Nebraska Heritage Health Medicaid Autism/ABA Program Provider Training

Optum with UnitedHealthcare
Community Plan of Nebraska

BH4556_01/2023

UnitedHealthcare Community Plan of Nebraska

Mission

Helping people live healthier lives and helping make the health system work better for everyone.

Vision

Be the most trusted name in healthcare.

Our goal is to deliver simplicity and earn trust from our members...

Be a catalyst for person-centered, community-based health transformation…

And be the recognized leader for our state partners in delivering person-centered, community-based health transformation.

UnitedHealth Group structure

UNITEDHEALTH GROUP®

Optum

Helping make the health system work better for everyone

Information and technology-enabled health services:

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

United Healthcare

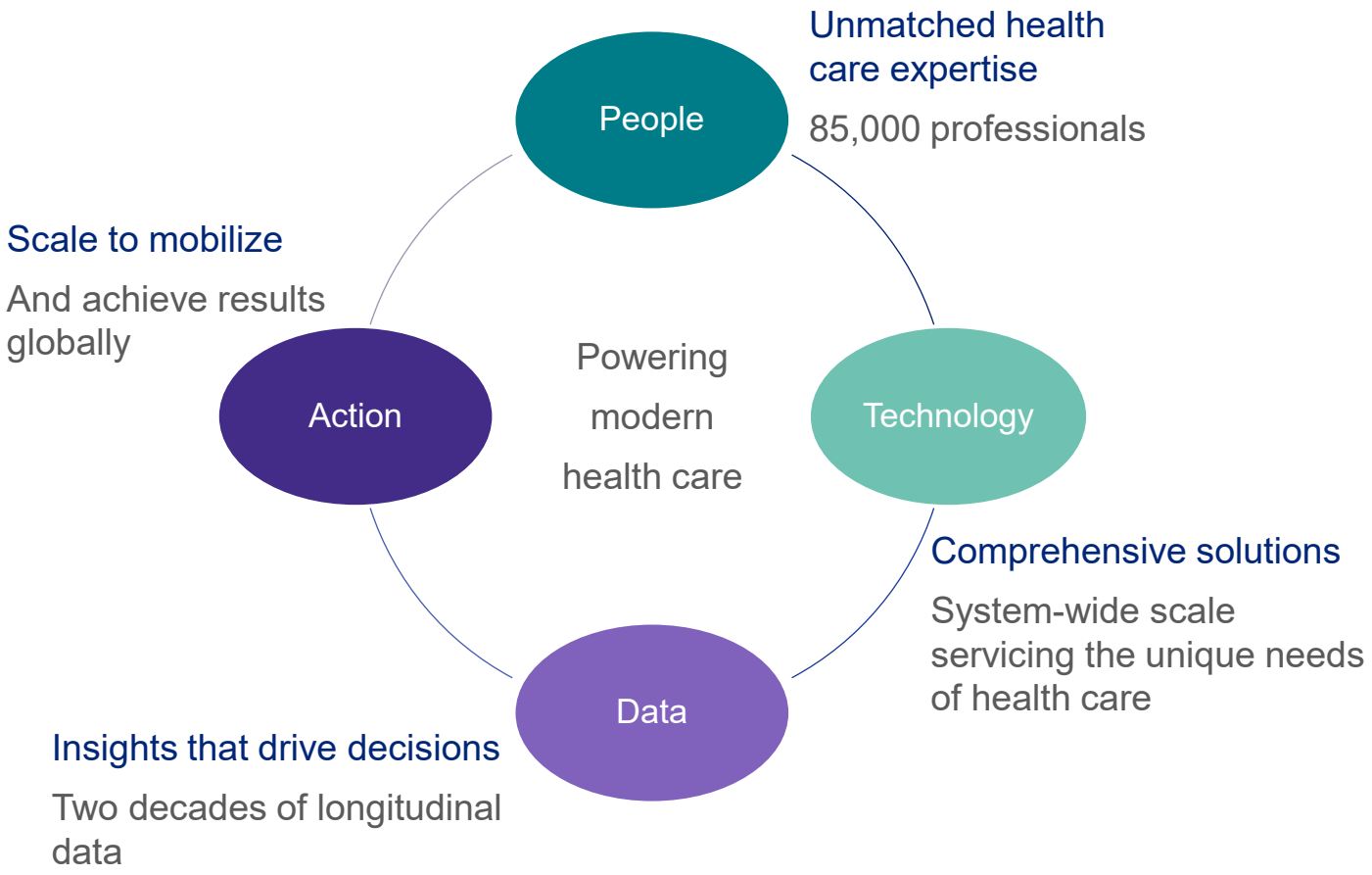
Helping people live healthier lives

Health care coverage and benefits:

- Employer & Individual
- Medicare & Retirement
- Community & State
- Global

Who is Optum?

- Optum is a collection of people, capabilities, competencies, technologies, perspectives and partners sharing the same simple goal: to make the health care system work better for everyone
- Optum works collaboratively across the health system to improve care delivery, quality and cost-effectiveness
- We focus on three key drivers of transformative change: engaging the consumer, aligning care delivery and modernizing the health system infrastructure



Our United culture

Our mission is to help people live healthier lives

Our role is to make health care work for everyone

Integrity.

Compassion.

Relationships.

Innovation.

Performance.

Honor commitments
Never compromise

Walk in the shoes of the 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

Who is Optum?

Making care simpler and more effective for everyone

Whole person health - physical, mental and social

Simpler, smarter care coordination

Health intelligence and innovation

Proven clinical expertise and informed decision support

Connecting every aspect of health
Designing care around the person
Making health care smarter
Ensuring equitable health for all

Seamless administrative transactions

Health equity ingrained into every aspect of our company culture

Innovative community care models

Information when you need it

Optum and you

Our relationship with you is foundational to the recovery and well-being of the individuals and families we serve. We are driven by a compassion that we know you share. Together, we can set the standard for industry innovation and performance.

Achieving our Mission:

- Starts with Providers
- Serves Members
- Applies global solutions to support sustainable local health care needs

From risk identification to integrated therapies, our mental health and substance abuse solutions help to ensure that people receive the right care at the right time from the right providers.

Specialty Network Services

Customers we serve:

- 50% of the Fortune 100 and 34% of the Fortune 500
- Largest provider of global Employee Assistance Programs (EAP), covering more than 19 million lives in over 140 countries
- Local, state and federal government contracts (Public Sector)

Serving almost 43 million members:

- 1 in 6 insured Americans
- The largest network in the nation, delivering best in class density, discounts and quality segmentation
- More than 140,000 practitioners; 4,200 facilities with 9,000 facility locations

Simultaneous NCQA and URAC accreditation

Staff expertise:

- Multi-disciplinary team of 50 staff Medical Directors, (e.g., child and adolescent, medical/psychiatric, Board-Certified Behavior Analysts, and addiction specialists) just to name a few

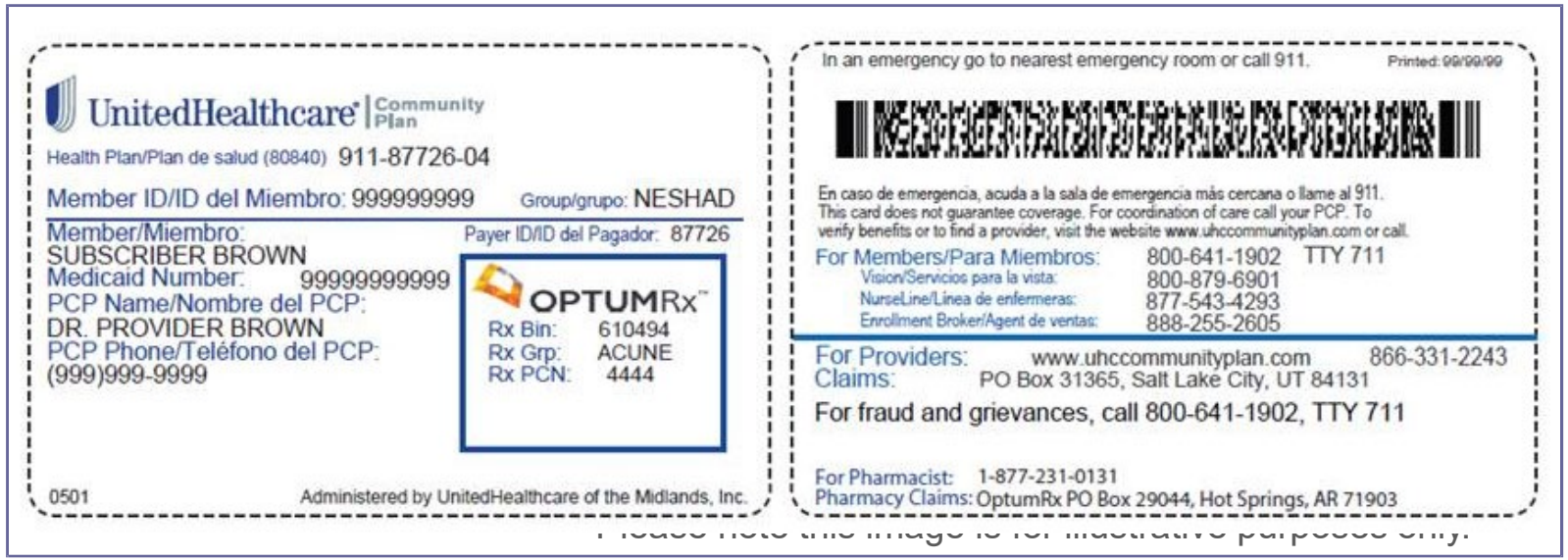
URAC
ACCREDITED
HEALTH UTILIZATION
MANAGEMENT

MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION
NCQA
ACCREDITATION
FULL

Optum ABA Member Information

Member ID card

- Will be sent directly to the member
- The member's ID number will be their Medicaid number
- All relevant contact information will be on the back of the card for both medical and behavioral customer service



Please note this image is for illustrative purposes only.

Member Rights and Responsibilities

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

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

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

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

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

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

Member Website

liveandworkwell.com makes it simple for members to:

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

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

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

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

Who is eligible?

To be eligible for ABA services, a client must meet both of the following criteria:

- Be younger than age 20
- Be covered under Nebraska Heritage Health Medicaid Program

Autism/ABA Program Services

Optum | United Healthcare Community

Nebraska Heritage Health Medicaid - Autism/ABA Program Credentialing Criteria

Individual Board Certified Behavior Analysts—Solo Practitioner

- Board Certified Behavior Analyst (BCBA) with active certification from the national Behavior Analyst Certification Board, ***and***
- State Medicaid certification in good standing
- Compliance with all state/autism mandate requirements as applicable to behavior analysts
- A minimum of six (6) months of supervised experience or training in the treatment of applied behavior analysis/intensive behavior therapies
- Minimum professional liability coverage of $1 million per occurrence/$1 million aggregate

Nebraska Heritage Health Medicaid - Autism/ABA Program Credentialing Criteria

ABA / IBT Groups

- BCBAs must meet standards above and hold supervisory certification from the national Behavior Analyst Certification Board if in supervisory role
- Licensed clinicians must have appropriate state licensure, Medicaid certification in good standing, and six (6) months of supervised experience or training in the treatment of applied behavior analysis/intensive behavior therapies
- Compliance with all state/autism mandate requirements as applicable to behavior analysts/ABA practices
- BCaBAs must have active certification from the national Behavior Analyst Certification Board, and appropriate state licensure in those states that license assistant behavior analysts
- Behavior technician must have RBT certification from the national Behavior Analyst Certification Board, or alternative national board certification, and receive appropriate training and supervision by BCBAs or licensed clinician
- BCBA or licensed clinician on staff providing program oversight
- BCBA or licensed clinician performs skills assessments and provides direct supervision of behavior technician in joint sessions with client and family
- $1 million/occurrence and $3 million/aggregate of professional liability and $1million/$1million of general liability if services are provided in a clinic setting
- $1million/occurrence and $3million/aggregate of professional liability and $1million/$1million of supplemental insurance if the agency provides ambulatory services only (in the patient's home)

Steps in Providing Treatment

Optum | United Healthca Community

Clinical Team: Nebraska Heritage Health Medicaid Autism/ABA program

Autism/ABA Clinical Team

There is a dedicated autism/ABA clinical team that will be supporting the Nebraska Heritage Health Medicaid Autism/ABA program:

- Each team member is a licensed behavioral health clinician or BCBA with experience in Autism and training in ABA
- Supervised by a manager who is a licensed psychologist and BCBA-D

Authorization Process - Assessment

- All Autism Services require Prior Authorization
- Forms are available on the Nebraska Heritage Health Medicaid Autism/ABA Program page of providerexpress.com
- The provider will need to submit a written request for the initial ABA assessment including write-up time
- Utilize the treatment request form to submit and indicate that this is an assessment request - fax form to **1-888-541-6691**
- The initial assessment can include a Functional Behavioral Assessment of other skilled assessments
- Provider should include a copy of the diagnostic evaluation, Functional Behavior Assessment or Initial Diagnostic Evaluation with the assessment request

Authorization Process – Ongoing Treatment

- Fax number: **1-888-541-6691**
  - online at optumpeeraccess.secure.force.com/ABAtreatment/
  - or via fax at **1-888-541-6691**
- Meet Medical Necessity – this applies to initial and concurrent reviews
- Provider must submit the evaluation from the diagnosing provider and the treatment request

Treatment request requirements

Meet Medical Necessity

Goals are:

- Related to the core deficits
- Objective
- Measurable
- Individualized

Includes:

- Baseline and mastery criteria
- Transition Plan to lower level of care
- Discharge Criteria
- Behavior Reduction Plan/Crisis Plan
- Parent Goals
- Supervision and treatment planning hours
- Relevant psychological information
- Coordination of care with other providers

Not educational in nature

For more information, please see the Treatment Request Guidelines on the Autism/Applied Behavior Analysis page of Provider Express.

Clinical information requirements for each review

- Any medical or other mental health diagnoses
- Any other mental health or medical services member is in
- Any medications member is taking
- How many hours per week is member in school?
- Parent participation
- Why ABA now?

- How long has member been in services?
- Goals must not be educational or academic in nature; they must focus only on the core deficits such as imitation, social skills deficits and behavioral difficulties
- Discharge criteria
- Must meet medical necessity (see Provider Express for the Clinical Criteria)

For more information, please see the Treatment Request Guidelines on the Autism/Applied Behavior Analysis page of Provider Express.

Concurrent reviews

The same information will be needed for each review:

- Any medical or other mental health diagnoses
- Any other mental health or medical services member is in
- Any medications member is taking
- How many hours per week is member in school?
- Parent participation

- Progress or lack thereof
- Goals must not be educational or academic in nature – focusing only on the core deficits such as imitation, social skills deficits and behavioral difficulties
- Discharge criteria
- Must meet medical necessity (see Provider Express for the Optum Autism/ABA Clinical Policy)

Discharge Planning

Must include the following components in every plan

- Anticipated date of discharge
- Objective, measurable goals that would need to be met for the child to be discharged
- Identify next level of care for the child, (e.g., school-based services only, outpatient therapy)---Include contact info if appropriate
- Resources in the community for the parents and member
- How discharge is coordinated with the school and other providers
- Member and/or parent agreement with plan
- How to resume services if needed
- Contact the primary insurance company advocate to notify within 2 weeks
- Send a final summary treatment request indicating:
  - Progress member made
  - Reasons for discharge
  - Services post discharge

Coding, Billing and Reimbursement

Nebraska Heritage Health Medicaid Autism/ABA Provider fee schedule

UNITED BEHAVIORAL HEALTH			
Billing Code	Modifier	Service Description	Units
97151		Behavior identification assessment administered by Dr. or other healthcare professional, F2F, one patient, each 15 minutes.	15 min
97152		Behavior identification supporting assessment administered by one tech under the direction of a Dr. or other qualified healthcare professional, F2F, onepatient, each 15 minutes.	15 min
97153		Adaptive behavior treatment by protocol, administered by tech under the direction of a Dr. or other qualified healthcare professional, F2F, one patient, each 15 minutes.	15 min
97154		Group adaptive behavior treatment by protocol, administered by tech under the direction of a Dr. or other qualified healthcare professional, F2F, with two or more patients, each 15 minutes.	15 min
97155		Adaptive behavior treatment by protocol, administered by Dr. or other qualified healthcare	15 min
97156		Family adaptive behavior treatment guidance, administered by Dr. or other qualified healthcare professional, (with or without patient present), F2F with guardian or care giver, each 15 minutes.	15 min
97158		Adaptive behavior treatment social skills group, administered by Dr. or other qualified healthcare	15 min

1	Per 15 Minute Payment: The Reimbursement Rate made to Provider for each unit of service provided to a Member as defined by the definition of the Billing Code. Such payment shall be considered payment in full for all MH Services provided to the Member, included but not limited to nursing care, diagnostic and therapeutic services, and supplies. Such payment is exclusive of physician fees. If physician services are rendered, such services are included in the rate of reimbursement.
2	The MH Services authorized by UBH and provided to a Member on an outpatient basis of the diagnosis, testing, and/or treatment of a mental health condition, other than Emergency MH Services or as part of a partial hospitalization or day treatment program, Provider shall be paid by Payor the lesser of (a)Provider's Customary Charge for such MH Services, less any applicable Member Expenses; or (b)the Method of Payment set forth above, less any applicable Member Expense(s).
3	Proper billing form: CMS 1500

Claims submission

Required Claim Forms

- Form 1500

Claims/Customer Service # :

- Phone: **1-866-331-2243**
- Fax: **1-855-312-1470**

Electronic Claims Payer ID:

- 87726

Paper Claims:

When submitting behavioral Claims by paper, please mail claims to:

United Healthcare
P.O. Box 31365
Salt Lake City, UT 84131

Claims submission

- If not submitting claims online, providers must submit claims using the current 1500 Claim Form with appropriate coding
- UnitedHealthcare Community Plan requires that you initially submit your claim within 180 days of the date of service
- When a provider is contracted as a group, the payment is made to the group, not to an individual
- All claim submissions must include:
  - ❑ Member name, Medicaid identification number and date of birth
  - ❑ Provider's Federal Tax I.D. number
  - ❑ National Provider Identifier (NPI)
  - ❑ Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at cms.gov

Claims Submission Option 1- Online

Log on to unitedhealthcareonline.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 claim form
- Allows claims to be paid quickly and accurately

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**

Claims Submission Option 2 - EDI/ Electronically

Electronic Data Interchange (EDI) is an exchange of information

Performing claim submission electronically offers distinct benefits:

- **Fast** - eliminates mail and paper processing delays
- **Convenient** - easy set-up and intuitive process, even for those new to computers
- **Secure** - data security is higher than with paper-based claims
- **Efficient** - electronic processing helps catch and reduce pre-submission errors, so more claims auto-adjudicate
- **Notification** - you get feedback that your claim was received by the payer; provides claim error reports for claims that fail submission
- **Cost-efficient** - you eliminate mailing costs, the solutions are free or low-cost

Claims Submission Option 2 - EDI/ Electronically (cont.)

- 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/health- professionals/la/electronic-data-interchange.html

  and

- unitedhealthcareonnline.com

Optum Pay

With Optum Pay, you receive electronic funds transfer (EFT) for claim payments, plus your EOBs are 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 Optum Pay you need to enroll at myservices.optumhealthpaymentservices.com. Here is what you will 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 Optum Pay with UnitedHealthcare Commercial or UnitedHealthcare Medicare Solutions, you will automatically receive direct deposit and electronic statements through Optum Pay for UnitedHealthcare Community Plan when the program is deployed.

*Note: For more information, please call **1-866-842-3278**, option 5, or go to **UnitedHealthcareOnline.com** > Quick Links > Optum Pay.*

Claims Tips

To ensure clean claims remember:

- An NPI number is always required on all claims
- A complete diagnosis is also required on all claims

Claims Filing Deadline:

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

Claims Processing:

- Clean claims, including adjustments, will be adjudicated within 15 days of receipt

Balance Billing:

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

Claims Tips (Cont.)

Member Eligibility

- Provider is responsible to verify member eligibility through DHS website

Coding Issues

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

Provider information missing/incorrect

- Example: provider information has not been completely entered on the claim form or place of service

Prior Authorization Required

- Prior Authorization is required for all services or when additional units are being requested

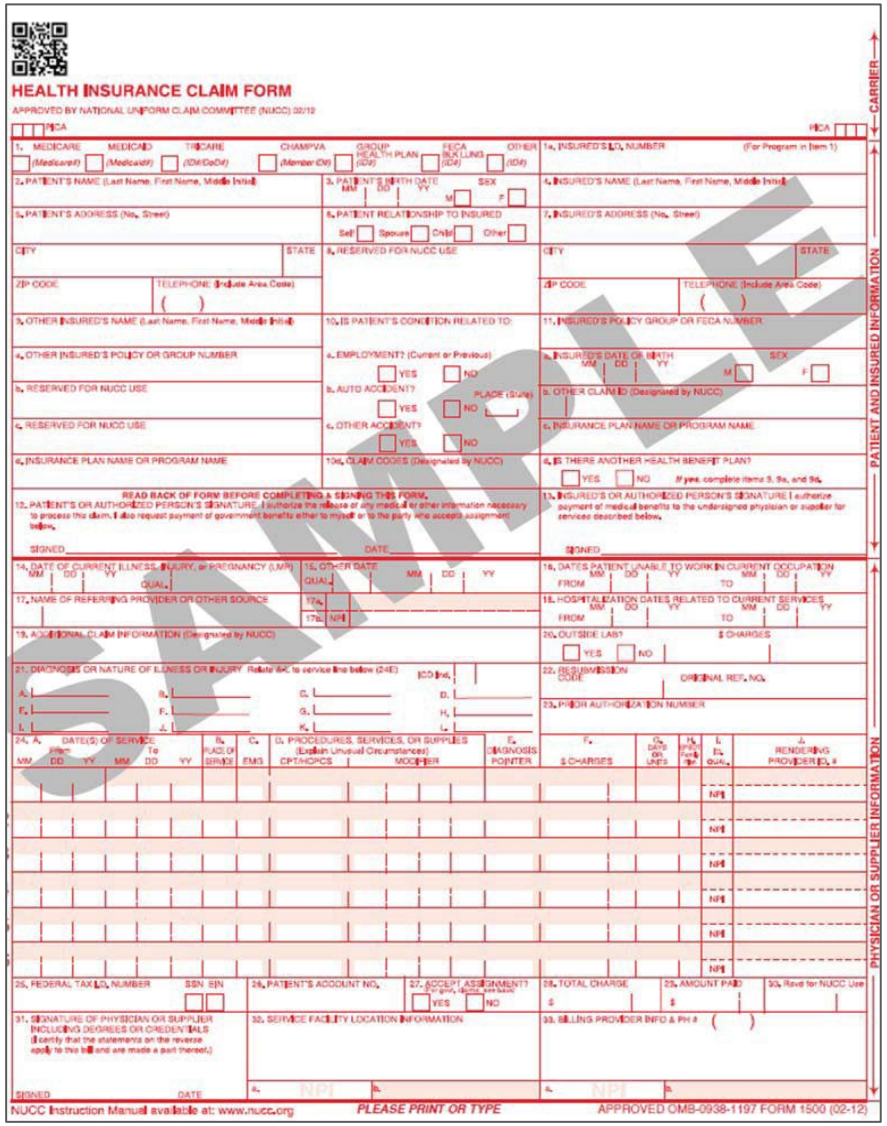
Form 1500 - Claim Form

All billable services must be coded. Coding can be dependent on several factors:

- Type of service (assessment, treatment, etc.)
- Use appropriate modifier for specific provider type
- Rate per unit (BCBA vs. Paraprofessional)
- Place of service (home or clinic)
- Duration of therapy (1 hr vs. 15 min)
- One DOS per line

You must select the code that most closely describes the service(s) provided.

Please note: Field 31 must have a rendering provider name. Rendering supervisor (BCBA/Licensed Clinician) will bill for all services by them or the BCaBAs/RBTs under the supervisory protocol.



Diagnostic Coding

Guides for Coding

- DSM-5 defined conditions:
  - ❑ Clinical criteria for ASD
  - ❑ Maps to the appropriate ICD billing code
- ICD-10 required for dates of service 10/1/15 and later

ASD Coverage

- Autism Spectrum Disorder, F84.0 (ICD-10)
- Developmental Disability

A complete diagnosis with all 4 digits is required on all claims utilizing the ICD-10 coding.

Appeals and Grievance

Grievances, Appeals and State Fair Hearings

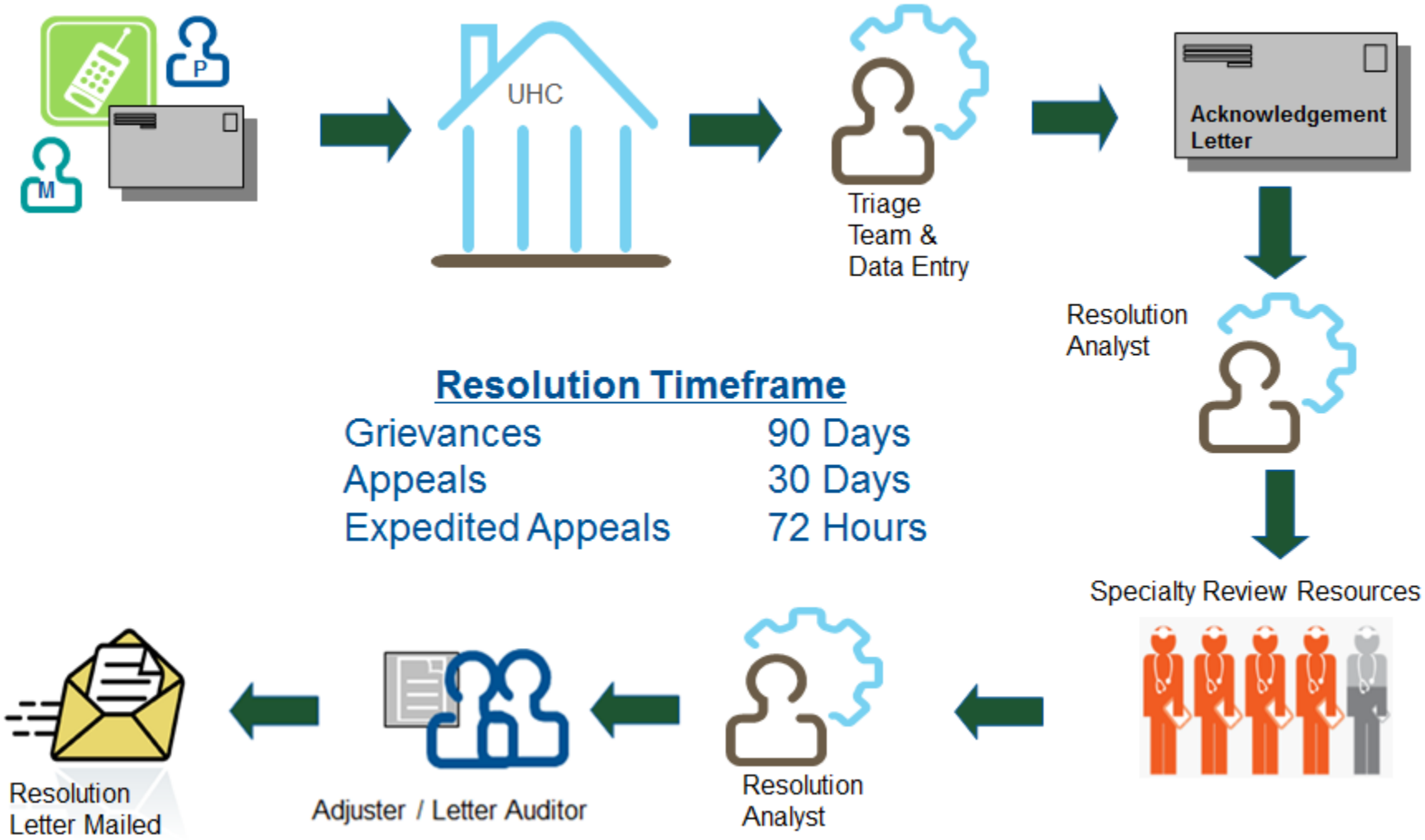
- Effective for dates of service Jan. 1, 2017 and after, the Medicaid Managed Care Rule has updated the timeframes for Grievance, Appeals and State Fair Hearings:

- The timeframe to file a grievance or appeal was changed from 90 calendar days to **60 calendar days after** the notice of adverse benefit determination.

- The standard resolution timeframe for appeals was changed from 45 calendar days to **30 calendar days.**

- The timeframe to file a Nebraska State Fair Hearing was changed from 90 calendar days to **120 calendar days** from the appeal decision notice.

Appeals & Grievance (A&G) overview



How to File a Grievance

You and your patients who are UnitedHealthcare members may file a grievance in three ways:

- **Phone:**

  Call Provider Services at **1-866-331-2243**

- **Writing:**

  Mail

  UnitedHealthcare Community Plan

  P.O. Box 31364

  Salt Lake City, Utah 84131

- **In person:**

  Visit

  UnitedHealthcare Community Plan

  2717 North 118th Street, Suite 300

  Omaha, Nebraska 68164

How to File an Appeal

- Submit a written request within 60 calendar days following the notice of adverse benefit determination.

- If you file an appeal on behalf of the member, the member's written consent must be filed within same timeframe.

- To submit a request and any medical records, you can:

  - ❑ *Call* Provider Services at **1-866-331-2243**

  - ❑ *Write* UnitedHealthcare Community Plan
    P.O. Box 31364
    Salt Lake City, Utah 84131

You may request an expedited 72-hour appeal if a delay would seriously jeopardize the life, health, or ability to attain, maintain or regain maximum function of a member. To request an expedited appeal, call **1-866-331-2243**.

How to File a State Fair Hearing

- A provider may request a State Fair Hearing if they are acting as the member's authorized representative, with the member's written consent.
- A State Fair Hearing can be requested only after the appeals process has been completed.
- You may file a written request within 120 calendar days from the MCO Notice of Adverse Benefit Determination by writing to:

  Nebraska Department of Health & Human Services
  Legal Services - Hearing Section
  P.O. Box 98914
  Lincoln, Nebraska 68509-8914

- If the member needs help writing a letter, they can call UnitedHealthcare customer service or call the NHHSS Legal Services at **1-402-471-7237**.
- The member, the provider or other delegated person acting as an authorized representative for the member may appear in person or via telephone to present the case at the State Fair Hearing.

Resources

Optum | United Healthcare Community

UnitedHealthcare Provider website

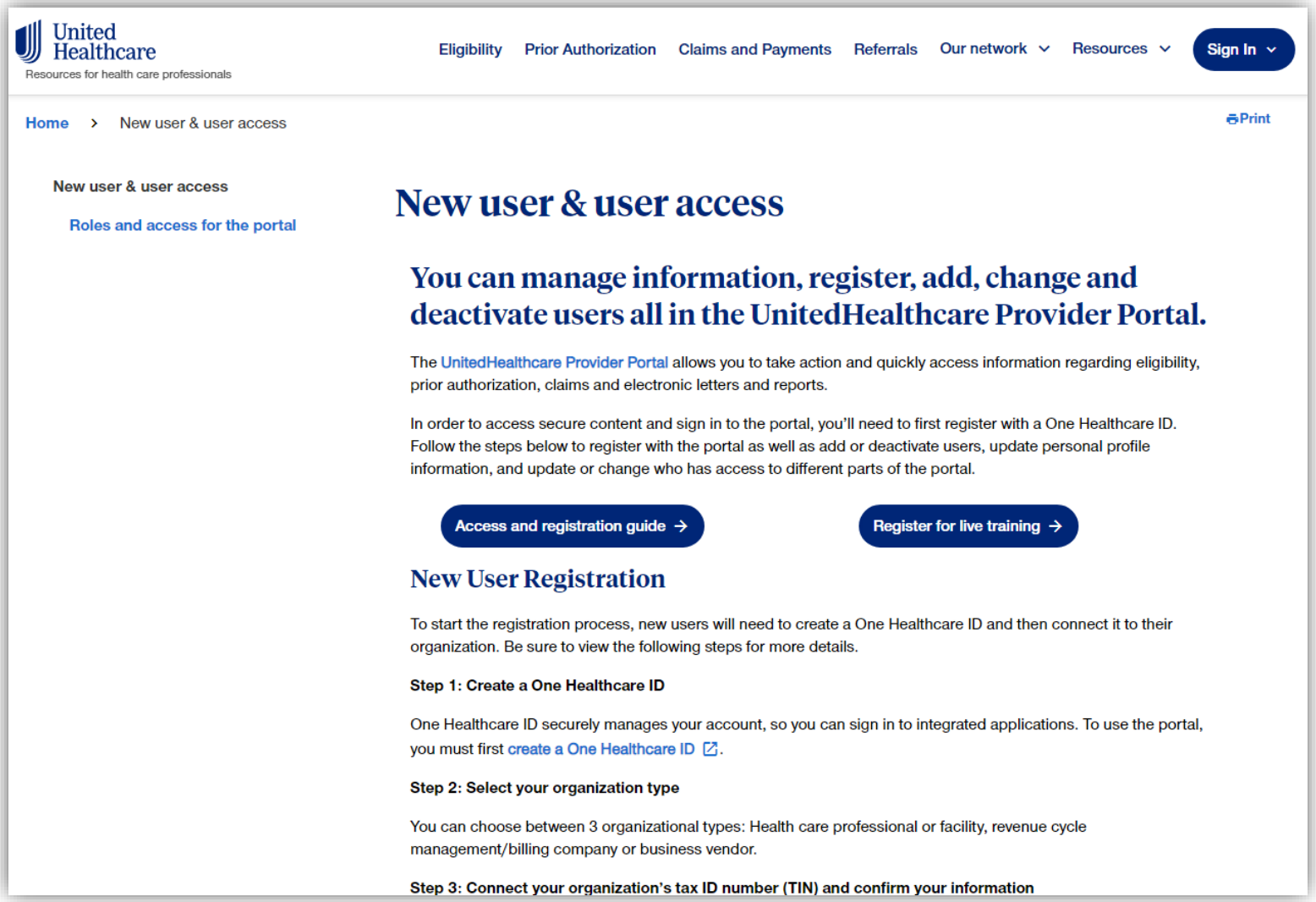
uhcprovider.com

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 Optum Pay
- To request a user ID to the secure transactions on uhcprovider.com, select New User &user access from the home page
- You may also obtain additional information through the help desk at **1-866-842-3278**

For member eligibility, claim status, and reference materials, go to > *Tools and Resources* > *UnitedHealthcare Community Plan Resources Customer Service for website support:* **1-800-600-9007**

uhcprovider.com – Login page



Nebraska Heritage Health Medicaid Autism/ABA Program page

Nebraska Heritage Health Medicaid Autism/ABA Program providers has their own page on providerexpress.com

Optum | Provider Express

Log In | First-time User | Global | Site Map

Search: Search Search

Home | Our Network | Clinical Resources | Admin Resources | Video Channel | Training | About Us | Contact Us

Optum - Provider Express Home > Clinical Resources > Applied Behavior Analysis Information > NE Medicaid ABA Program

NE Heritage Health ABA Program

UnitedHealthcare Community Plan, is one of the selected managed care plans providing coverage to Heritage Health enrollees in Nebraska. Optum has been selected by UnitedHealthcare Community Plan to develop and manage the ABA network for NE Heritage Health members, effective January 1, 2017.

To assist you in your participation in this program, learn more about the process for applying to the network, and the clinical protocols required in this unique network, please review the resource materials below.

- NE Heritage Health ABA Provider Orientation
- NE Heritage Health ABA Provider Quick Reference Guide
- NE Heritage Health ABA Treatment Request Form and Guidelines
- ABA Treatment Request Form Electronic Submission

Contact Us/Request to Join the Network

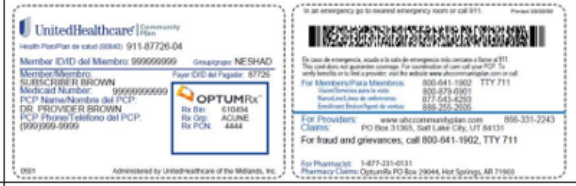
Karen Keith, Specialty Network Manager
karen_keith@optum.com

Nebraska Heritage Health Medicaid - Autism/ABA Provider Quick Reference Guide

Optum | United Healthcare Community Plan

NE Heritage Health Medicaid ABA Program

Quick Reference Guide

ID Card	
Clinician is Responsible for:	Verifying benefits/eligibility by calling the Behavioral Health number located on the back of the member's ID card or contacting Nebraska Medicaid Eligibility System (NMES) line at 1-800-642-6092 • Obtaining authorization as necessary • Being familiar with the Network Manual located on our web site: uhccommunityplan.com/health-professionals/ne/ Provider-Manual.html • Being familiar with Autism/ABA resource information and guidelines located at providerexpress.com > Home > Autism ABA Corner > Autism/ABA Information > State Medicaid ABA Programs > NE Heritage Health ABA Program

Prior Authorization	All autism services require prior authorization:
	• Verify benefits/eligibility online at providerexpress.com or call the Behavioral Health number located on the back of the member's ID card
	• Prior Authorization can be obtained via Treatment Authorization Request Form and submitted either
	  ○ Online at https://optumpeeraccess.secure.force.com/ABAtreatment/
	  ○ Or via fax at 1-855-268-9392

Claims Paper Submission	Mail paper claims to: • United Healthcare, P.O. Box 31365 Salt Lake City, UT 84131 • All autism provider services must be billed on a Form 1500 • Submission should occur within 180 days of date of service
Electronic Submission	Submit claims online through: • Payer ID for submitting claims using the EDI clearing house is: 87726
Claim Status	Claims status can be obtained by calling Customer Service Center: • 1-866-331-2243 • Or through the Web portal at providerexpress.com
Claim Appeals	Claim appeals process: • Appeals must be requested within 60 calendar days of disposition on the remittance report (Explanation of Benefits) • Mailed to UnitedHealthcare Community Plan P.O. Box 31364, Salt Lake City, UT 84131
Update Practice Info	You can update your practice information by contacting your designated Autism Network Manager.
Disclaimer	Information contained herein is subject to change. Please contact your Provider Advocate with any questions.
Network Management	Karen Keith, Specialty Network Manager Email: karen_keith@optum.com

Provider and Member Resources

An extensive condition-based library covering key behavioral and medical topics can be found on liveandworkwell.com under the Health and Well-Being Center within BeWell.

- Abuse & Neglect: Child
- Abuse: Domestic Violence
- Abuse & Neglect: Elder
- ADHD (Adult)
- ADHD (Youth)
- Alzheimer's & Dementia
- Anxiety
- Arthritis
- Asthma
- Autism
- Bipolar (Adult)
- Bipolar (Youth)
- Cancer
- Childhood Illness
- Chronic Pain
- Depression (Adult)
- Depression (Youth)
- Diabetes
- Eating Disorders (Adult)
- Eating Disorders (Youth)
- Heart Disease/Circulatory
- HIV
- Infertility
- Obesity
- Obsessions & Compulsions
- Personality Disorders
- Phobias
- Postpartum Depression
- Post-Traumatic Stress Disorder
- Schizophrenia (Adult)
- Schizophrenia (Youth)
- Sexual Problems
- Stress
- Traumatic Brain Injury