

Provider Orientation: Louisiana Medicaid, Behavioral Health



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Louisiana Medicaid Behavioral Health



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Introduction to Optum

- United Behavioral Health (UBH) was officially formed on February 2, 1997, via the merger of U.S. Behavioral Health, Inc. (USBH) and United Behavioral Systems, Inc. (UBS)
- United Behavioral Health, operating under the brand Optum, is a wholly owned subsidiary of UnitedHealth Group
 - Optum is a health services business; you will see both UBH and Optum in our communications to you
- Optum will assume management of the behavioral health benefits for Louisiana Medicare and Medicaid eligible (MME) Members with coverage through UnitedHealthcare
- UnitedHealthcare Community Plan of Louisiana has contracted with Optum to administer the behavioral health portion of the Louisiana Plan to include mental health and substance use disorders

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.



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UnitedHealthcare Community Plan

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

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 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

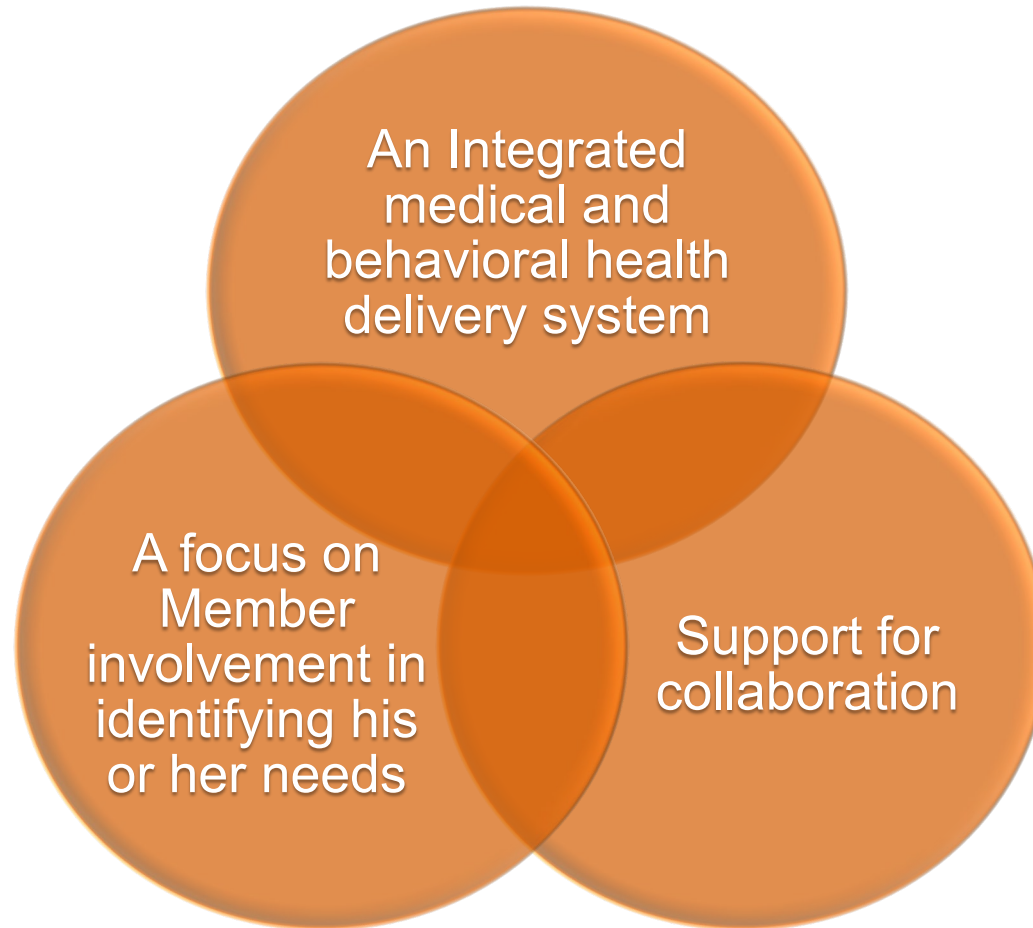


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Optum philosophy of care



Integrated care

Better care through Integrated Care Delivery System (ICDS)


- New Program:
 - Louisiana has created a new health benefits program to coordinate the physical and behavioral healthcare needs for individuals who are eligible for Medicaid
 - The Combined Benefit Package includes all traditional benefits available through Medicaid programs, including Specialized Behavioral Health Services
- Team Members involved in Care Coordination:
 - Member and their family/caregiver
 - Care Advocate
 - Community Care Manager
 - Waiver service coordinator (if appropriate)
 - Primary care provider
 - Specialists and other providers as applicable

Covered behavioral health populations

Covered Populations:

- **TANF:** Temporary Assistance for Needy Families
- **ABD:** Aged, Blind and Disabled
- **CHIP:** The Children's Health Insurance Program
- **IDD:** Intellectual and/or Developmental Disability
- **LTSS:** Long Term Services and Supports
- **LTC:** Long-Term Care
- **DUALS:** Members who are enrolled in Medicare and Medicaid

Member identification card, front

 **UnitedHealthcare**® | Community Plan

Health Plan (80840) 911-87726-04

000000417

Member:


Medicaid ID:

PCP Name:

PCP Phone/24 hours:

DOB:

Payer ID: 87726

 **OPTUMRx**™

Rx Bin: 610494
Rx Grp: ACULA
Rx PCN: 9999

0501

Administered by UnitedHealthcare of Louisiana, Inc.

Member identification card, back

In an emergency go to nearest emergency room or call 911. Printed: 07/30/15

This card does not guarantee coverage. By using this card you agree to the release of medical information as stated in your Member handbook. To find a provider visit the website www.MyUHC.com/CommunityPlan.

For Members:	1-866-675-1607	TTY 711
NurseLine:	1-877-440-9409	TTY 711
Report Fraud:	1-800-488-2917	TTY 711

For Providers: www.UnitedHealthcareOnline.com 1-866-675-1607
Claims: PO Box 31341, Salt Lake City, UT 84131-0341

Pharmacy Claims: OptumRX, PO Box 29044, Hot Springs, AR 71903
For Pharmacists: 1-866-328-3108 Rx Prior Auth: 1-800-310-6826

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.

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

Types of providers in the behavioral health network

Licensed Mental Health Professionals:

- Psychiatrist
- Advanced Psychiatric Nurse Practitioner
- Medical Psychologist
- Licensed Psychologist
- Licensed Clinical Social Worker
- Licensed Professional Counselor
- Licensed Addiction Counselor
- Licensed Marriage and Family Therapist

Other Types of Providers:

- Peer Support Specialist
- Case Manager

Covered behavioral services

- Pharmacological Management
- Psychosocial Rehabilitation (PSR)
- Family Psychotherapy
- Outpatient Therapy
- Therapeutic Group Home (under age 21)
- Group Psychotherapy
- Peer Support Services (age 21 and over)
- Community Psychiatric Supportive Treatment (CPST)
- Individual Psychotherapy
- Crisis Intervention

Covered behavioral services, continued

- Multi-Systemic Therapy (under age 21)
- Functional Family Therapy (under age 21)
- Inpatient Hospitalization
- Homebuilders (under age 21)
- Electroconvulsive Therapy
- Intensive Outpatient
- Psychological and Neuropsychological Testing
- Residential Substance Abuse (per ASAM)
- Psychiatric Residential Treatment Facility (under age 21)
- Assertive Community Treatment (18 years and above)

Covered behavioral services, continued

- 23-Hour Observation Services
- Crisis Stabilization
- Peer Run Warm Line, supported by all Managed Care Organizations

CPST, PSR, Crisis Intervention and Nursing Homes

- Effective December 1, 2015, Medicaid State Plan Mental Health Rehabilitation (MHR) services became available to nursing facility residents. These services include PSR, CPST and Crisis Intervention.
- Nursing facility residents must meet the same diagnosis and LOCUS-based eligibility criteria as Members residing in the community.
- 51% of MHR services must be delivered in the community. MHR services for nursing facility residents must not duplicate services provided by the nursing facility or covered by Medicare or other payer sources.
- Providers can use Place of Service (POS) code 12 (home) when delivering CPST/PSR services to Members in nursing facilities.

Prior Authorization Requirements

No Authorization Required

- Pharmacologic Management
- Individual Psychotherapy
- Family Psychotherapy
- Group Psychotherapy
- Neuropsychological Testing

Authorization Required

- Inpatient Psychiatric Hospitalization
- Psychiatric Residential Treatment Facilities (PRTF)
- Inpatient Detoxification
- Ambulatory Detoxification
- Intensive Outpatient Program
- Assertive Community Treatment (ACT)
- Peer Support Services
- Therapeutic Group Homes
- Electroconvulsive Therapy (ECT)
- Psychological Testing
- Crisis Intervention (Services should be initiated at the time the crisis begins; an authorization request must be submitted within 24 hours following the onset of services)

New Requirements for MHR Services and EBP

- Beginning September 1, 2018 UnitedHealthcare Community Plan will require prior-authorization for MHR Services and Evidence Based Practices **not previously** requiring authorization.

Services Now Requiring Prior-Authorization

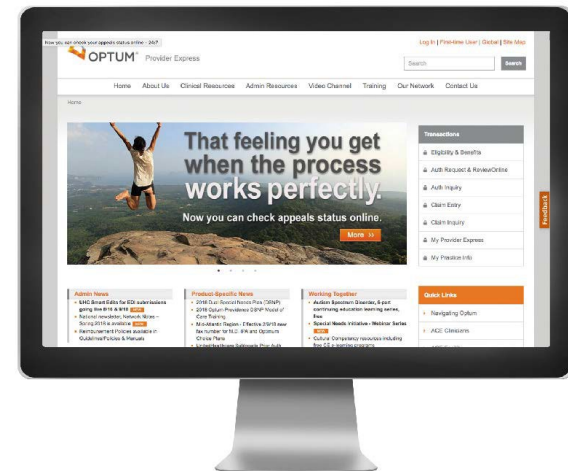
Pre-Authorization Now Required

- Community Psychiatric Support and Treatment (CPST)
- Psychosocial Rehabilitation (PSR)
- Multi-Systemic Therapy (MST)
- Functional Family Therapy (FFT)
- Homebuilders Services

* This includes CPST and PSR associated with the Permanent Supportive Housing Waiver

Provider Express

- All MHR services are now being prior authorized through a portal located on the Provider Express website
- To access the request form link go to: providerexpress.com
> Our Network > Welcome to the Network > Louisiana > Authorization Templates



Health LA MHR and EBP Request Form

Welcome to the Optum Network!

Louisiana Provider Resources

Optum Network Manual

- Network Manual
- LA Medicaid Behavioral Health Provider Manual 

Level of Care Guidelines

- LOC Guidelines

Best Practice Guidelines

- BP Guidelines

Algorithms for Effective Reporting and Treatment (ALERT)

- Intro to ALERT 
- ALERT Resources

Coordination of Care (COC)

- COC Flyer 
- COC Checklist 

LA Medicaid ABA

Louisiana Medicaid-Specific Resources

UnitedHealthcare and Optum to Support Louisianans Affected by Hurricane Harvey 

Louisiana Department of Health Behavioral Health Provider Manual

▶ General Information

▼ Authorization Templates

- Assertive Community Treatment (ACT) Template 
- Crisis Intervention Template 
- Electroconvulsive Therapy (ECT) Template 
- Healthy Louisiana Mental Health Rehabilitation and Evidence Based Practices Request Form (online)
- Substance Abuse Intensive Outpatient Program (SA IOP) Template 
- Therapeutic Group Home (TGH) Template 

▶ Healthy Louisiana Audit Tools

▶ Adverse Incident Reporting

▶ Level of Care Guidelines

▶ Archived Documents



Authorizations

- Authorizations can be requested in different ways:

Telephone: (866) 675-1607

- Mental Health Inpatient
- Substance Abuse Inpatient
- Residential Substance Abuse

At this time, these are the only services that are requested telephonically.

Fax: (855) 202-7023
Email: LA.Beh.Auths@uhc.com

- Psychiatric Residential Treatment Facility (PRTF)
- Electroconvulsive Therapy (ECT)
- Assertive Community Treatment (ACT)
- Crisis Intervention
- Intensive Outpatient (IOP)
- Therapeutic Group Home

Please Note: templates for authorizations that are submitted by fax or email are located on Provider Express: from the home page: Our Network > Welcome to the Network > Louisiana



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Medicare Primary Notification

- Providers have one business day from admit to verify Medicare benefits and request authorization if Medicare benefits are exhausted
- In the event Medicare benefits are exhausted during a Member's hospitalization, the provider has 24 hours from the date that Medicaid becomes the primary payer to request authorization

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
- Louisiana Behavioral Health Partnership (LBHP) Service Definitions Manual
- American Society of Addiction Medicine (ASAM) Criteria

Level of Care Guidelines can be found at providerexpress.com.

Optum does not reward Medical Directors or licensed clinical staff for issuing denials of coverage or service

Level of Care Utilization System (LOCUS®)

The Level of Care Utilization System (LOCUS) for Psychiatric and Addiction Services was developed by the American Association of Community Psychiatrists' Health Care Systems Committee Task Force on Level of Care Determinations.

The LOCUS is used to determine eligibility for Mental Health Rehabilitation Services for adults (ages 21 and older):

- Psychosocial Rehabilitation (PSR)
- Community Psychiatric Support and Treatment (CPST)
- Crisis Intervention
- Assertive Community Treatment (ACT)

For adults, the standardized assessment and LOCUS score sheet may be faxed to **(844) 480-5705**

Level of Care Utilization System (LOCUS[®]), continued

The LOCUS is completed by a Licensed Mental Health Professional (LMHP) who has received training on how to complete the LOCUS.

The assessment and LOCUS must be completed by your agency prior to services being rendered *and* **be updated on an annual basis and sent to us.**

There are three objectives:

- Provide a system for assessment of service needs for adult clients based on six evaluation parameters
- Describe a continuum of service arrays
- Create a methodology for quantifying the assessment, allowing for a reliable determination for placement in the service continuum

Level of Care Utilization System (LOCUS[®]), continued

The LOCUS assessment evaluates 6 dimensions:

- Risk of Harm
- Functional Status
- Medical, Addictive, and Psychiatric Co-Morbidity
- Recovery Environment
- Treatment and Recovery History
- Engagement

The outcome of the assessment provides a recommendation for the level of care. The assessment does not take the place of clinical judgment.

Rehabilitation Services

- CPST and PSR does require prior authorization; however,
 - For adults, the LOCUS and assessment is required to be completed and maintained in the Member’s record prior to service delivery; these must be updated annually **and** submitted to Optum as part of the CPST and PSR authorization process.. The state approved standardized assessment for adults and the LOCUS score sheet are located on makingmedicaidbetter.com.
 - For children and adolescents, CALOCUS and assessment is required to be completed and maintained in the Member’s record prior to service delivery; the assessment must be updated annually **and** submitted to Optum as part of the CPST and PSR authorization process.. A specific assessment is not required but the 1915c is recommended.
 - Assessment documents for adults, children/adolescent, CALOCUS and the LOCUS (for adults) may be scanned an attached to the [Healthy Louisiana Mental Health Rehabilitation and Evidence Based Practices Request Form \(online\)](#).

Rehabilitation Services, continued

- Assessments must be conducted by LMHPs. They cannot be conducted by an unlicensed provider even with a supervising clinician. Only HCPC services are allowable to be rendered by unlicensed providers (e.g., CPST, PSR).

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

Outpatient management

Reduced administrative burden

- We have removed precertification requirements for in scope services

Management strategy

- Algorithms for Effective Reporting and Treatment (ALERT)
- Practice Management

In scope services

- Individual/Group/Family Therapy
- Outpatient Addiction Services (ASAM level 1)

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.

Program Components

- Regular and comprehensive analysis of claims data by provider/provider group
 - Service/diagnostic/age distribution
 - Proper application of eligibility criteria
 - Appropriate frequency of service/duration of service
- Outreach to provider group when appropriate to discuss any potential concerns that arose from the claims analysis
- Potential outcomes from discussion
 - No additional action necessary
 - Program audit including record review
 - Corrective Action Plan (CAP)
 - Targeted precertification as part of CAP

Psychological Testing

- Information related to Psychological Testing is located on providerexpress.com
- Our clinical criteria for reviewing psychological and neuropsychological testing requests is located in the Psychological/Neuropsychological Testing Guidelines, (Provider Express > Quick Links > Guidelines/Policies & Manuals > Psychological/Neuropsychological Testing Guidelines)
- Psychological testing requests are made via faxed submission of completed Optum Psych Testing Request Form: From *Provider Express* home page > Quick Links > Forms > Optum Forms – Clinical > Optum Psych Testing Request Form and faxed to **(888) 216-4795**
- Upon review by our staff, providers are notified telephonically of authorizations or requests for peer-to-peer review to discuss the request

Cultural Competency

- As a health care provider, it is important for you to reMember to be culturally sensitive to the diverse population you serve:
 - There are diverse cultural preferences that we ask providers to keep in mind when serving Members
 - 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

Cultural Competency, continued

- 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
- Healthy Louisiana providers are required to complete 3 hours of Cultural Competency trainings on an annual basis.

Cultural competency, continued

- Providers shall take positive action to ensure that applicants for employment, employees, and persons to whom it provides service are not discriminated against due to race, creed, color, religion, sex, age, income, sexual orientation, gender identity, national origin, political affiliation, or disability. 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:
 - cms.hhs.gov/ocr – Office of Civil Rights
 - [LEP.gov](https://lep.gov) – Promotes importance of language access to federal programs and federally assisted programs
 - crosshealth.com – Quarterly newsletters on cultural competence topics for staff
 - diversityrx.org – Promotes language and cultural competence to improve the quality of health care for minorities
 - ncihc.org – Organization to promote culturally competent health care
 - focusondiversity.com – Provides statistics
 - providerexpress.com – Find key resources to help you on your journey, including free continuing education e-learning programs available through the Office of Minority Health, U.S. Department of Health & Human Services.

Importance and Value of Cultural Competence

- Given the diverse ethnic population in Louisiana, 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

Provider Quality Audits

- Provider audits are completed for a variety of reasons:
 - High volume Licensed Mental Health Professional (LMHP) office and agency treatment record reviews
 - At the time of Credentialing and Recredentialing for providers 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

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 five (5) audit tools for Louisiana Medicaid:
 - Organizational Provider Site Tool
 - Case Management Record Audit Tool
 - Psychosocial Rehab Record Audit Tool
 - Treatment Record Audit Tool
 - Fidelity Monitoring Tool
- The audit tools are posted to *providerexpress.com*: from the home page, choose Our Network > Welcome to the Network > Louisiana > Audit Tool Names

Documentation Standards

- Information regarding documentation standards for behavioral health providers can be located in 3 places:
 - Optum Network Manual (located on providerexpress.com): from the home page, choose Clinical Resources > Guidelines/Policies & Manuals > Optum Network Manual > Treatment Record Documentation Requirements
 - Louisiana Medicaid Behavioral Health Provider Manual (located on providerexpress.com): from the home page choose Our Network > Welcome to the Network > Louisiana > Louisiana Medicaid Behavioral Health Provider Manual)
 - Audit tools

Documentation Standards, continued

Highlights of documentation standards:

- A psychiatric history, including the presenting problem, is documented
- A medical history, including the presenting problem, is documented
- A current medical screening is documented; at minimum, options for documenting the screening include (but are not limited to):
 - Healthy Living Questionnaire 2011
 - Primary and Behavioral Health Care Integration (PBHCI) Medical Short Screening Form
- 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

Documentation Standards, continued

- 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

Documentation Standards, continued

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 Network Manual.

Integration of Physical and Behavioral Health

- It is essential to integrate physical and behavioral health services
- We require that coordination of care occur on a routine basis
- At the beginning of treatment, appropriate releases of information should be obtained to support coordination of care activities
- 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
 - The Member needs to be educated regarding how coordination of care is beneficial to their overall treatment

Prescription Monitoring Program (PMP)

- The Louisiana Board of Pharmacy in 2006 implemented an electronic system for the monitoring of controlled substances which are dispensed in the state of Louisiana
- The goal of the program is to improve the state's ability to identify and inhibit the diversion of controlled substances and drugs of concern in an efficient and cost-effective manner that shall not impede the appropriate utilization of these drugs for legitimate medical purposes
- Access to the program can be requested by visiting labppmp.com

Phone: **(866) 683-2476**

Email: LABPPMP@otech.com

Prescription Monitoring Program (PMP), continued

- Louisiana requires that prescribers query the PMP prior to initially prescribing a controlled substance to a Member
- The PMP query must be printed and placed in the Member's treatment record
- The PMP must be queried on an annual basis if a Member is prescribed a controlled substance; the printed copy is placed in the Member's treatment record
- Additional PMP queries may be conducted at the prescriber's discretion
- We will complete random chart audits of prescribers to monitor compliance to this process:
 - The audit will confirm that queries are placed in the Member's treatment record

Claims Submission

- Providers must submit claims using the current CMS Form 1500 or UB-04 with appropriate coding including, but not limited to, ICD-10, CPT, and HCPCS coding
- Louisiana Community Health Plan requires that you initially submit your claim within 365 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) (unique NPI's for rostered clinicians)
 - Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at [cms.gov](https://www.cms.gov)

Claims submission option 1 – online

Entry through uhcprovider.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 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 **(866) 842-3278**



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Claims submission option 2 – EDI/ Electronically

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

Claims submission option 2 – EDI/ Electronically, continued

- You may use any clearinghouse vendor to submit claims
- Payer ID for submitting claims is 87726
- Additional information regarding EDI is available on uhcprovider.com > resource library > EDI

Claims submission option 3 – hardcopy

- Use the Form 1500 claim form:
 - Claim elements include but are not limited to diagnosis **DSM-5**
 - 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 Healthcare Community Plan of Louisiana
PO Box 31341
Salt Lake City, UT 84131-0341

- Use DSM-5 for assessment and the associated ICD-10 coding for billing

Submitting a Claims Reconsideration Request

- In order to submit a claims reconsideration request, you must log into LINK on the uhcprovider.com webpage.
- Click on the box that says "UHC Claims Management" or "UHC Claims Reconsideration" to submit your request. **From the dropdown box, please ONLY select "Louisiana Behavioral Health Appeals Only".**
- Please refer to the training materials available in the Help section of the website for live webinars and Quick Reference Guides to assist with using LINK.

Louisiana Provider Services: (866) 675-1607

Electronic Payment & Statements (EPS)

With EPS, 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 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 UnitedHealthcare Community Plan of Louisiana.

Note: For more information, please call (866) 842-3278, option 5, or go to uhcprovider.com > Claims, Billing and Payments > Enroll in Electronic Payments and Statements.



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ACT 582: Legislation Summary


- This piece of legislation, now law, affects Behavioral Health Services Providers (BHSPs) who provide Psychosocial Rehabilitation (PSR) or Community Psychiatric Supportive Treatment (CPST) to Medicaid recipients.
- More specifically, it changed the law regarding several requirements for provider agencies and individuals providing services within those agencies.



What are the new requirements?

- Beginning January 1, 2019, UnitedHealthcare Community Plan (UHCCP) will require unlicensed staff rendering and receiving reimbursement for MHR services, to obtain and submit NPI numbers to UHCCP, prior to reimbursing agencies for services provided by these staff. This includes Evidence-Based Practice (EBP) MHR services.
- UHCCP will also require documentation verifying that non-licensed staff meet all qualifications and requirements for providing MHR Services.
- For more information regarding this requirement, please refer to the Non-Independently Licensed Clinician Roster Submission Train Deck located on the Louisiana Page of Provider Express.

Claims form – Form 1500 (formerly CMS 1500)



HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

<input type="checkbox"/> MEDICARE <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA (including ALE) <input type="checkbox"/> OTHER		<input type="checkbox"/> FECA <input type="checkbox"/> FECA (former)	
1. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE SEX	
5. PATIENT'S ADDRESS (No. Street)		7. INSURED'S ADDRESS (No. Street)	
CITY STATE		CITY STATE	
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		11. INSURED'S POLICY GROUP OR FECA NUMBER	
4. OTHER INSURED'S POLICY OR GROUP NUMBER		10. IS PATIENT'S CONDITION RELATED TO:	
6. RESERVED FOR NUCC USE		8. EMPLOYMENT? (Current or Previous)	
7. RESERVED FOR NUCC USE		12. INSURED'S DATE OF BIRTH SEX	
8. RESERVED FOR NUCC USE		9. OTHER CLAIM ID (Designated by NUCC)	
9. INSURANCE PLAN NAME OR PROGRAM NAME		13. IS THERE ANOTHER HEALTH BENEFIT PLAN?	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE	
SIGNED DATE		SIGNED DATE	
14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (EMPLOYEE ONLY)		15. OTHER DATE QUALIFYING	
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES	
18. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		19. OUTPATIENT LAB? \$ CHARGES	
21. ICD-9-CM OR NATURE OF ILLNESS OR INJURY (Include ICD-9-CM to service line below (IME))		22. RESUBMISSION CODE ORIGINAL REF. NO.	
24. A. DATES OF SERVICE B. PLACE OF SERVICE C. D. PROCEDURES, SERVICES, OR SUPPLIES (Include Unusual Circumstances) E. MONITORING F. POINTS G. CHARGES H. RATE OR UNIT I. IN. DUAL J. RENEWED PROVIDER ID #		23. PRIOR AUTHORIZATION NUMBER	
25. FEDERAL TAX ID NUMBER SSN/EIN		26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (If not, specify reason)	
28. TOTAL CHARGE 29. AMOUNT PAID 30. Reveal for NUCC Use		31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Include address of provider or supplier)	
32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH #	
SIGNED DATE		SIGNED DATE	

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



BH1808_012019



Form-1500 Provider Section

- Box 24J:** Licensed Mental Health Professionals and Non-Licensed Mental Health Professionals*, who render services enter their **NPI number** in the non-shaded portion.

* New Requirement for Licensed & Non-licensed Mental Health Professionals

24. A. DATE(S) OF SERVICE					B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID.#
From	To													
MM	DD	YY	MM											DD
													NPI	1234567890
													NPI	
													NPI	
													NPI	
													NPI	
													NPI	
													NPI	

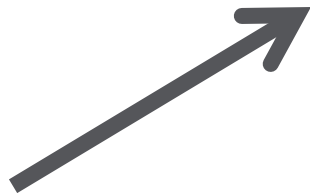
Form-1500 Provider Section, continued

- **Box 31:** Licensed Mental Health Professionals (LMHPs) who render services enter their name and licensure in Box 31.
- **Box 31:** Non-licensed providers who render services will now be required to enter their name and licensure in Box 31 blank.*

*New Requirement for Licensed and Non-Licensed Providers

**31. SIGNATURE OF PHYSICIAN OR SUPPLIER
INCLUDING DEGREES OR CREDENTIALS
(I certify that the statements on the reverse
apply to this bill and are made a part thereof.)**

SIGNED **DATE**



Form-1500 Provider Section, continued

- **Box 33:** Agency name, address, and phone number
- **Box 33a:** Agency NPI number

33. BILLING PROVIDER INFO & PH # ()

a. NPI	b.
--------	----

The diagram shows a rectangular box representing Form-1500 Box 33. The top portion of the box is labeled "33. BILLING PROVIDER INFO & PH # ()". Below this is a horizontal line, and underneath that line is a row of two sub-fields: "a. NPI" and "b.". A grey arrow points from the top right of the box down to the "33. BILLING PROVIDER INFO & PH # ()" text. Another grey arrow points from the bottom left of the box up to the "a. NPI" field.

Corrected Claim Submission for Form -1500

Box 22 – Form 1500

<input type="checkbox"/> YES <input type="checkbox"/> NO
M22. MEDICAID RESUBMISSION
CODE ORIGINAL REF. NO
7 17H123456789
62 PRIOR AUTHORIZATION NUMBER

Please input the number 7 for the Resubmission Code and the original UnitedHealthcare Claim Number under original Ref. No

Claim tips

To ensure clean claims remember:

- NPI numbers are always required on all claims
- A complete diagnosis is required on all claims

Claims filing deadline:

- UnitedHealthcare Community Plan allows claims submission of up to 365 days from the date of service

Claims Processing:

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

Balance Billing:

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

Claim tips, continued

Member Eligibility:

- Provider is responsible to verify Member eligibility through unitedhealthcareonline.com

Examples of coding issues related to claims denials:

- Incomplete or missing diagnosis
- Invalid or missing HCPCS/CPT codes
- Use of codes that are not covered services
- Required data elements missing, (e.g., number of units)

Provider information missing/incorrect

Prior Authorization required when:

- Required authorization missing
- Units exceed authorization (e.g., 10 inpatient days were authorized, facility billed for 11 days)

Billing tips

U8 Modifier:

- Always use the U8 modifier with the appropriate and consistent Place of Service (POS) code.

Age Modifiers:

- Always use the appropriate age modifier when indicated on the fee schedule.

One Exception: H2017 Individual vs. Group:

- For Individual Rehab – H2017, providers should bill their services with all proper modifiers and omit modifier HA, HB, and HQ. This will allow reimbursement to seamlessly be paid at the higher individual rehab rate.
- For Group Rehab – H2017, providers should bill their services with all proper modifiers and include modifier HQ or include modifier HA/HB, as appropriate by the age of the Member.

Same day billing tips

MD and LCSW: E & M and therapy (e.g., 99214 & 90832)

- Allowable on the same day, and each rendering provider must bill the service with their individual NPI

LCSW and LCSW: Assessment and therapy (e.g., 90791 & 90832)

- Not allowable on the same day for either same LCSW or two LCSWs

LCSW and LCSW: Group and individual therapy (e.g., 90853 & 90832)

- Allowable for either the same LCSW or two different LCSWs on the same day, as long as the rendering providers' NPI numbers are included for each appropriate separate and distinct service along with an appropriate modifier appended to CPT 90832. If it is different LCSWs with different Federal Tax Identification numbers then the 59 modifier is not required. If two LCSWs bill under the same Federal Tax Identification number then the modifier would be required to indicate a separate service.

Introduction to Fraud, Waste, Abuse & Error



Fraud

Example:

Knowingly billing for a service that was never performed.



Waste

Example:

Billing for services 5X per week when 1X per week would have been medically appropriate.



Abuse

Example:

Billing for a 90792 (diagnostic evaluation) when individual therapy was performed.



Error

Example:

A billing representative transposes numbers on a claim and submits it.

Program and Network Integrity (PNI) will:

- Carefully monitor for and take action to prevent FWAE
- Appropriately & consistently evaluate suspected FWAE
- Tailor corrective action to effectively stop/change the outlier behavior
- Offer a robust education program that engages the provider in changing outlier billing and coding behavior to accurately reflect the services rendered

PNI Evaluates the Optum Provider Network for FWA&E

- Retrospective Investigations
 - Example: Tip comes to PNI, information is gathered
 - Focus: “What really happened here?”
- Prospective Review
 - Example: A combination of procedures on a claim is detected by PNI flags or algorithms. The claim is reviewed before payment is released
 - Focus: “Let’s get more information before we pay this claim.”
- Business Intelligence / Data Analytics
 - Example: When running analytics on our historical claim data, we may find outliers, anomalies or patterns
 - Focus: “Let’s use ‘big data’ to detect outlier billing behavior.”
- Provider Education
 - Example: An Investigation has been completed and it has been determined that the provider requires an Education referral for better understanding of the coding concepts.
 - Focus: “Educate to genuine mistakes and misunderstandings while keeping an eye out for fraud.”
- Other strategic methods (such as forensic accounting) and supporting functions (such as compliance, quality, financial reporting)



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When and How to contact PNI

- When to contact PNI:
 - All of us have a duty to be vigilant regarding potential fraud, waste or abuse. Send a tip to PNI or reach out to a Member of the PNI team, whenever you see something that “doesn’t seem right.”
- How to contact PNI:

Contact Information for the Program and Network Integrity Department

Telephone: (877) 972-8844
E-mail for TIPs: optum.pni.tips@optum.com
Mail: P.O. Box 30535, Salt Lake City, UT 84130-0535
Fax: (248) 733-6379
General inquiries: optum.pni.communications@optum.com
Website:

Visit our Provider Express website at:

providerexpress.com/content/ope-provexpr/us/en/admin-resources/fraud--waste--abuse--error-and-payment-integrity.html



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Focus on Provider Education

Goal of the program: to create a robust Education Program that engages the provider in changing outlier billing and coding behavior to accurately reflect the services rendered.

- An educator teaches on the following concepts:
 - Outlier billing
 - Code definitions and intention of that particular code
 - 1995/1997 Coding Guidelines
 - Documentation standards
 - Current CPT, HCPCS and ICD-10 guidelines and references
 - Code combinations that may not be acceptable due to National Correct Coding Initiative (NCCI) edits
 - Provides references that would assist the provider in determining their billing needs
- Overall, the reception of the Provider Education program has been very favorable. It is a great way to prevent waste and abuse while helping deter and prevent fraud.

Additional Details on Provider Education

- We listen then respond and follow-up with you
- Assist with understanding of coding concepts
- Maintain interactive, respectful discussions with you to address your specific concerns
- Provide links and references for source of truth to support future billing
- Facilitate collegial meetings with other departments to assist in a more productive exchange of ideas and plans

Member website: Live and Work Well

- liveandworkwell.com 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

Provider and Member resources

Educational information is available on liveandworkwell.com (Log-in and from the home page, choose BeWell)

BeWell Health & Well-Being	WorkWell Education, Work & Career	My Benefits & Programs
<p>Living Healthy</p> <ul style="list-style-type: none"> Aging Well Brain Health & Fitness Exercise & Fitness Healthy Eating Holidays & Vacations Pets Relaxation & Hobbies Sleep Socializing Volunteering & Community Service <p>Coping & Resiliency</p> <ul style="list-style-type: none"> Alternative Therapies Controlling Anger Coping & Peace of Mind Coping with Change Grief & Loss Recovery & Resiliency Responses to Trauma Care & Treatment Mindfulness 	<p>Addictions</p> <ul style="list-style-type: none"> Alcoholism Children & Addiction Other 'Addictions' Drug Use Tobacco <p>Conditions by Name</p> <ul style="list-style-type: none"> Abuse & Neglect: Child Abuse : Domestic Violence Abuse & Neglect: Elder ADHD (Adult) ADHD (Youth) Alzheimer's & Dementia Anxiety Arthritis Asthma Autism Bipolar Disorder (Adult) Bipolar Disorder (Youth) Cancer Childhood Illnesses 	<ul style="list-style-type: none"> Chronic Pain Depression (Adult) Depression (Youth) Diabetes Eating Disorders (Adult) Eating Disorders (Youth) Heart Disease & Circulatory Disorders HIV Infertility Obesity Obsessions & Compulsions Personality Disorders Phobias Postpartum Depression Post-Traumatic Stress Disorder Schizophrenia (Adult) Schizophrenia (Youth) Sexual Problems Stress Traumatic Brain Injury




LA Medicaid Quick Reference Guide (QRG)

Louisiana Medicaid-Specific Resources

LA NILC Medicaid Provider Registration Form - Please use this form to provide all necessary information needed to submit your roster of unlicensed or non-independently licensed clinicians (NILCs). Before submitting, verify that the NILCs have obtained individual NPI numbers and are ready to be registered with the UHC Community Plan. By initialing this document, you and the individual providers are attesting that all information is true and accurate and all requirements have been completed as identified in the Louisiana Department of Health Behavioral Health Services Provider Manual.

Louisiana Department of Health Behavioral Health Provider Manual

▼ General Information

- Behavioral Health Provider Training Deck 
- Cultural Competency Training Presentation 
- Cultural Competency Training Resources 
- LA Medicaid QRG
- MHR Prior Auth FAQ



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 Electronic Payments and Statements (EPS)
 - To request a user ID to the secure transactions on the uhcprovider.com, select New User from the Home Page; you may obtain additional information through the Help Desk at **(866) 842-3278**
- For Member eligibility, claim status, and reference materials, go to uhcprovider.com > Menu > Resource Library
- Customer Service for website support: **(800) 600-9007**

UHCprovider.com: LINK

MENU **UnitedHealthcare** What can we help you find? **MEMBERS** **FIND DR.** **LINK** **NEW USER** **SIGN IN**

Resources for physicians, administrators and healthcare professionals

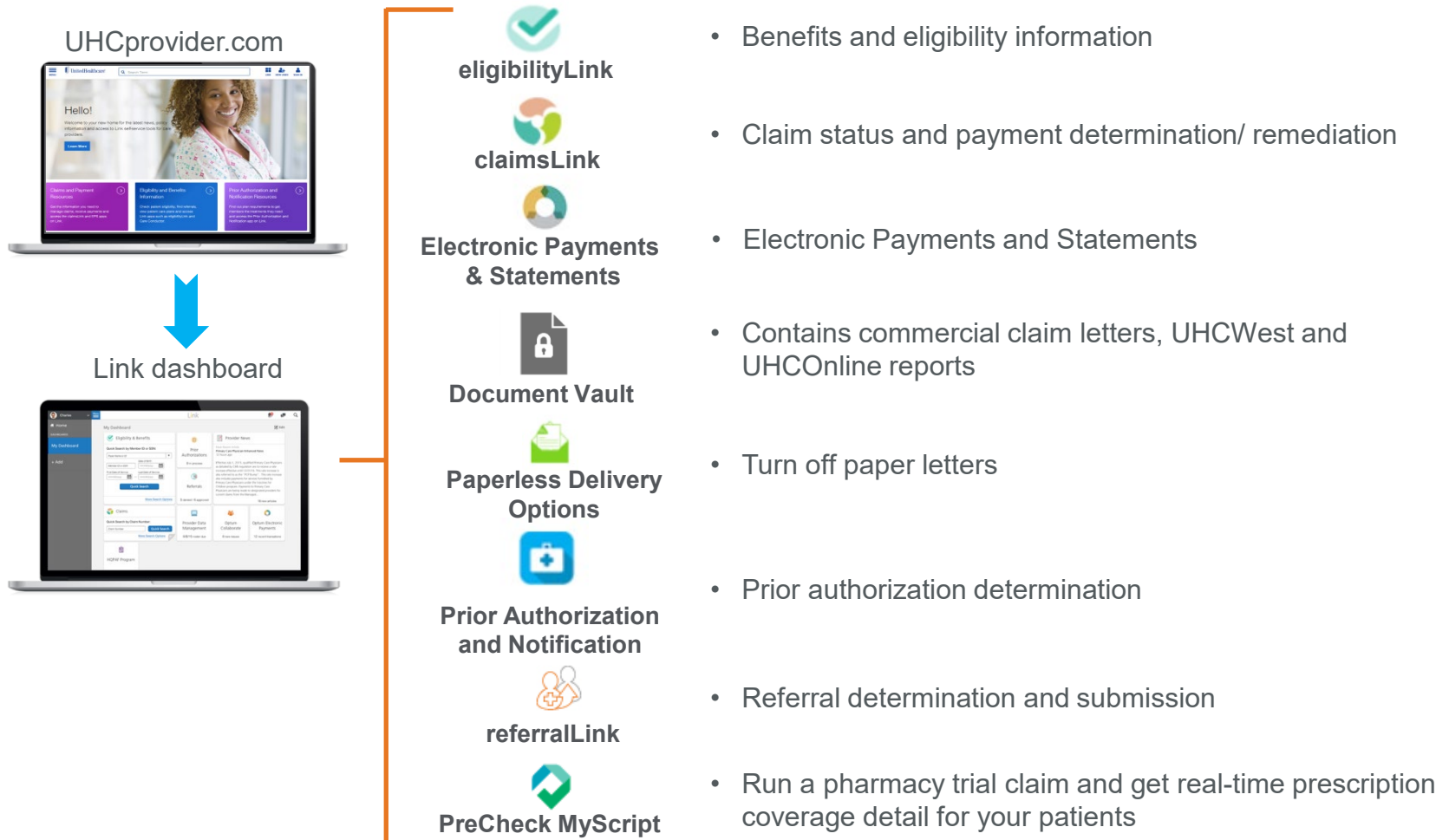
Hello!

Welcome to your new home for the latest news, policy information and access to Link self-service tools for care providers.

[Learn More About Site Features](#)

- Claims and Payments**
[Learn More](#)
- Eligibility and Benefits**
[Learn More](#)
- Policies and Protocols**
[View Current](#)
- Prior Authorization and Notification**
[Learn More](#)

Access all of these online tools and resources in a single website:



LINK Dashboard

The dashboard features a search bar on the left and a grid of service tiles on the right. The search bar includes fields for Payer Name (UnitedHealthcare - 87726), Member ID, Date of Birth, First Date of Service, and Last Date of Service. The grid contains 14 tiles: UnitedHealthcare Eligibility & Benefits, Prior Authorization and Notification (highlighted), UnitedHealthcare Claims Reconsideration, claimsLink, UnitedHealthcare Claims Management, UHC On Air, Electronic Payments & Statements, My Practice Profile, UHCprovider.com Policies, News Guides & More, Link Resource Library, and UnitedHealthcare Community Plan.

Provider Express

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 Louisiana Medicaid providers access to provider-specific information.

Provider Express, continued

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
- Louisiana page (from the Home Page, choose Our Network > Welcome to the Network > Louisiana)

Provider Express, 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 **(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 – Log In

[Log In](#) | [First-time User](#) | [Global](#) | [Site Map](#)

Search

Search

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

Home



Substance Use Disorder Helpline.

24/7 support for providers and patients dealing with Substance Use Disorder.

1-855-780-5955

[More >>](#)

Transactions

- Eligibility & Benefits
- Claims
- Authorizations
- Appeals
- My Practice Info
- and More....

Provider Express – Tech Support Live Chat feature

If you are contracted in the Optum/OHBS-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

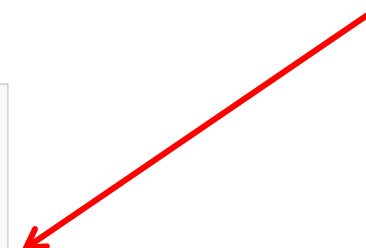
Groups/Practices (contracted for outpatient, professional services):

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)

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 7 A.M. to 9 P.M. Central time or chat with a tech support representative online.



[Security Notice](#) | [Privacy](#) | [Site Use Agreement](#) | [Site Map](#)

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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:	<input type="text" value="John Doe"/>
NPI:	<input type="text" value="not on file"/>
Taxonomy code:	<input type="text" value="View Taxonomy Code(s)"/>
Licensure:	<input type="text" value="MD - Medical Doctor"/>
Language(s):	<input type="text" value="ENGLISH"/>
Clinician E-mail Address:	<input type="text" value="email@email.com"/>
Gender:	<input type="text" value="M"/>
Medicaid Number:	<input type="text"/>
Medicare Number:	<input type="text"/>
Expertise:	<div style="border: 1px solid #ccc; padding: 5px; min-height: 50px;">Expertises listed here</div>
Ethnicity:	<input type="text" value="none listed"/>
Tax Id(s):	<input type="text" value="99999999"/>

Practice Addresses by Tax ID

Please select a Tax ID:

Tax ID	Practice Name	Primary Address
99999999	Doe, John A.	123 Anywhere Street Somewhere 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.

Credentialing 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 Credentialing Address to update.

[123 Anywhere Street](#)
[Somewhere USA 55555](#)



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My Practice Info – Clinician Addresses

- 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. **Add New Address**

Delete	Address	Primary	Mailing	Remit	Practice	Accepting?	Phone	Secured Fax	Address Conditions
		<i>Only one per column</i>			<i>Select all that apply</i>				
<input type="checkbox"/>	123 Anywhere Street Somewhere USA 55555	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="checkbox"/>	Yes	555-555-5555	666-555-5555	None Listed

1099 Address

Address	Phone
123 Anywhere Street Somewhere USA 55555	(555)555-5555

Submit All Changes Remember to click the "Submit All Changes" button when you are done making your updates.

Primary	Primary practice address	Remit	Remit address
Mailing	Primary mailing address	Practice	Secondary practice address
1099	1099 mailing address	Accepting?	Accepting new patients?

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

My Practice Info - Review Practice Profile

Practice Name: Practice Name
Tax ID Number: 999999999 [update](#)
NPI: 1111111111
Medicaid Number: [add](#)
Medicare Number: [add](#)

[View Address Info](#)

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

Contact Name	Contact Phone Number	Action
First Last Name	555-555-5555	update

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](#).

One item found.1

Providers	NPI
Name, Provider	1234567890

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.

Address	Address Type	Phone	Secured Fax	Conditions of Address	Action
123 Anywhere Street Somewhere USA 55555	Remit, Practice, Primary	(555)555-5555		None Listed	update delete

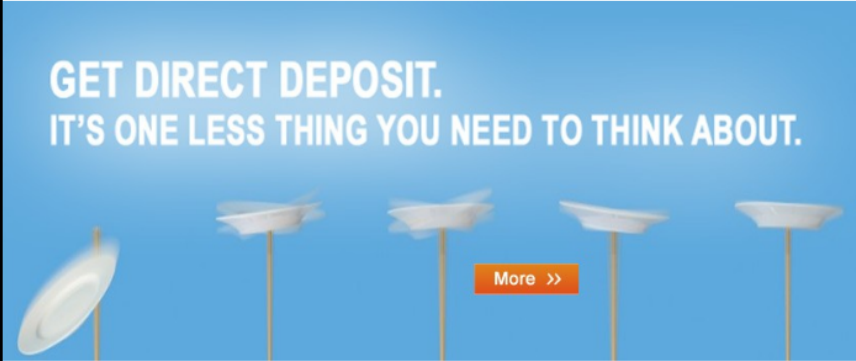
[Add New Location](#)



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Clinician Add/Change Form



Transactions

- Eligibility & Benefits
- Auth Request & ReviewOnline
- Auth Inquiry
- Claim Entry
- Claim Inquiry
- My Provider Express
- My Practice Info

Autism/ABA Corner

- Autism/ABA Information
- ABA Commercial Providers: As of 2/1/16 you will no longer fax in reviews

Admin News

- 1099 Hotline: (866) 343-0236**
- Attending Information Requirements for all Hospital-Based (UB-04) Claims
- Introducing Compass Plans via UHC for small business
- Clean Claim Submission Guidelines for Outpatient Services on the UB-04

State & Product-Specific News

- AZ: LTC changes for providers**
NEW
- IA: Health Link Training for BH Providers
- MD: Uniform Treatment Plan Notification
- NY: Medicaid Changes for Providers
- LA: Medicaid Changes for Providers
- MA: Senior Care Options (SCO) Changes for Providers

Working Together

- ICD-10 and DSM-5 Resources
- Haven't migrated your Provider Express account to Optum ID? You have until the end of March.**
NEW
- ICD-10 claim submission support – View pre-recorded Webinar
- Medicare HMO Benefits: Transfers to In-Network Facilities
- Our Medical Behavioral Integration series is full; recordings and materials available
- Learn about the ACE Clinicians program
- ACE Facility - learn more about this new program
- Healthcare Cost Estimator FAQs

Quick Links

- Individual Provider Disclosure Form
- ACE Clinicians
- ACE Facility
- Medication Assisted Treatment
- LAI Medication
- Clinician Add/Change Form
- Join Our Network

Clinician Add/Change Application Form

- What would you like to do?
 - Add new (Additional) Tax Identification Number (TIN) and related practice information
 - Delete an existing TIN
 - Change existing TIN to a new TIN
 - Add new practice location in a new state for existing TIN
 - Demographic changes

RETURN THIS SIGNED FORM AND APPLICABLE ATTACHMENTS TO YOUR NETWORK MANAGEMENT TEAM.

Attention: Louisiana Network

Fax: (855) 228-3939

Important Reminder

Please update your rosters within 10 days of a change on providerexpress.com

Provider responsibilities

- Render services to Member in a non-discriminatory manner:
 - Maintain availability for a routine level of need for services
 - Offer routine non-urgent appointments within 14 days of the request for services
 - Provide after-hours coverage
 - Support Members in ways that are culturally and linguistically appropriate
- Determine if Member have benefits through other insurance coverage
- Advocate for Member 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

Adverse Incident Reporting Form 326

- Providers are required to notify the health plan within **24 hours** of the occurrence of a reportable adverse incident involving a health plan Member, whether it occurs at the provider's location or at another location.
- The report and instructions can be found at:
<http://new.dhh.louisiana.gov/index.cfm/page/2454>

Note: The definition of adverse incident for the 326 reporting may be broader than required by JCAHO. Please refer to 326 instructions for the definition and reporting requirements.

Access to care standards

<p>Routine Outpatient, Mental Health and Substance Use</p>	<p>Members will be offered an initial appointment within 14 days</p>
<p>Urgent If not addressed in a timely way could escalate to an emergency situation</p>	<p>Members will be offered an appointment within 24 hours</p>
<p>Life threatening emergencies Imminent risk of harm or death to self or others due to a medical or psychiatric condition</p>	<p>Referral is Immediate</p>
<p>Post Inpatient Discharge If you are unable to see the Member during this time – refer to another in-network provider to satisfy this deadline</p>	<p>All Members must be seen within 7 days post discharge</p>
<p>Special Health Care Needs Intravenous (IV) drug users identified as having used drugs within the last 6 months, will need to be seen for treatment</p>	<p>Within 14 calendar days of initial contact</p>
<p>Missed an Appointment Optum will contact Members who have missed a post-discharge appointment to reschedule that appointment</p>	<p>Within 24 hours to schedule an appointment; within 30 days of the hospital discharge if outside of the 7 day period</p>

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
 - Signed Louisiana Medicaid Addendum:
 - One per clinician pursuing individual contracting
 - One per agency/group if pursuing a group contract
- 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



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Join Our Network, continued

CMHCs, FQHCs, Agencies and Groups:

- For LGE/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

Supervisory Protocol Addendum

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

- Only applies to HCPC codes on the Louisiana Department of Health published fee schedule
- 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

The Credentialing Committee

A standing committee, chaired by an Optum Medical Director (licensed psychiatrist), 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)

The Credentialing Committee, continued

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 clinicians in the service area

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

Contact Information

Important Phone Numbers, Emails, and Fax Numbers:

- Louisiana Provider Services: **(866) 675-1607**
- For Pharmacist: **(866) 328-3108**
- For BH Authorizations: LA.Beh.Auths@uhc.com or Fax: **(855) 202-7023**
- For Assessments (Adults & Youth), CALOCUS and LOCUS (Adults): Authorizations for CPST, PSR, FFT, MST, and Homebuilders can be submitted using the Healthy Louisiana Mental Health Rehabilitation and Evidence Based Practice Request

Important Addresses:

- Behavioral Health or Medical Claims -
PO Box 31341, Salt Lake City, UT 84131-0341
- Pharmacy Claims -
OptumRX, PO Box 29044, Hot Springs, AR 71903
- Website – uhcprovider.com
- Website – providerexpress.com



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Contact Information (continued)

Louisiana Medicaid Network Services

(866) 675-1607

or

networkse@optum.com



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Thank You

We Appreciate Your Attendance Today



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