3:00 p.m., EST

December Webinars
- Monday, December 3, 2018 - 2:30 p.m., EST
- Friday, December 7, 2018 - 11:00 a.m., EST
- Tuesday, December 11, 2018 - 8:30 a.m., EST
- Wednesday, December 12, 2018 - 4:00 p.m., EST
- Monday, December 17, 2018 - 8:00 a.m., EST
- Wednesday, December 19, 2018 - 10:00 a.m., EST

January Webinars
- Tuesday, January 8, 2019 - 8:30 a.m., EST
- Friday, January 11, 2019 - 11:00 a.m., EST
Importance and Value of Cultural Competence

• 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 experience

• Emphasizing individualized goals and self-sufficiency encourages Members to live their lives to the fullest
Cultural Competency

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

- All services should be conducted in accordance with Title VI of the Civil Rights Act of 1964 and should be provided in a manner that respects the Member’s cultural heritage and appropriately utilizes natural supports in the Member’s community.

- Providers are required to deliver services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, and to provide for interpreters in accordance with 42 CFR §438.206.

- All providers shall comply with any state or federal law which mandates that all persons, regardless of race, creed, color, religion, sex, age, income, sexual orientation, gender identity, national origin, political affiliation, or disability, shall have equal access to employment opportunities, and all other applicable federal and state laws, rules and regulations, including the Americans with Disabilities Act and Title VI.
Cultural Competency, (continued)

- Some cultural preferences to remember include:
  - Ask what language the Member prefers to help eliminate communication barriers and, when necessary, use the interpretation services available to you
  - Understand the Member’s religious and health care beliefs
  - Understand the role of the Member’s family and their decision-making process

- Providers should collect Member demographic data, including, but not limited to ethnicity, race, gender, sexual orientation, religion, and social class:
  - Members must be given the opportunity to voluntarily provide this information, it cannot be required
Cultural Competency, (continued)

Some additional resources for information on Cultural Competency are:

- [www.cms.hhs.gov/ocr](http://www.cms.hhs.gov/ocr) – Office of Civil Rights
- [www.LEP.gov](http://www.LEP.gov) – Promotes importance of language access to federal programs and federally assisted programs
- [www.diversityrx.org](http://www.diversityrx.org) – Promotes language and cultural competency to improve the quality of health care for minorities
- [www.ncihc.org](http://www.ncihc.org) – Organization to promote culturally competent health care
Clinical Overview
Behavioral Health Clinical Model

Six key principles behind the Behavioral Health Clinical Model center on a change from traditional to integrated care:

1. Moving from a disease-centric model to a Member-Driven, Medical-Behavioral-Social Health Model by operating with a collaborative team approach to deliver care using a standardized protocol

2. Treating Members in a holistic manner by using a single Member driven treatment plan, including helping the Member access their natural community supports based on their strengths and preferences

3. Use of clinical systems and claims platforms that allow for a seamless coordination across inter-disciplinary care teams of the Member’s needs

4. Focused on multimorbidities in patients with chronic clinical conditions to improve health outcomes and affordability

5. Improved screening and treatment of Mental Health and Substance Use Disorder diagnoses

6. Treating individuals at the point of care where they are comfortable
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
- Behavioral Health Clinical Policies
- American Society of Addiction Medicine (ASAM) Criteria

Level of Care Guidelines can be found at providerexpress.com
Behavioral and Medical Integration

Our Goal: Increase medical and behavioral health care integration

• Providers are asked to refer Members with known or suspected and untreated physical health problems or disorders to their Primary Care Physician for examination and treatment

Our Goal: Increase integration of treatment for mental health and substance use disorder conditions

• Our care management program assists Members with complex medical and/or behavioral health needs in the coordination of their care
• All Members are expected to be treated from a holistic standpoint, including high-risk, high-service utilizers with complex needs
Discharge Planning

• Effective discharge planning addresses how a Member’s needs are met during a level of care transition or change to a different treating provider.

• Discharge planning begins at the onset of care and should be documented and reviewed over the course of treatment.

• Discharge 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:
  – Members discharged from an acute inpatient program must have a follow-up appointment scheduled prior to discharge for a date that is within seven (7) days of the date of discharge.

• Throughout the treatment and discharge planning process, it is essential that Members be educated regarding:
  – The importance of enlisting community support services.
  – Communicating treatment recommendations to all treating professionals.
  – Adhering to follow-up care.
Documentation Standards

- Information regarding **documentation standards** for behavioral health providers can be located in 3 places:
  - Rhode Island Provider Manual (located on providerexpress.com): from the home page choose Clinical Resources > Guidelines/Policies & Manuals > Manuals > State-Specific Manuals and Addendums
  - Audit tools
Highlights of documentation standards:

• A psychiatric history, including the presenting problem, is documented
• A 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-term 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
Documentation Standards, (continued)

• Discharge planning should be on-going and a discharge summary is documented when services are completed

• 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)

• Medical necessity for services that are rendered is clearly documented
Reminders: Release of Information (42 CFR §431.306):

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

Optum expects that all state and federal guidelines related to confidentiality are followed. For more information regarding documentation and storage of records, refer to the Optum National Network Manual.
Claim Overview
Claims filing made easy

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

• **It's fast** - eliminates mail and paper processing delays
• **It's convenient** - easy set-up and intuitive process
• **It's secure** - data security is higher than with paper-based claims
• **It's efficient** - electronic processing helps prevent errors
• **It's cost-efficient** - eliminates mailing costs and the solutions are free or low-cost
• **It's complete** - receive feedback that your claim was received by the payer; provides claim error reports for claims that fail submission
Claims Submission - Option 1 – Online

Entry through 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 Form 1500
• Allows claims to be paid quickly and accurately
• Submission of claims via this option is free to providers

You must have a registered user ID and password to gain access to the online claim submission function:

• To obtain a user ID, call toll-free 1-866-842-3278
Quick and accurate electronic claim entry

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

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

Get started today with your Optum ID:
- Register for an Optum ID today by clicking this [First-time User link](#)
- Need help registering for an Optum ID? Watch this [quick video](#)
Claims Submission Option 2 – EDI/Electronically

Electronic Data Interchange (EDI) is an exchange of information:

- You may use any clearinghouse vendor to submit claims
- Payer ID for submitting claims is 87726
What to know about Electronic Data Interchange (EDI)

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

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

To learn more about EDI, visit Provider Express. From the Home Page, select Admin Resources > Claim Tips > EDI/Electronic Claims
Tips for timely and accurate payment

Filing electronically can help prevent these common errors:

- **Missing or incomplete information**
  - Provider Express “Claim Entry” prevents the submission of claim if required fields are blank
  - Examples: NPI number, ICD10 diagnosis code

- **Member demographic info has errors**
  - Member information is auto-populated when you use “Claim Entry” on Provider Express
  - Examples: Name, DOB, ID number

- **Unclear or illegible information**
  - The Claim Entry form on Provider Express ensures legibility
  - Examples: Provider or Member information illegible, diagnosis code unclear
Filing paper claims

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

- Use an original 02/12 - Form 1500 claim form (no photocopies)
- Type information to ensure legibility
- Use a ICD-10 code for primary
- Complete all required fields (including ICD indicator and NPI number)
Claims Submission Option 3 – **Paper**

**Use the Form 1500 claim form:**

- Claim elements include but are not limited to diagnosis *(ICD10)*
- Member name, Member date of birth, Member identification number, dates of service, type and duration of service, name of clinician (e.g., 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:

  United Behavioral Health  
  PO Box 30760  
  Salt Lake City, Utah 84130-0760

**Institutional claims must be submitted using the UB-04 claim form**
Receive payments faster

Benefits of Electronic Payments and Statements (EPS):

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

Registering for EPS is easy!

- Login to Provider Express with your Optum ID
- Select “EPS” under the “More” heading and follow the prompts to enroll
- Contact Optum Financial Services for assistance: 1-877-620-6194
Electronic Payment & Statements (EPS)

With EPS, you receive electronic funds transfer (EFT) for claim payments, plus your Provider Remittance Advice (PRA) is delivered online:

• Lessens administrative costs and simplifies bookkeeping
• Reduces reimbursement turnaround time
• Funds are available as soon as they are posted to your account

To receive direct deposit and electronic statements through EPS you need to enroll at myservices.optumhealthpaymentservices.com. Here’s what you’ll need:

• Bank account information for direct deposit
• Either a voided check or a bank letter to verify bank account information
• A copy of your practice’s W-9 form

If you’re already signed up for EPS with UnitedHealthcare Commercial or UnitedHealthcare Medicare Solutions, you will automatically receive direct deposit and electronic statements through EPS for Neighborhood Health Plan of Rhode Island
Timely filing of claims

• Providers contracted with Optum are required to submit claims for services rendered to Optum Members within 90 days of the date of service

• Corrected claims can be submitted up to 365 days from the denial

• Services that span 2018-2019 dates of service must be split with dates of service prior to and including December 31, 2018 submitted to Beacon, and those post January 1, 2019 submitted to Optum
Medicaid Claim Submission for HBTS, IHH, OTP and ACT Services

The following services only must be billed referencing the group/agency name and the organization NPI # in order to ensure proper processing. Please work directly with your EDI clearinghouse to ensure they are aware of the distinction between the billing of these services and the remaining codes contained within your fee schedule.

<table>
<thead>
<tr>
<th>Code</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0001</td>
<td>Alcohol and/or drug assessment</td>
</tr>
<tr>
<td>H0005</td>
<td>SA Group Counseling by Clinician</td>
</tr>
<tr>
<td>H0014</td>
<td>SA Ambulatory Detox Per diem</td>
</tr>
<tr>
<td>H0020</td>
<td>Methadone Treatment Program</td>
</tr>
<tr>
<td>H0032</td>
<td>MH Service Plan Development by Non-Physician</td>
</tr>
<tr>
<td>H0036</td>
<td>Community Psychiatric Services per 15 minute EOS Level</td>
</tr>
<tr>
<td>H0036 HN</td>
<td>Integrated Dual Diagnosis Treatment (15 minutes - max 4 units)</td>
</tr>
<tr>
<td>H0037</td>
<td>Integrated Health Home Services for Adults</td>
</tr>
<tr>
<td>H0038</td>
<td>MH Self Help Peer Svc Per 15 min</td>
</tr>
<tr>
<td>H0038 HQ</td>
<td>MH Self Help Peer Group Svc Per 15 min</td>
</tr>
<tr>
<td>H0040</td>
<td>Assertive Community Treatment</td>
</tr>
<tr>
<td>H0046</td>
<td>Mental Health Services, Not Otherwise Specified (60 Min)</td>
</tr>
<tr>
<td>H0046 HO</td>
<td>HBTS- Clinical Supervision – Master’s level</td>
</tr>
<tr>
<td>H0046 HP</td>
<td>HBTS - Clinical Supervision – Doctoral Level Clinician</td>
</tr>
<tr>
<td>H0047</td>
<td>OTP Health Homes</td>
</tr>
<tr>
<td>H2011 U1</td>
<td>Crisis Intervention (15 minutes - max 4 units)</td>
</tr>
<tr>
<td>H2012</td>
<td>Behavioral Health Day Treatment, per Hour - Child/Adolescent</td>
</tr>
<tr>
<td>H2014 HO</td>
<td>Skills Training and Development (15 Min) Master Level Clinician</td>
</tr>
<tr>
<td>H2014 HP</td>
<td>Skills Training and Development (15 Min) Doctoral Clinician</td>
</tr>
<tr>
<td>H2016</td>
<td>PASS - Service Plan Implementation/Day</td>
</tr>
<tr>
<td>H2017</td>
<td>Psychiatric Rehabilitation (15 minutes)</td>
</tr>
<tr>
<td>H2019</td>
<td>Therapeutic Behavioral Services (15 Min)</td>
</tr>
<tr>
<td>H2021</td>
<td>In-Home Intervention/Community-Based Wrap Around Services</td>
</tr>
<tr>
<td>H2023</td>
<td>Supported Employment</td>
</tr>
<tr>
<td>H2024</td>
<td>Intensive Psychiatric Support Services</td>
</tr>
<tr>
<td>H2031</td>
<td>Mental Health Clubhouse services, per diem</td>
</tr>
<tr>
<td>T1005</td>
<td>Respite (Under age 21)</td>
</tr>
<tr>
<td>T1005 UN</td>
<td>Respite (Under age 21)</td>
</tr>
<tr>
<td>T1005 UP</td>
<td>Respite (Under age 21)</td>
</tr>
<tr>
<td>T1016</td>
<td>Case Management (15 Min)</td>
</tr>
<tr>
<td>T1016 U1</td>
<td>Case Management, each 15 minutes formerly known as Service Plan Implementation - Direction Coordination</td>
</tr>
<tr>
<td>T1019</td>
<td>PASS - Direct Services, Personal Care Services</td>
</tr>
<tr>
<td>T1019 TF</td>
<td>PASS - Direct Services, Personal Care Services</td>
</tr>
<tr>
<td>T1019 TG</td>
<td>PASS - Direct Services, Personal Care Services</td>
</tr>
<tr>
<td>T1023 U1</td>
<td>PASS - Assessment and Service Plan Development</td>
</tr>
<tr>
<td>T1024</td>
<td>HBTS - Home Based – Treatment Support/specialized treatment</td>
</tr>
<tr>
<td>T1027</td>
<td>PASS - Clinical Consultation</td>
</tr>
<tr>
<td>T2024</td>
<td>Respite (Under age 21) Service assessment</td>
</tr>
</tbody>
</table>
Example of Date Span Billing for Health Home-IHH services Billed on a Form 1500

<table>
<thead>
<tr>
<th>Line 2 – Encounter Code Associated with Line 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>24A – single date</td>
</tr>
<tr>
<td>24D – billing code</td>
</tr>
<tr>
<td>24F – 0.00 (not a billable code)</td>
</tr>
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<td>24G – # of units</td>
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Example: 02/01/17 to 02/28/17

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<td>24A - date span</td>
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Example: 02/01/17 to 02/28/17

Form 1500 Example:
Billing for all other Outpatient service codes (not HBTS, IHH, OTP and ACT Services)

All other service codes bill under individual clinician, include 24 J Rendering Provider information

| Box 24J: Enter Rendering Provider NPI |
| Box 31: Enter Rendering Provider Name |
| Box 33a: Enter Group/Agency NPI |
| Box 33: Enter Group/Agency Name and Billing Address |

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BH1733_11/2018

United Behavioral Health operating under the brand Optum
Clean claims

Required Fields

<table>
<thead>
<tr>
<th>Field Number</th>
<th>Notes</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Claim Receiver Type</td>
<td>Optum requires you check “Other”</td>
<td>Other (ID)</td>
</tr>
<tr>
<td>1a. Insured's ID #</td>
<td>Typically the number is on the Member’s ID card, usually 9 digits in length, and consisting of an alternate ID or the subscriber’s SSN, note it may begin with a letter</td>
<td>123456789</td>
</tr>
<tr>
<td>2. Patient’s Name</td>
<td>Last name, First name, Middle Initial Last name must be at least 2 characters</td>
<td>Doe, John, J</td>
</tr>
<tr>
<td>3. Patient’s DOB</td>
<td>Enter DOB as 8 digits: MM</td>
<td>01</td>
</tr>
<tr>
<td>Patient’s Sex</td>
<td>DD</td>
<td>YYYY</td>
</tr>
<tr>
<td>4. Insured’s Name</td>
<td>Last name, First name, Middle Initial The insured is the person who holds the policy</td>
<td>Doe, Jane J</td>
</tr>
<tr>
<td>5. Patient Address</td>
<td>First line is for the street address Second line is for city and state Third line is for the zip code Do not include punctuation (periods or commas)</td>
<td>321 E Elm St Anytown, NY 55555</td>
</tr>
<tr>
<td>6. Relationship to Insured</td>
<td>Must choose one to reflect the patient’s relationship to the insured: Self, Spouse, Child or Other</td>
<td>Self</td>
</tr>
</tbody>
</table>
## Clean claims

### Required Fields

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<tr>
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</thead>
<tbody>
<tr>
<td>11. Insured’s Policy, Group or FECA number</td>
<td>Enter the number as it appears on the card, including zeros, if number is less than 5 digits, add leading zeros</td>
<td>00123</td>
</tr>
<tr>
<td>13. Insured’s or Authorized Person’s Signature</td>
<td>Must either have the legal signature or note that signature is on file meaning that the provider has authorization on file authorizing payment of medical benefits</td>
<td>Signature on File or SOF</td>
</tr>
<tr>
<td>21. Diagnosis</td>
<td>ICD-10 diagnostic billing codes are typically alphanumeric and 5-6 digits in length</td>
<td>Major depressive disorder, recurrent, severe is: F332</td>
</tr>
<tr>
<td>24A. Date of Service</td>
<td>Enter date span of service: single day or consecutive days of service</td>
<td>Example: client received services daily from Feb 1 through Feb 7, 2018: 02</td>
</tr>
<tr>
<td>24B. Place of Service</td>
<td>Enter the industry standard Place of Service (POS) code based on where care is delivered</td>
<td>Community Mental Health Centers POS is: 53</td>
</tr>
</tbody>
</table>
## Clean claims

### Required Fields

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>24D. Procedures/Services</td>
<td>Must be a valid CPT or HCPCS Code and include industry standard modifiers as indicated by the service provided</td>
<td><strong>Example Code</strong>: H0046 <strong>Possible Modifiers</strong>: HN, HO or HP (use as indicated)</td>
</tr>
<tr>
<td>24E. Diagnosis Pointer</td>
<td>Enter the line letter(s) from Field 21 (A-L) that relate to the reason services were provided, may enter up to 4 letters</td>
<td>Alpha character A would “point” to the first/primary diagnosis list</td>
</tr>
<tr>
<td>24F. Charges</td>
<td>Enter the charge amount for each listed service; no dollar signs, enter 00 to the right of the line if charges are a whole number</td>
<td>Enter fee without dollar signs, for example a charge amount of $50 would be entered: 50</td>
</tr>
<tr>
<td>24J. Rendering Provider</td>
<td>Enter the 10-digit NPI number of person or organization providing (As required by service rendered)</td>
<td><strong>Example</strong>: 1234567890</td>
</tr>
<tr>
<td>24G. Days/Units</td>
<td>Enter the number of units/days of service for each service line; the number of days should correspond to date spans listed in 24A for each line of service</td>
<td><strong>Example</strong>: If 24A has date span 02</td>
</tr>
</tbody>
</table>
Clean claims

Required Fields

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<tr>
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<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>25. Federal TIN, SSN or EIN</td>
<td>Enter the Tax ID number (SSN or EIN) of the billing provider as listed in Field 33; put an “X” in the SSN or EIN box indicating which your are reporting</td>
<td>Enter without hyphens, for example: 987654321 SSN ☐ EIN ☒</td>
</tr>
<tr>
<td>31. Clinical Signature Date</td>
<td>Enter legal name with degree or credential (As required by service)</td>
<td>First Name Last Name MD 02/07/18</td>
</tr>
<tr>
<td>33. Billing Provider</td>
<td>Enter the Address in this way: 1st Line: Billing Provider Name 2nd Line: Address 3rd Line: City, State and Zip Code</td>
<td>Billing Agency/Provider Name 123 Main Street Anytown, RI 11111-1111</td>
</tr>
<tr>
<td>33a. Billing Provider's NPI</td>
<td>Billing Provider/Agency NPI</td>
<td>Example: 1234567890</td>
</tr>
</tbody>
</table>
Corrected claim submission

Corrected claims are typically submitted when the original claim had an error in data supplied.

When submitting a corrected claim, enter “7” to indicate “Replacement of prior claim.”

Paper Form 1500
- Enter “7” in Field 22 (highlighted)

<table>
<thead>
<tr>
<th>16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>FROM MM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>FROM MM</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>20. OUTSIDE LAB?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>22. REsubmission code</th>
</tr>
</thead>
<tbody>
<tr>
<td>ORIGINAL REF. NO.</td>
</tr>
</tbody>
</table>

| 23. PRIOR AUTHORIZATION NUMBER |

Electronic/EDI Transaction
- Enter “7” in Box 12A
Claims Payment Timelines

EFT funding is 2x per week (Tuesday and Saturday)

Paper checks are cut on a daily basis (Tuesday through Saturday)
Oversight Programs
**Optum Program & Network Integrity (PNI) Department**

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

**The department consists of three main investigative pathways:**

<table>
<thead>
<tr>
<th>Prospective (Pre-Pay)</th>
<th>Retrospective (Post Pay)</th>
<th>Intelligence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Analyze member, provider and claims data</td>
<td>• Analyze Member, provider and claims data</td>
<td>• Anonymous TIP line</td>
</tr>
<tr>
<td>• Identify trends, current/upcoming schemes or unusual behavior</td>
<td>• Identify trends, schemes or unusual behavior, then investigate</td>
<td>• Email / PO Box</td>
</tr>
<tr>
<td>• Stop potentially fraudulent or defective claims from being paid</td>
<td>• Work with state and federal agencies to stop fraud, waste and abuse consistently across the industry</td>
<td>• Internal and external training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Provider Education</td>
</tr>
</tbody>
</table>

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What PNI (FWAE) looks for…

1. Inconsistent coding patterns within a group practice
2. Coding at high levels for Evaluation and Management (E&M) Services
3. Services not rendered due to no records submitted, incorrect name of Member, incorrect date of service or illegible records
4. Unbundling of procedures and services
5. Diagnosis concerns - does diagnosis make sense to documentation studied?
6. Inadequate documentation -- missing pages, no Member name on every page submitted, dates of service are missing or appear altered
7. Misrepresentation of rendering provider -- different provider then billing provider
8. Misrepresentation of non-covered services as covered
9. Double billing
10. Improper use of modifiers

(Medical Record Auditor, AMA 3rd Edition, 2011)
FWAE market research and collaboration

General Market Research (all markets)

Prospective Flagging & Retro Investigations

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

Algorithms and Analytics

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

Customer Collaboration

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

Member identification
- Claims data
- Service combinations
- Frequency and/or duration that is higher than expected

Licensed care advocate reach out telephonically to treating provider to:
- Review eligibility for the service(s)
- Review the treatment plan/plan of care
- Review the case against applicable medical necessity guidelines

Potential outcome of review:
- Close case (Member is eligible, treatment plan/plan of care is appropriate, care is medically necessary)
- Modification to plan (e.g., current care is not evidence-based but there is agreement to correct)
- Referral to Peer Review (e.g., Member appears ineligible for service; treatment does not appear to be evidence based; duration/frequency of care does not appear to be medically necessary)
Practice Management Program

As an alternative to requiring precertification for routine and community-based outpatient services, we will provide oversight of service provision through our practice management program.

<table>
<thead>
<tr>
<th>Program Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Regular and comprehensive analysis of claims data by provider/provider group</td>
</tr>
<tr>
<td>• Service/diagnostic/age distribution</td>
</tr>
<tr>
<td>• Proper application of eligibility criteria</td>
</tr>
<tr>
<td>• Appropriate frequency of service/duration of service</td>
</tr>
<tr>
<td>• Outreach to provider group when appropriate to discuss any potential concerns that arose from the claims analysis</td>
</tr>
<tr>
<td>• Potential outcomes from discussion:</td>
</tr>
<tr>
<td>• No additional action necessary</td>
</tr>
<tr>
<td>• Program audit including record review</td>
</tr>
<tr>
<td>• Corrective Action Plan (CAP)</td>
</tr>
<tr>
<td>• Targeted precertification as part of CAP</td>
</tr>
</tbody>
</table>
Provider Quality Audits

Provider audits are completed for a variety of reasons:

• At the time of Credentialing and Recredentialing for organizational providers without a national accreditation (for example, The Joint Commission or CARF)
• Quality of Care (QOC) and Sentinel Event investigations
• 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
Provider Quality Audits, (continued)

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
Audit Tools

There are four (4) audit tools for Medicaid:

1. Organizational Provider Site Tool
2. Case Management Record Audit Tool
3. Psychosocial Rehab Record Audit Tool
4. Treatment Record Audit Tool

The audit tools are posted to providerexpress.com: from the home page, choose Our Network > Welcome to the Network
Contacting Optum
Best way to contact Optum

Go to Provider Express and click on “Contact Us”

From the “Contact Us” page you can get help with claims, Network Management or website support.

Live Chat is available for website technical support.

Check out our brief Contact Us video.
Send secure communications on “Message Center”

- “Message Center” is an online tool that enables you and Optum staff to communicate with one another within a secure channel.
- The “Message Center” is located within the secure Transactions area.

**Message Center Categories**

- Authorizations/Notifications
- Previously submitted claims
- Your contract
- Previously submitted demographic changes/Tax ID number changes
- Credentialing status
- Member Eligibility and/or benefits
- Inquires for Network Management
- Use of the Provider Express Web portal

Check out our brief Message Center video.
As a new Provider to the network, your Network Manager is your local guide to Navigating Optum

Your Network Manager can:
- Act as your Optum liaison
- Answer important questions
- Facilitate ongoing process improvement
- Keep you abreast of changes that impact your practice
- Provide useful tools and resources
Optum Contacts

**Wendy Hamel Sherzer**  
Network Manager  
Phone: 1-401-732-7120  
Email: wendy.hamel.sherzer@optum.com

**Alec Ward**  
Associate Director Provider Service  
Phone: 1-781-419-8321  
Email: alec.ward@optum.com

**Colleen Chesney**  
Regional Vice President Provider Services  
Phone: 1-612-1632-5069  
Email: colleen.chesney@optum.com
## Optum and Neighborhood Escalation Process

<table>
<thead>
<tr>
<th>Issue Type</th>
<th>Issue Type(s) Examples</th>
<th>Contact</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Inquires</strong></td>
<td>• Claims payments no more than 30 days for electronic claims</td>
<td>INTEGRITY 1-401-443-5995</td>
<td>On Call</td>
</tr>
<tr>
<td></td>
<td>• Credentialing of new Providers up to 45 days</td>
<td>Medicaid 1-401-443-5997</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Claims reprocessing post phone call 7-10 business days</td>
<td>Commercial 1-833-470-0578</td>
<td></td>
</tr>
<tr>
<td><strong>Non-Standard Inquiries</strong></td>
<td>• Single claims issue impacting greater than 25 claims</td>
<td>Network Manager: Wendy Hamel-Sherzer 1-401-732-7120 Email: <a href="mailto:wendy.hamel.sherzer@optum.com">wendy.hamel.sherzer@optum.com</a></td>
<td>Within 48 hours</td>
</tr>
<tr>
<td></td>
<td>• Delayed claims payments (greater than 30 days for electronic submissions or 40 days for paper)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Credentialing applications greater than 45 days</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Unresolved Issues</strong></td>
<td>• Issue remains unresolved after engaging contacts for standard and non-standard inquiries</td>
<td>Optum Executive Director Dee Tavares 1-763-595-3480 Email: <a href="mailto:dolores.tavares@optum.com">dolores.tavares@optum.com</a></td>
<td>Within 24 hours</td>
</tr>
<tr>
<td><strong>NHPRI Escalation</strong></td>
<td>• Contact the NHPRI Ombudsman for issues that are not resolved after working through previous 3 resolution channels</td>
<td>NHPRI Ombudsman</td>
<td>Within 24 hours</td>
</tr>
</tbody>
</table>

*At each step of the escalation process providers will be supplied with an estimated resolution timeframe, which if not met moves the provider to the next stage of escalation*
Provider Resources
Member Website and Resources

www.nhpri.org makes it simple for Members to:

• Identify participating providers:
  - Geographic location
  - Provider specialty type/areas of expertise
  - License type

• Locate community resources
• Find articles on a variety of wellness and work topics
• Complete self-assessments

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

**providerexpress.com**

- **Secure transactions for Medicaid include:**
  - Check eligibility and authorization or notification of benefits requirements
  - Submit professional claims and view claim status
  - Make claim adjustment requests
  - Register for Electronic Payments and Statements (EPS)
  - To request a user ID to the secure transactions on the **providerexpress.com** select “First-time User” from the Home Page; you may obtain additional information through the Help Desk at **1-866-842-3278**

- **Customer Service for website support:** **1-866-209-9320**
Provider Resources

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 Neighborhood Health Plan of RI providers access to provider-specific information.
Public Pages include general updates and other useful information:

- Download standard forms (e.g., provider demographic updates, authorization forms, psych testing authorization forms)
- Find network contacts
- Review clinical guidelines
- Access archived issues of Network Notes, the provider newsletter
- Level of Care Guidelines
- Training/Webinar offerings
- Rhode Island page (from the Home Page, choose Our Network > Welcome to the Network > Rhode Island)
Provider Resources, (continued)

• 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 1-866-209-9320 (toll-free) from 8 a.m. to 10 p.m. Eastern time, or chat with a tech support representative online
Thank you.