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Mass General Brigham Health Plan ACO Model A Medicaid ABA

Program Provider Orientation

Published January 2023

BH4628 01/2023

Introductions and Background

Mass General Brigham Health Plan

Effective January 1, 2023, AllWays Health Partners became Mass General Brigham Health Plan

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Optum, the behavioral health partner for **Mass General Brigham Health Plan** is a leading health services organization dedicated to making the health system work better for everyone.

Mass General Brigham ACO currently partners with MassHealth as the payer. Starting April 1, 2023, Mass General Brigham (the delivery system) will partner with Mass General Brigham Health Plan for ACO patients. Members who have MGB ACO today will remain with MGB ACO unless they opt for another plan/provider.

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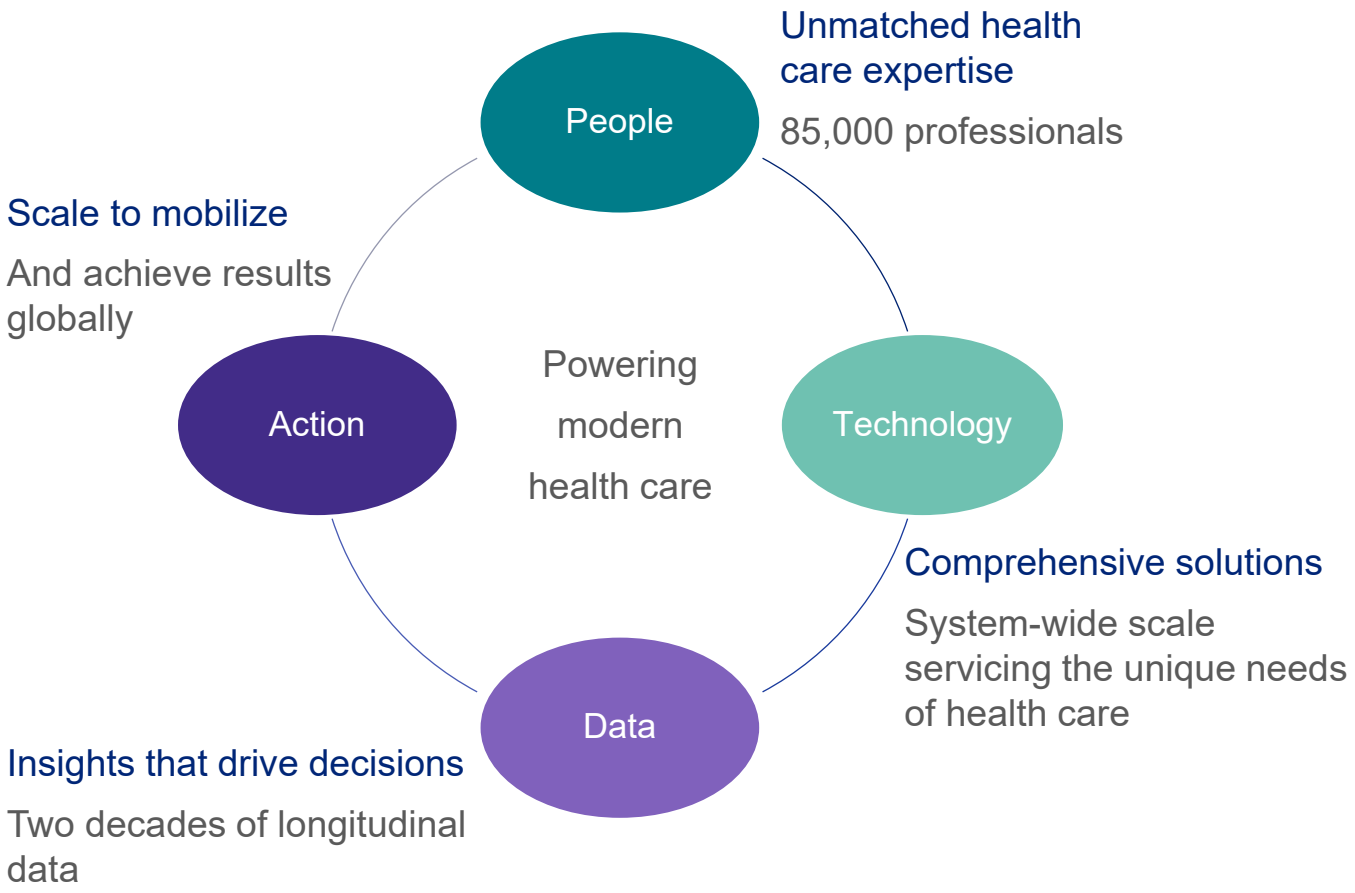
Who is Optum?

- 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:
  1. Engaging the consumer
  2. Aligning care delivery
  3. Modernizing the health system infrastructure



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Who is Optum?

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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.

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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

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Optum Autism/ABA Member Information

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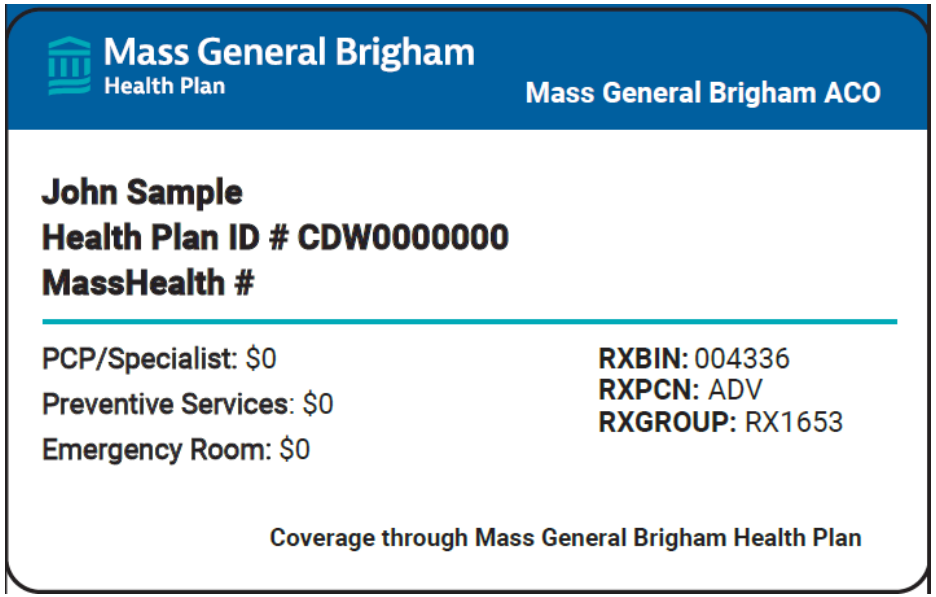
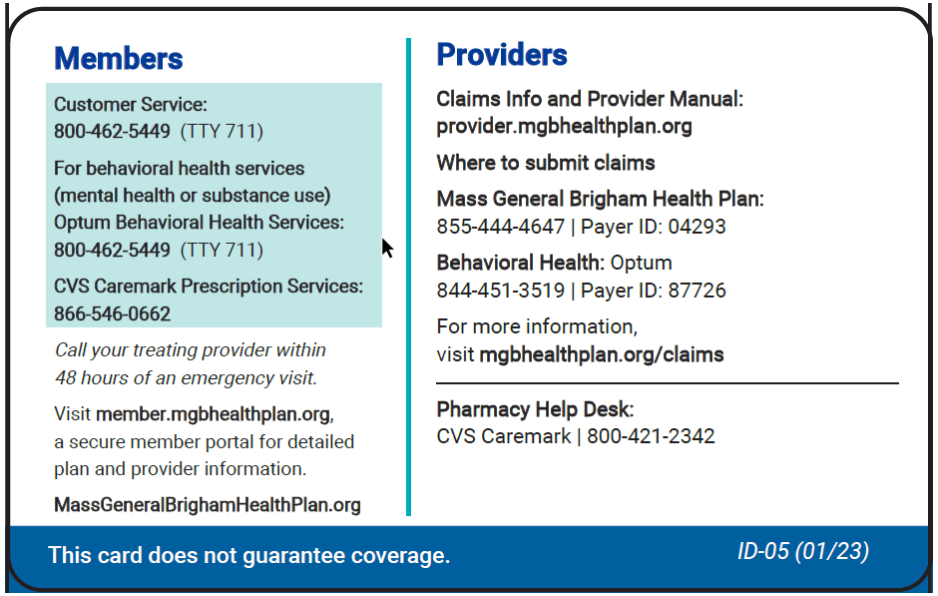
Member ID card

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





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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

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Member website

Live and Work Well 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.

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Who is eligible?

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

- Be 21 or younger
- Be covered under Mass General Brigham Health Plan Medicaid Program

AND:

- Have a documented Autism Spectrum Diagnosis, as defined by the most current version of the *Diagnostic and Statistical Manual (DSM-5)*

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ABA Program Services

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ABA Credentialing Criteria (1 of 2)

Individual Board-Certified Behavior Analysts—Solo Practitioner

- Board Certified Behavior Analyst (BCBA) with active certification from the national Behavior Analyst Certification Board, and
- State licensure
- 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 one million per occurrence/one million aggregate

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ABA Credentialing Criteria (2 of 2)

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 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
- Paraprofessionals 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 paraprofessionals in joint sessions with client and family
- One million/occurrence and Three million/aggregate of professional liability and $1m/$1m of general liability if services are provided in a clinic setting
- One million/occurrence and three million/aggregate of professional liability and $1m/$1m of supplemental insurance if the agency provides ambulatory services only (in the patient's home)

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Required: NPI and EIN/TIN

Massachusetts Medicaid enrollment is required to provide services

National Provider Identifier (NPI):

- Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of standard unique identifiers for health care providers and health plans
- The purpose of these provisions is to improve the efficiency and effectiveness of the electronic transmission of health information
- We require that all claims submitted have an NPI number and taxonomy codes for reimbursement

To obtain an NPI number, follow the instructions on the NPI web site:

- nppes.cms.hhs.gov

Tax Identification Number (TIN), Employee Identification Number (EIN), or Social Security Number (SSN) information:

- nppes.cms.hhs.gov

Tax Identification Number (TIN), Employee Identification Number (EIN), or Social Security Number (SSN) information:

- irs.gov
- Apply for an Employer Identification Number (EIN) Online | Internal Revenue Service (irs.gov)

Professional Liability Insurance:

- BACB - Behavior Analyst Certification Board has coverage information; enter “liability in the site’s “Search” feature located in the right side of the menu

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ABA Remote supervision

Optum allows BCBAs/Licensed BH Clinicians within contracted ABA practices to conduct ABA supervision and/or caregiver training via telehealth.

In order to be eligible to provide ABA remote supervision via videoconferencing technology you must do the following:

1. Complete and submit a virtual visits attestation on our virtual visits page of Provider Express and you will be notified of approval or denial:
   - Complete the Autism/ABA Remote Supervision Compliance Attestation by clicking here, and faxing it to your Regional ABA Network Manager
   - Ensure that your videoconferencing technology is HIPAA compliant and meets current American Telemedicine Association minimum standards
   - After you receive approval from your Regional ABA Network Manager, you must indicate on each applicable treatment request that ABA remote supervision will be utilized
2. Billing for ABA remote supervision services:
   - Continue to bill for supervision with H0032, whether performed remotely or in person

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Steps in Providing Treatment

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Clinical Team: Mass General Brigham Health Plan

Enhanced Autism/ABA Clinical Team

There is a dedicated, enhanced autism/ABA clinical team that will be supporting the Mass General Brigham Health Plan ABA program:

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

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Intake

At intake:

- Copy front and back of the member's insurance card
- Record subscriber's name and date of birth

Additional information to obtain from the member:

- Consent for services
- Informed Consent: services, to leave voicemail, email, etc.
- Release of Information to communicate with other providers
- Consent for billing using protected health information, including signature on file

Information to provide to the member or subscriber:

- Your HIPAA policies
- Your billing policies and procedures

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Release of information

- We release information only to the individual, or to other parties designated in writing by the individual, unless otherwise required or allowed by law
- Members must sign and date a Release of Information for each party that the individual grants permission to access their PHI, specifying what information may be disclosed, to whom, and during what period of time
- The member may decline to sign a Release of Information which must be noted in the Treatment Record; the decline of the release of information should be honored to the extent allowable by law
- PHI may be exchanged with a network clinician, facility or other entity designated by HIPAA for the purposes of Treatment, Payment, or Health Care Operations

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Eligibility and prior authorization

- Call the number on the back of the member's insurance card to see if member is eligible for your services or verify on provider portal
- Check benefit coverage relating to both the service and the diagnosis on provider portal or by calling the number on the member's insurance card.
- Make sure all services receive prior approval before beginning services
- When calling the Autism Care Advocate, you must have:
  - ❑ Member's name
  - ❑ ID #
  - ❑ Date of birth
  - ❑ Address
- Prior authorization required for all ABA services
- Treatment Authorization Request Form can be submitted either online at electronicforms.force.com/ABATreatment/s/ or via fax at **1-888-541-6691**
- Meet Medical Necessity -this applies to initial and concurrent reviews
- Provider must submit the results of the ABA assessment and the treatment request for any treatment requests

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Prior Assessment Authorization – online portal submission

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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.

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Clinical information requirements for each review

- Confirmation member has an appropriate DSM-5 diagnosis that can benefit from ABA
- 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 IBT 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.

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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)

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Prior Assessment Authorization – online portal submission

Mass General Brigham Health Plan

Mass General Brigham Health Plan is one of the selected managed care plans within the state of Massachusetts providing coverage to the MassHealth membership.

Optum collaborates with Mass General Brigham Health Plan and is responsible for securing and managing the Autism/ABA Network for this initiative, effective 1/1/2019. Your participation in our network helps to ensure access to comprehensive quality care for covered behavioral health services for enrolled members.

- Mass General Brigham Health Plan
- Mass General Brigham Health Plan - Quick Reference Guide
- Mass General Brigham Health Plan ABA Treatment Request Form and Guidelines
- Mass General Brigham Health Plan ABA Treatment Request Form - Electronic Submission
- Mass General Brigham Health Plan ABA Rate & Code Change Provider Alert

Contact Us:
Please contact Heather Willis, Specialty Network Manager,
at heather.willis@optum.com to learn more about this network .

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Coding, Billing and Reimbursement

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Mass General Brigham Health Plan Fee Schedule

UNITED BEHAVIORAL HEALTH			
Billing Code	Modifier	Service Description	Units
97151		Behavior identification assessment administered by a physician or other qualified health care professional, each 15 minutes of the physician's or other qualified health care professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments; discussing findings and recommendations and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan. (Initial functional behavior assessment and reassessment)	15 min
97153		Adaptive behavior treatment by protocol; administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes. (Adaptive behavior treatment)	15 min
97154		Group adaptive behavior treatment by protocol; administered by technician under the direction of a physician or other qualified health care professional, face-to-face with two or more patients, each 15 minutes. (Social skills group, up to 8 participants)	15 min
97155		Adaptive behavior treatment with protocol modification; administered by physician or other qualified health care professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes. (Adaptive behavior treatment)	15 min
97156		Family adaptive behavior treatment guidance; administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes. (Parent training with or without child present)	15 min
97157		Multiple-family group adaptive behavior treatment guidance; administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes. (Multiple group parent training, up to 8 participants)	15 min
H0031	U2	Mental health assessment by physician or other qualified health professional. (Assessment and case planning for home services by a licensed professional, each 15 minutes.)	15 min

1	Per Hour or Unit 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	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.
3	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).
4	Proper billing form: CMS 1500

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Claims submission

All Autism/ABA Claims must be:

- Submitted on a Form 1500 (v.02/12) claim form
- Submit electronically using an EDI clearinghouse and payer ID # 87726
- Include appropriate taxonomy codes
- Mass General Brigham Health Plan requires that you initially submit your claim within 90 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

Please send paper claims to:

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

Claims status can be obtained by calling the Claims Customer Service Center:

- Optum – **1-888-980-8728**
- Logging into providerexpress.com or UHCprovider.com

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Claims submission (cont.)

All claim submissions must include:

- Member name
- Medicaid identification number
- Member Health Plan ID number
- 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

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Claims submission, Option 1- Online

Log on to providerexpress.com

Secure HIPAA-compliant transaction features streamline the claim submission process:

- Performs well on all connection speeds
- Submitting claims closely mirrors the process of manually completing a Form 1500 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**

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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:

- 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

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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:

- EDI Contacts | UHCprovider.com

and

- providerexpress.com

Electronic Data Interchange (EDI) Support Services:

- Provides support for all electronic transactions involving claims and electronic remittances

EDI Issue Reporting Form:

- This form should be used to report EDI related issues
- Providers can also call us at **1-800-210-8315** or e-mail us at ac_edi_ops@uhc.com

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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/registrationSignIn.do

Here's what you'll need:

- Bank account information for direct deposit
- Voided check or bank letter to verify bank account information
- A copy of your practice's W-9 form

If a provider is already signed up for Optum Pay with UnitedHealthcare, they will automatically receive direct deposit and electronic statements through Optum Pay for UnitedHealthcare Community Plan of Massachusetts when the program is deployed.

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Claims Tips

To ensure clean claims:

- An NPI number and taxonomy code is always required on all claims
- Complete diagnosis is also required on all claims

Claims Filing Deadline:

- Providers have 90 days from the date of service to file claims

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

Examples of coding Issues related to claims denials:

- Incomplete or missing diagnosis
- Invalid or missing HCPCS/CPT codes and modifiers
- Use of codes that are not covered services
- Required data elements missing, (e.g., number of units)
- Provider information is missing/incorrect
- Required authorization missing
- Units exceed authorization (e.g., 10 inpatient days were authorized, facility billed for 11 days)

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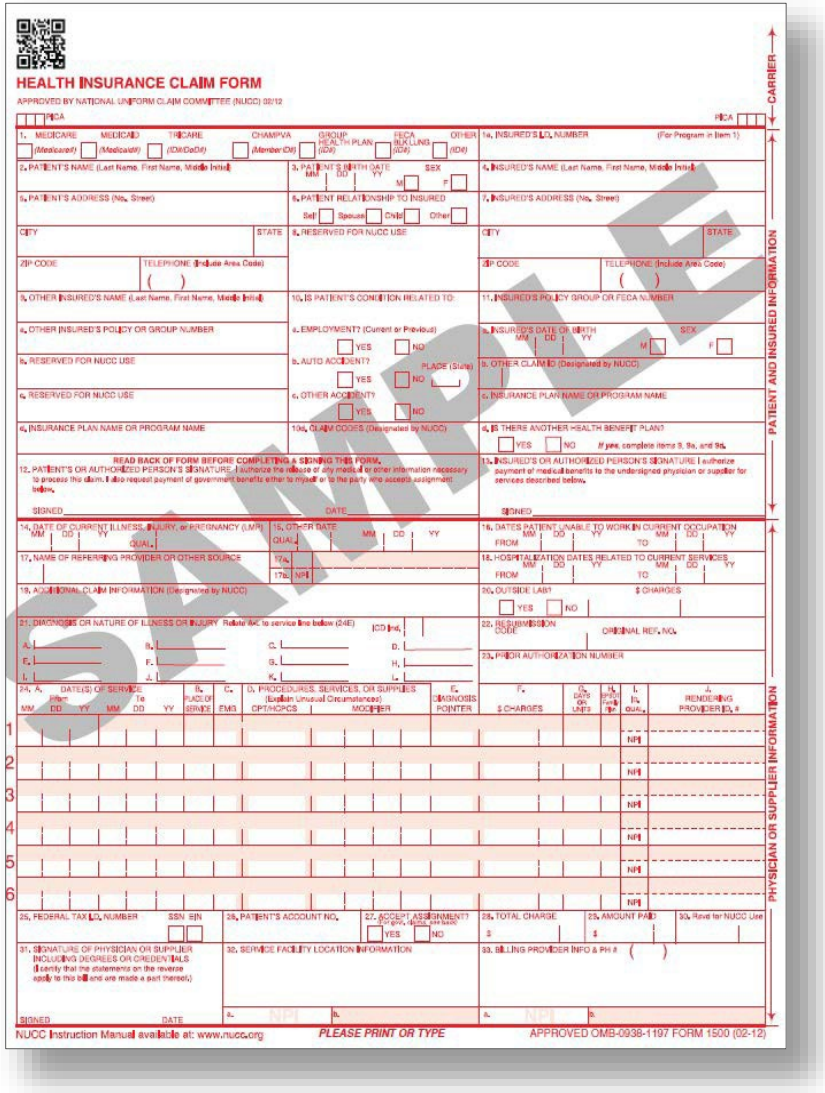
Form 1500 - claim form

All billable services must be coded:

- Coding can be dependent on several factors:
  - ❑ Type of service (assessment, treatment, etc.)
  - ❑ 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 follow billing instructions provided by your Network Manager based on your contract and system set-up.



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Diagnostic coding

Guides for Coding:

- DSM-5 defined conditions:
- Current autism diagnosis, F84.x
- A complete diagnosis with all 4 digits is required on all claims utilizing the ICD-10 coding

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Appeals

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Appeals

Provider Disputes

- Optum has a formal process for handling practitioner/facility disputes that is compliant with the standards and regulations set forth by National Committee for Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) and state/federal regulations. These standards and regulations serve as guidelines to ensure that:
- Review turnaround time requirements are met
- Appropriately qualified professionals are involved in the review of practitioner/facility disputes
- Relevant clinical/administrative information is consistently gathered and reviewed as part of the investigation
- Practitioners/facilities are informed of the rationale for disputes that are upheld, in whole or in part

One (1) level of internal dispute review is available through Optum, unless required by state law or contractual requirement.

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Appeals: Standard and Expedited

Non-Urgent (Standard)

- MassHealth (Medicaid): must be requested within 60 calendar days from receipt of the notice of adverse determination
- Optum will make an appeal determination and notify the practitioner or facility in writing within 30 calendar days of receipt of request

Urgent (Expedited)

- Practitioner/facilities can file an urgent appeal on behalf of a member
- Must be requested as soon as possible after the adverse determination
- Optum will make a reasonable effort to contact you prior to making a determination on the appeal. If Optum is unsuccessful in reaching you, an urgent appeal determination will be made based on the information available to Optum at that time
- Notification will occur as expeditiously as the member's health condition requires, not exceeding 72 hours of the receipt of the request

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Appeals

To submit an appeals please send request to the Provider Appeals Address:

Optum Appeals & Grievances
P.O. Box 30512
Salt Lake City, UT 84130-0512

Fax: **1-855-312-1470**

Phone: **1-866-556-8166**

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Resources

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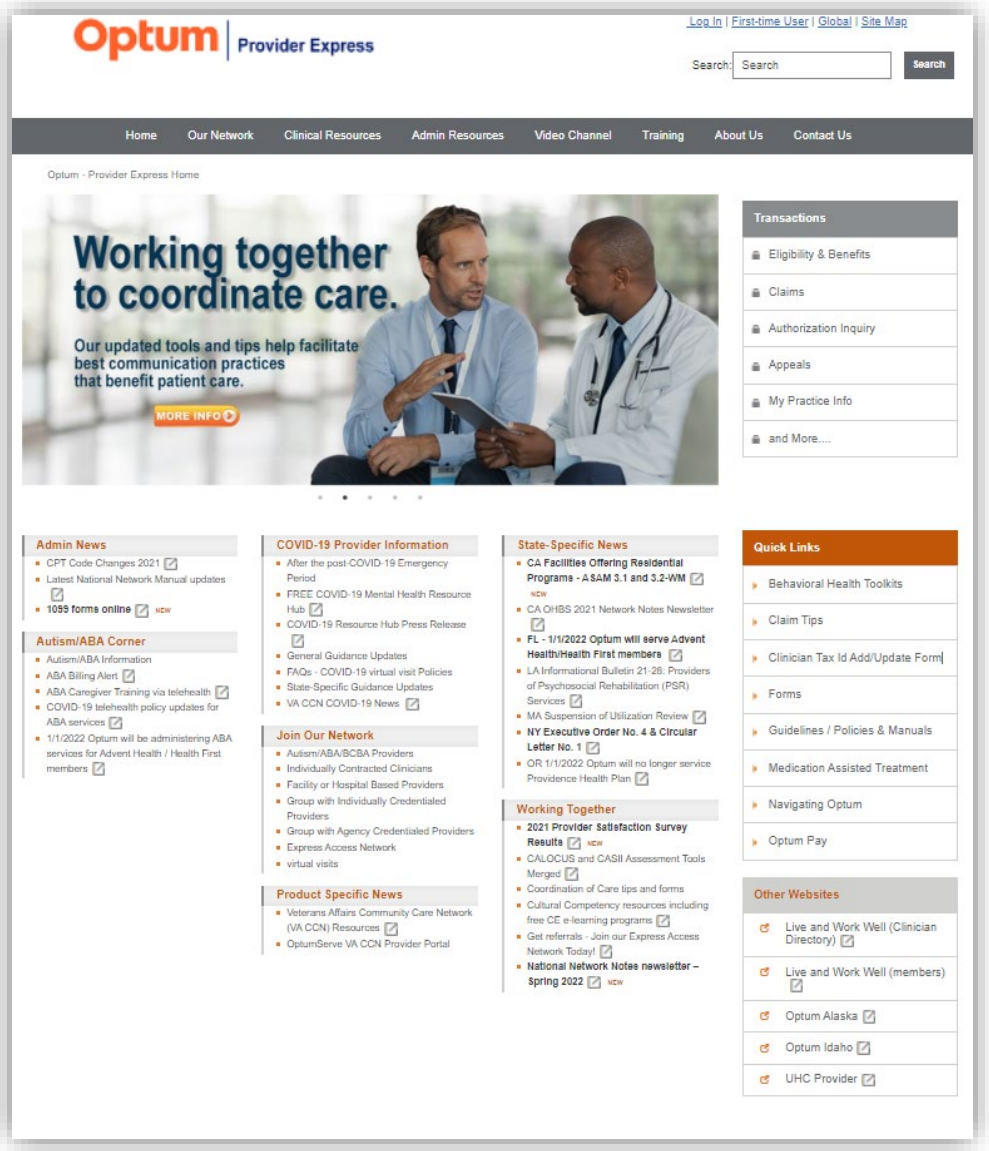

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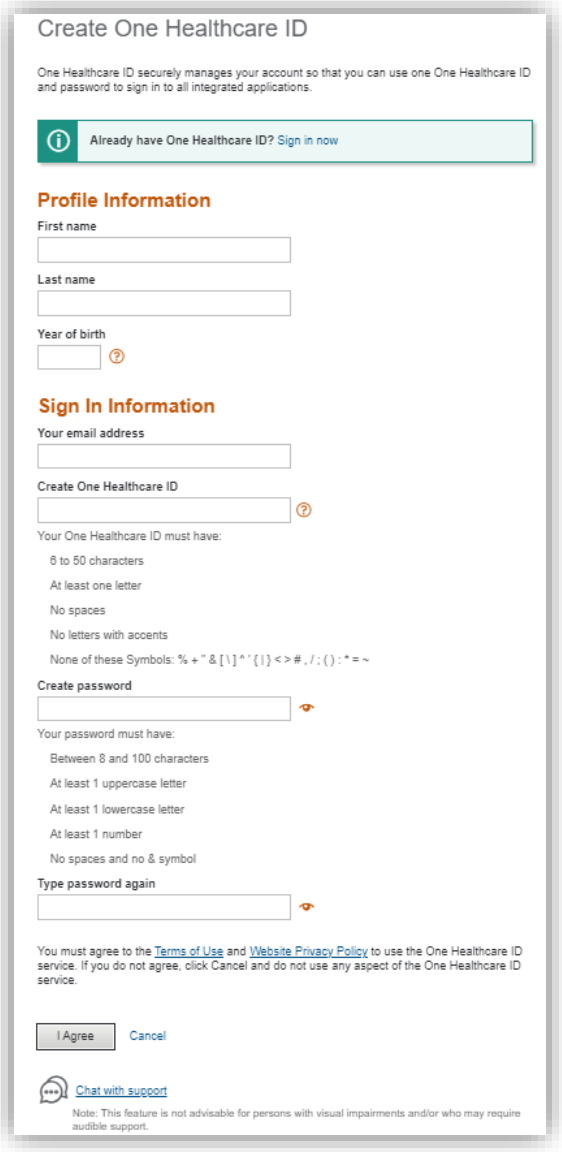
providerexpress.com - First Time users

- Register online for immediate access to secure Transactions
- No fees apply
- Provider Express Support Center available from 7 a.m. to 9 p.m. Central time – toll free at **1-866-209-9320**
- Live chat feature also available



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Mass General Brigham Health Plan ABA provider Quick Reference Guide

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Mass General Brigham Health Plan ABA Program
Quick Reference Guide

ID Card	
Clinician is Responsible for:	• Verifying benefits/eligibility online at providerexpress.com or call the Behavioral Health number located on the back of the Member's ID card • Obtaining authorization as necessary • Being familiar with the Network Manual located on our web site: providerexpress.com > Guidelines / Policies & Manuals > Network Manual

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 optumpeeraccess.secure.force.com/ABAtreatment/
	  ○ Or via fax at **1-888-541-6691**

Claims Paper Submission	Mail paper claims to: • UnitedHealthcare, P.O. Box 30760, Salt Lake City, UT 84130-0760 • All autism provider services must be billed on a Form 1500 • Submission should occur within 90 days of date of service
Electronic Submission	Submit claims online through: • providerexpress.com • Payer ID for submitting claims is 87726
Claim Status	Claims status can be obtained by calling Customer Service Center: • **1-877-843-4366** • Or through the Web portal at providerexpress.com
Claim Appeals	Claim appeals process: • Process for appeal will be detailed in the Member's Rights Enclosure which accompanies the Explanation of Benefit (EOB) denial notice sent to the Provider and the Member • Appeals must be requested within 60 calendar days from receipt of the notice of adverse determination
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 Network Manager with any questions.
Network Management	Heather Willis, Specialty Network Manager Email: heather.willis@optum.com

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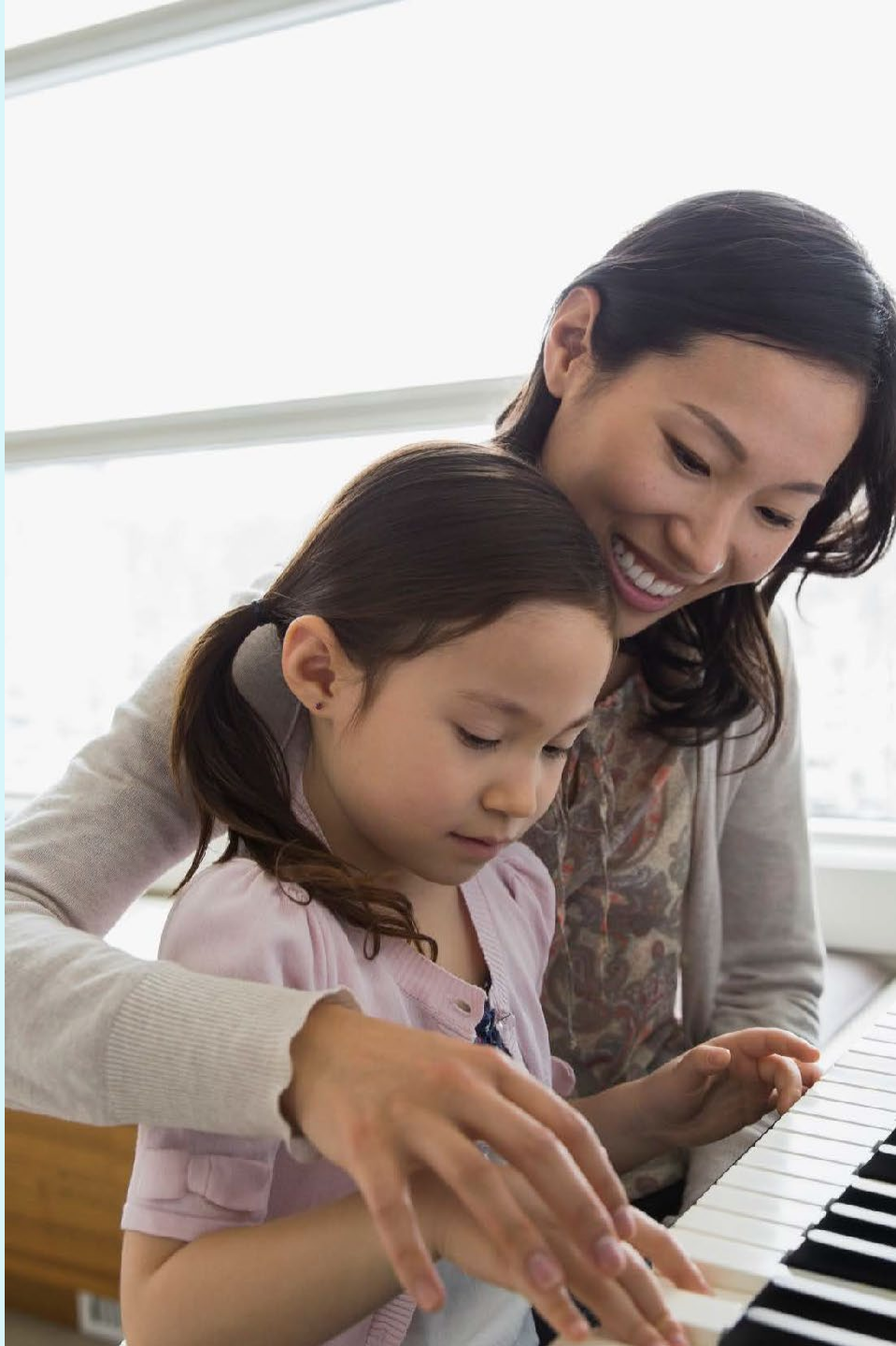
Appendix



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Helpful Websites

To get an NPI number:

- NPPES (hhs.gov)

To learn more about HIPAA:

- HIPAA Home | HHS.gov

To learn more about Tax IDs or Employee IDs:

- irs.gov

Optum provider website:

- providerexpress.com
- Claim Tips: Provider Express > Quick Links > Claim Tips
- Claim Forms: Provider Express > Quick Links > Forms > Optum Forms - Claims

Autism Votes website:

- Advocate | Autism Speaks

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Key Terms: General

- NPI
- CPT
- HCPCS
- HIPAA
- Form 1500
- HCFA 1500
- CMS 1500
- Modifiers
- Units
- Prior authorization
- Signature on file
- DSM-5 diagnosis
- ICD-10 diagnosis code
- Subscriber ID or Member ID
- Dependent
- Policy or Group Number
- TIN or EIN
- Place of Service
- Diagnosis Pointer
- Fee schedule
- Par/Non-Par
- SPD/COC

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Key Terms: Completing Claim Forms

- Type of plan box
- Patient name
- Dependent
- Subscriber ID or Member ID Signature on File
- Patient address
- Policy or Group Number
- Prior authorization
- DSM-5 diagnosis
- ICD-10 diagnosis code
- ICD indicator
- Dates of Service
- Place of Service
- Procedure Code
- Modifiers
- Diagnosis Pointer
- Charges (total)
- Units
- NPI and Provider ID
- TIN or EIN
- Accept assignment
- Total charge
- Amount paid by patient
- Balance due

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