



**UnitedHealthcare Community Plan,
a Commonwealth Coordinated
Care Plus Health Plan**

Important Notice

Optum provides this manual as a more focused resource for clinicians and facilities serving the UnitedHealthcare Community Plan CCC Plus Medicaid membership. This manual supplements but does not replace the primary national *Network Manual*. Topics or requirements that are specific to the CCC Plus Medicaid programs as offered through UnitedHealthcare Community Plan are included here. In addition, many important requirements are outlined on the state's website.

Governing Law

This manual shall be governed by, and construed in accordance with, applicable federal, state and local laws. To the extent that the provisions of this manual conflict with the terms and conditions outlined in your Agreement, the subject matter shall first be read together to the extent possible; otherwise and to the extent permitted by, in accordance with, and subject to applicable law, statutes or regulations, the Agreement shall govern.

Benefit Administration

Behavioral benefits for members of UnitedHealthcare Community Plan, a Commonwealth Coordinated Care (CCC) Plus Health Plan, are administered by Optum.

You can inquire about eligibility and benefits at [unitedhealthcareonline.com](https://www.unitedhealthcareonline.com), on Provider Express ([providerexpress.com](https://www.providerexpress.com)) or by calling the phone number on the back of the Member's ID card. Services and/or conditions not covered under the Member's specific Benefit Plan are not eligible for payment. We comply with regulatory requirements related to coverage election periods and payment grace periods. These requirements can lead to delays in our knowledge of a Member's eligibility status. As a result, the Member is the best source for timely information about eligibility, coverage changes and services utilized to-date.

Please refer to the State's information regarding retroactive eligibility. Optum will process claims in accordance with the State's requirements.

When a provider is rendering services for a Community Plan member in the CCC program and receiving payment from the health plan for services rendered, they must have a valid National Provider Identification (NPI) number.

Benefits Exclusions and Limitations

Please refer to the Department of Medical Assistance Services website (DMAS.virginia.gov) for additional resources and to review applicable benefit exclusions and limitations:

The Addiction and Recovery Treatment Services Manual, Chapter IV

- DMAS.virginia.gov > Behavioral Health, Addiction and Recovery Treatment Services > Addiction and Recovery Treatment Services > ARTS Covered Services – Chapter IV

An Introduction to Commonwealth Coordinated Care Plus

- DMAS.virginia.gov > Commonwealth Coordinated Care Plus (MLTSS) > CCC Plus Information > CCC Plus Overview Presentation June 2017

Level of Care Guidelines

For ARTS services, ASAM Level of Care guidelines apply. DMAS provides a crosswalk between ASAM Levels of Care (LOC) and the provider qualification requirements associated with the array of services on the DMAS website:

- DMAS.virginia.gov > Behavioral Health, Addiction and Recovery Treatment Services (left directory) > Addiction and Recovery Treatment Services > Department of Behavioral Health and Developmental Services (DBHDS) Resources > DBHDS Licensing and ASAM LOC Crosswalk

Authorizations

Inpatient and Sub-Acute Services

Virginia Community Plan Substance Use Disorder (SUD) services are referred to as Addiction Recovery Treatment Services (ARTS). All inpatient and sub-acute level of care admissions for Mental Health and ARTS services require pre-authorization by the network Provider or Facility.

Routine and Non-Routine Outpatient Services

Most routine outpatient behavioral health services do not require an initial pre-authorization.

Some non-routine outpatient services require ongoing authorization prior to providing services. This includes, but is not limited to, the following:

- Outpatient Electro-Convulsive Treatment
- ARTS Intensive Outpatient (IOP)
- ARTS Partial Hospitalization Program (PHP)
- Psychological Testing

Contacting Optum for Authorizations

To pursue authorization for Addiction Recovery Treatment Services (ARTS) services, ASAM levels 2.1 – 4.0, please complete the appropriate **ARTS Authorization Form**:

- For initial authorizations: **ARTS Initial Service Authorization Request form**
- For service extensions: **ARTS Service Authorization Extension Request form**

Providers will use the same ARTS authorization form(s) for all participating CCC Plus health plans. Upon completion for UnitedHealthcare Community Plan of Virginia members, these forms should be faxed to **1-844-881-4926**.

Claim Submission

Optum reimburses Providers seeing CCC Plus Members in accordance with the DMAS published rates. Refer to your Optum Fee Schedule or Payment Appendix for contracted services and associated rates.

As a contracted Provider, it is important that you follow your fee schedule to ensure proper payment of claims. Failure to follow the terms and conditions as set forth on your fee schedule may result in claim denial(s).

Timely Filing

In compliance with State regulations, Providers may submit claims up to 12 months from the provision of covered services. We will deny claims not received within these timely filing standards. A claim must contain all required fields and, when needed, all supporting documentation. Claim submissions with missing data are subject to rejection and/or denial. In addition, dates of service must be within the time span of the authorization, when applicable.

Under the terms of the Agreement, you may not balance bill Members for covered services provided during eligible visits. This means you may not charge CCC Plus Members the difference between your billed usual and customary charges and the amount reimbursed by Optum.

Clean claims shall include all data elements necessary to process a complete claim, including, but not limited to: the Member number, customary charges for the MH/SUD services rendered to a Member during a single instance of service, Provider's federal Tax Identification Number (TIN), National Provider Identifier (NPI), name of rendering Provider, code modifiers and/or other identifiers requested by Optum.

Claims will be adjudicated in compliance with state guidelines. This includes processing of clean claims from Nursing Facilities, Long Term Services and Supports (LTSS) providers (including when LTSS services are covered under EPSDT), ARTS and Early Intervention providers within fourteen (14) calendar days of receipt of the clean claim.

Should a claim be denied, Providers have 180 days to file an appeal from the date of denial.

Methods of Claim Submission

Claims may be submitted using an EDI Clearinghouse, UnitedHealthcareOnline.com, or on paper.

Electronic Data Interchange (EDI) Submission

- Providers may use the EDI Clearinghouse vendor of their choice
- Use Payer ID number: **87726**

Provider Websites

UnitedHealthcareOnline.com or Provider Express (**providerexpress.com**)

- Check eligibility and authorization or notification of benefits requirements
- Submit single 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 **unitedhealthcareonline.com**, select New User from the Home Page. You may also obtain additional information through the Help Desk at **1-866-842-3278**.

In the fall, UnitedHealthcareOnline will also support submission of bulk professional and institutional claims. Online users will be notified when this becomes available.

Paper Claims

- Professional claims must be submitted using the 1500 (v 02/12) claim form
- Institutional claims must be submitted using the UB-04 claim form
- Paper claims should be submitted to:

UnitedHealthcare Community Plan
P.O. Box 5270
Kingston, NY 12402

Please be aware that community-based benefits will continue to be administered by the current Behavioral Health Service Administrator (BHSA) until January 1, 2018.

Eligibility

It is important that you inquire about eligibility. We also encourage you to discuss with the Member the importance of keeping you informed of changes in coverage or eligibility status.

Helpful Resources

Department of Medical Assistance Services (DMAS)

Addiction and Recovery Treatment Services (ARTS)

http://www.dmas.virginia.gov/Content_pgs/bh-sud.aspx

ARTS Reimbursement Structure

http://www.dmas.virginia.gov/Content_atchs/bh/ARTS%20Reimbursement%20Structure%2004042017.pdf

ARTS Response to Opioid Epidemic

http://www.dmas.virginia.gov/Content_atchs/bh/ARTS%20One%20page%20handout%2009052016.pdf

An Introduction to Commonwealth Coordinated Care Plus (MLTSS)

http://www.dmas.virginia.gov/Content_atchs/mltss/CCC%20Plus%20program%20overview%20June%202017%20revised%206-27.pptx

Department of Behavioral Health and Developmental Services Licensing and ASAM Level of Care Crosswalk

http://www.dmas.virginia.gov/Content_atchs/bh/DBHDS%20Licensing%20and%20ASAM%20LOC%20Crosswalk%20v2%2005252016.pdf

Managed Long Term Services and Supports (MLTSS)

http://www.dmas.virginia.gov/Content_pgs/mltss-home.aspx

MLTSS Rural and Urban Localities Listing

http://www.dmas.virginia.gov/Content_atchs/mltss/MLTSS%20Rural%20and%20Urban%20Localities%20Listing.pdf

Rate Setting:

http://www.dmas.virginia.gov/Content_pgs/pr-rsetting.aspx

Provider Express - National Network Manual

<https://www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources/guidelines-policies/optum-network-manual.html>

- **Provider Express allows you to:**
 - Access trainings/webinars
 - View state specific form libraries
 - Complete Eligibility and Benefit Inquiries
 - Submit professional claims
 - Locate Network contacts
 - Review Level of Care guidelines
 - Complete network request updates, make any add/change or demographic updates