



Optum Provider Training for Mass General Brigham Health Plan – Mass General Brigham ACO Model A (Medicaid)

Published March 2023

BH4739 03/2023



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Introductions and Background



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



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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Definitions



Key Definitions

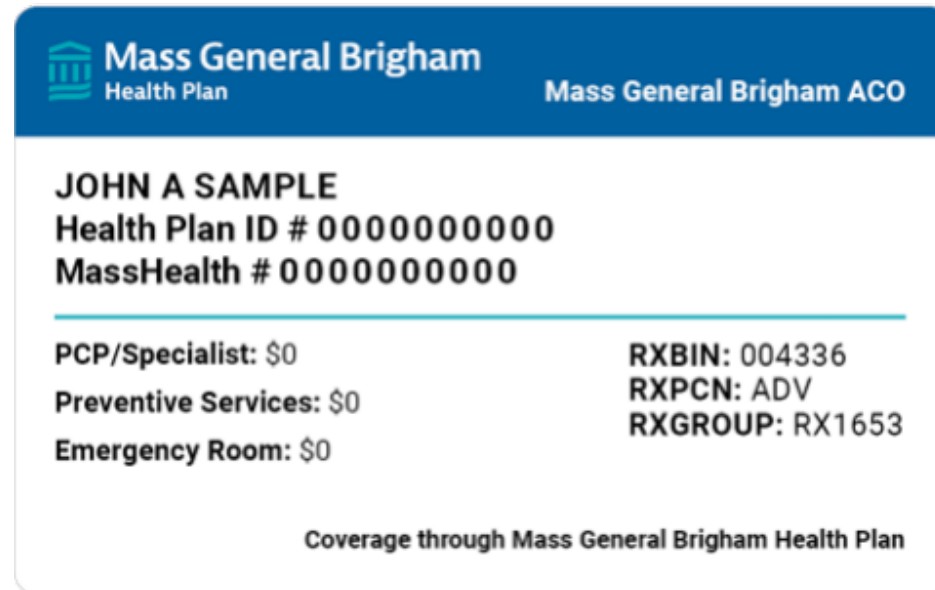
- Licensed provider: a professional licensed by the state to deliver behavioral health services
- Procedure Code: codes used to identify what service was provide to or given to a patient
- Modifier: a two-character descriptive add-on to a procedure code; modifiers can be a combination of alpha numeric characters
- Non-independently licensed provider: a Master's level provider professional who is NOT independently licensed by the state; may be able to deliver behavioral health services under the supervision of an independently licensed provider if employed by a group/agency with a Supervisory Protocol Addendum added to their Agreement
- Paraprofessional: a person to whom a particular aspect of a professional task is delegated but who is not licensed to practice as a fully qualified professional
- Peer Provided Services: Medicaid coverage includes services provided by peers with “lived experience” who meet performance specification, such as Recovery Coaches.
- Rostered provider: an independently licensed provider employed by a credentialed group/agency with a Group Agreement that requires submission and on-going maintenance of a roster of their employed, independently licensed providers
- Supervisory Protocol Addendum: an addendum to a group/facility Agreement that may be added to allow non-independently licensed providers to render services while under the supervision of an independently licensed provider within the group
- Supervision: an independently licensed supervising provider has regular, in-person, one-on-one supervision with the non-independently licensed provider to review the treatment provided to members. Supervision must be clinical in nature, documented and kept on file. Up to two (2) multi-disciplinary staff or group supervision meetings may be counted for two in-person supervision sessions per month so long as the supervising provider is in attendance

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Member ID Cards



Member identification card, front, ACO, Model A (Medicaid) plan



Member identification card, back, ACO, Model A (Medicaid) Plan

Members	Providers
<p>Customer Service: 800-462-5449 (TTY 711)</p> <p>For behavioral health services (mental health or substance use) Optum Behavioral Health Services: 800-462-5449 (TTY 711)</p> <p>CVS Caremark Prescription Services: 866-546-0662</p> <p><i>Call your treating provider within 48 hours of an emergency visit.</i></p> <p>Visit member.mgbhealthplan.org, a secure member portal for detailed plan and provider information.</p> <p>MassGeneralBrighamHealthPlan.org</p>	<p>Claims Info and Provider Manual: provider.mgbhealthplan.org</p> <p>Where to submit claims</p> <p>Mass General Brigham Health Plan: 855-444-4647 Payer ID: 04293</p> <p>Behavioral Health: Optum 844-451-3519 Payer ID: 87726</p> <p>For more information, visit mgbhealthplan.org/claims</p> <hr/> <p>Pharmacy Help Desk: CVS Caremark 800-421-2342</p>

This card does not guarantee coverage. ID-05 (01/23)

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Benefits and Eligibility



Understanding covered benefits



Clinical Criteria standardize the interpretation and application of terms of the Member's Benefit Plan; including terms of coverage, exclusions and limitations.



Clinical Criteria can be found on Provider Express, Optum's industry leading provider website: providerexpress.com



Mass General Brigham Health Plan ACO Model A Medicaid members benefits are determined by MassHealth.



Check a Member's benefits and eligibility on Provider Express, through secure Transactions.

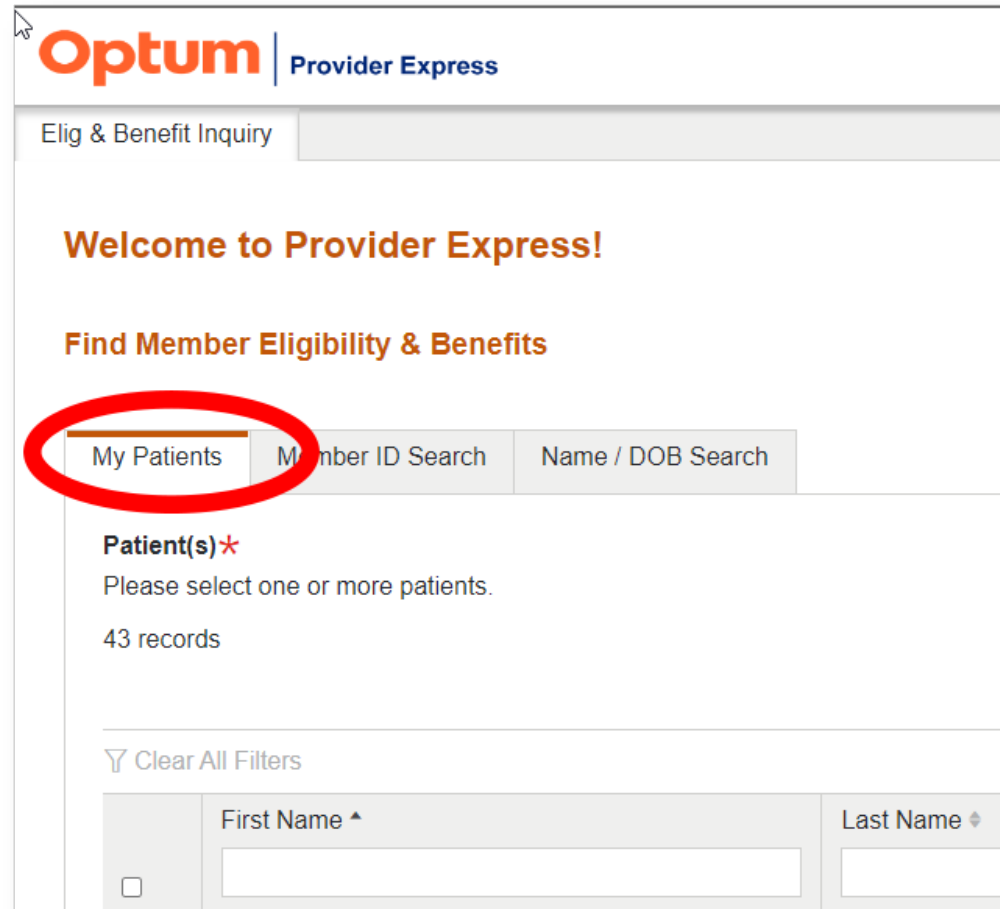
Eligibility and benefits verification using Provider Express

Provider Express - providerexpress.com

Our industry-leading provider website includes both public and secure pages for behavioral health providers.

“Eligibility & Benefits” allows users to search for a member’s eligibility by using My Patients list, Member ID Search or the Name/DOB Search. The My Patients list is also built using this transaction.

“My Patients” is a list of patients that can be stored on Provider Express and used for various online transactions without an additional search. The My Patients list is customizable at a User level.





Covered Services and Authorizations



Covered Services, Inpatient

Inpatient services: 24-hour services, delivered in a licensed hospital setting, that provide clinical intervention for mental health or substance use diagnoses, or both.

- Inpatient Mental Health Services
- Inpatient Substance Use Disorder Services (ASAM Level 4)
- Observation/Holding Beds
- Administratively Necessary Day (AND) Services
 - Available to Medicaid Members only
 - AND Services must be requested and authorized through a single case agreement
 - Reimbursement will be at the published state Medicaid rate for Administrative Days
 - Billing must be done using revenue code 0169

Covered Services, Diversionary Services

Diversionary Services: these services provide clinically appropriate alternatives to Behavioral Health Inpatient Services, or support returning to the community following a 24-hour acute placement; or provide intensive support to maintain functioning in the community

24-hour diversionary services:

- Community Crisis Stabilization (CCS)
- Community-Based Acute Treatment for Children and Adolescents (CBAT)
- Intensive Community-Based Acute Treatment for Children and Adolescents (ICBAT)
- Acute Treatment Services (ATS) for Substance Use Disorders (Level 3.7)
- Clinical Support Services (CSS) for Substance Use Disorders (Level 3.5)
- Residential Rehab Services (RRS), High Intensity, Population Specific (Level 3.1), MassHealth members only
- Residential Rehab Services (RRS), Low Intensity (Level 3.1), MassHealth members only
- Transitional Care Unit (TCU) for DCF Youth, MassHealth members only

Covered Services, Diversionary Services

Non-24-hour diversionary services:

- Community Support Program (CSP, CSP for Chronically Homeless Individuals, and CSP for Justice Involved), MassHealth members only
- Partial Hospitalization Program(PHP)
- Psychiatric Day Treatment
- Structured Outpatient Addiction Program (SOAP and eSOAP)
- Program of Assertive Community Treatment (PACT)
- Intensive Outpatient Program (IOP)
- Recovery Support Navigators, MassHealth members only
- Recovery Coaches

Covered Services, Standard Outpatient Services

- Family Consultation
 - Case Consultation
 - Diagnostic Evaluation
 - Dialectical Behavioral Therapy (DBT)
 - Psychiatric Consultation on an Inpatient Medical Unit
 - Medication Management (office based)
 - Medication Administration
 - Couples/Family Treatment
 - Group Treatment
 - Individual Treatment
 - Applied Behavioral Analysis for Members Under 21 Years of Age (ABA Services)
 - Family Support and Training
 - Intensive Care Coordination
 - Specialing – therapeutic services provided to a member in a variety of 24-hour settings, on a one-to-one basis, to maintain the individual's safety.
 - Preventive Behavioral Health Services for Members Younger than 21
- Assessment for Safe and Appropriate Placement (ASAP)
 - Collateral Contact
 - Opioid Treatment Services
 - Ambulatory Detoxification (Level II.d or 2WM)
 - Psychological Testing
 - Neuropsychological Testing
 - Special Education Psychological Testing for (MassHealth) members
 - ECT
 - Repetitive Transcranial Magnetic Stimulation (TMS)
 - In-Home Behavioral Services
 - In-Home Therapy Services
 - Therapeutic Mentoring Services
 - Inpatient-Outpatient Bridge Visit
 - BH Emergency Service/Crisis Evaluations
 - Youth Mobile Crisis Intervention
 - Behavioral Health Urgent Care

Authorization and Notification Definitions

- Mass General Brigham Health Plan has designated services which require providers to contact Optum Behavioral Health when a member accesses those services.
- Notification: when required, notification should occur prior to the delivery of certain non-routine outpatient services or within a specific timeframe for specific 24-hour levels of care. Notification requirements include clinical information to determine benefit coverage.
- Authorization (a.k.a.: prior authorization): occurs prior to a service being delivered to a member and is a result of the clinical and benefit determinations made per the provider notification.

Services Requiring Authorization and/or Notification

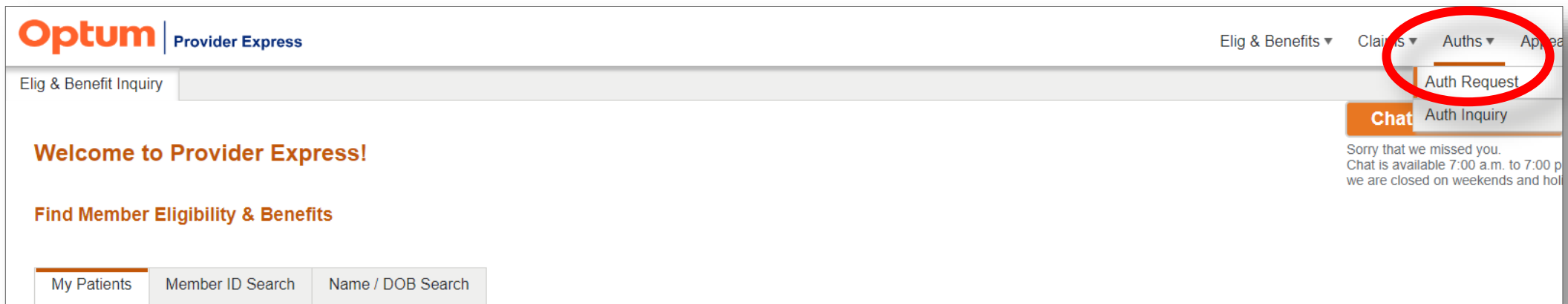
Services Requiring Authorization	Services Requiring Notification
Partial Hospitalization, Intensive Outpatient (IOP), and Day Treatment	Acute Inpatient Psychiatric Hospitalization (within 72 hours of admission)
Psych Testing greater than 5 hours	Community Based Acute Treatment (CBAT)/Intensive Community Based Acute Treatment (ICBAT) (within 72 hours of admission)
Electroconvulsive Treatment (authorization obtained by phone only)	Substance Use Disorder Acute and Residential (ASAM 4.0, 3.7, 3.5) (within 48 hours of admission)
Program for Assertive Community Treatment (PACT) Services	Residential Rehabilitation Services (RRS) (ASAM 3.1) (within 7 days of admission)
Administratively Necessary Days, Specialing, and Transitional Care Unit	Psych Testing 5 hours or less
Applied Behavioral Analysis (ABA) Services for Members with Autism Spectrum Disorder	
Transcranial Magnetic Stimulation	

Please reference the Authorization and Notification section of the Mass General Brigham Health Plan Manual Addendum located on provider express for detailed information regarding services requiring authorization and notification.

Authorization process

Authorizations can be requested in two ways:

1. Contracted providers can request authorizations for most services via the online portal system on Provider Express (providerexpress.com). You will need to log in to request authorizations.
 - View authorization details



2. Calling Optum via the number on the member's card

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
 - Begins at the onset of care and should be documented and reviewed over the course of treatment
 - Focuses 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

Discharge Planning – Experiencing or at Risk of Homelessness

MassHealth has outlined additional discharge planning requirements for enrollees experiencing or at risk of homelessness

- Hospitals must assess each admitted member's current housing situation within 24 hours of admission
- Hospitals must invite and encourage participation from the member, member's family, primary care providers, BH providers, key specialists, community partners, case managers and any other supports identified by the member. And, if applicable, Dept of MH (DMH), Dept of Developmental Svcs (DSS) or MA Rehabilitation Commission (MRC)
 - Determine whether any non-DMH, non-DSS or non-MRC involved member may be eligible to receive services from those agencies. Within 2 business days, offer to assist application to receive services
- If member is expected to remain in hospital less than 14 days, the hospital must contact:
 - Emergency shelter last resided in, if known, or contact local emergency shelter to discuss housing options
- Make reasonable efforts to prevent discharges to emergency shelters for members with skilled care needs or BH conditions that would impact the health and safety of individuals residing in the shelter
- Follow procedures for unavoidable discharges to emergency shelters or the streets
- Follow procedures for tracking and reporting

Additional detail related to MassHealth requirements can be found in the Mass General Brigham Health Plan Provider Manual Addendum located on Provider Express.

Medical necessity

Medically necessary services are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity.

Medically necessary services are appropriate when there is no other medical service or site of service, comparable in effect, available and suitable for the member requesting the service, that is more conservative or less costly

Medically necessary services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality.

Utilization management statement

Care Management decision-making is based only on the appropriateness of care as defined by:

- CASII, LOCUS, ESCII Clinical Guidelines Optum Psychological and Neuropsychological Testing Guidelines
- Behavioral Health Clinical Policies
- American Society of Addiction Medicine (ASAM) Criteria

LOCUS/CASII/ECSII Guidelines can be found at providerexpress.com:

- Path: Provider Express > Clinical Resources > Guidelines/Policies



**Children's
Behavioral Health
Initiative (CBHI)
and Outpatient
Management, for
Medicaid Members**



Covered Services: Intensive Home or Community Based Services for Youth (CBHI)

The Children's Behavioral Health Initiative (CBHI) is an interagency undertaking whose mission is to strengthen, expand and integrate behavioral health services for children.

Mental health and substance use disorder services provided to (MassHealth) youth members up to age 21 in a community-based setting such as home, school, or community. (e.g., CBHI Services):

- Family Support and Training
- Therapeutic Mentoring
- Intensive Care Coordination (ICC)
- In-Home Behavioral Services
 - Behavior Management Therapy
 - Behavior Management Monitoring
- In-Home Therapy Services
- Youth Mobile Crisis Intervention
- Intensive Hospitalization Diversion

Child and Adolescent Needs and Strengths (CANS) for MassHealth/ACO Members

All behavioral health providers treating children and adolescents who are enrolled in MassHealth and under the age of 21 must use the CANS tool as part of the clinical assessment process. The CANS must be updated every 90 days to ensure that treatment plans address strengths and needs as they evolve.

Services that Require Use of the CANS:

- Outpatient Therapy (diagnostic evaluations and individual, family and group therapy)
- In-Home Therapy Services
- Intensive Care Coordination
- The CANS must also be completed as part of the discharge planning process for the following 24-hour level of care services:
 - Psychiatric inpatient hospitalization at acute inpatient hospitals, psychiatric inpatient hospitals and chronic and rehabilitation inpatient hospitals
 - Community-Based Acute Treatment (CBAT) and Intensive Community-Based Acute Treatment (ICBAT)
 - Transitional Care Units (TCU)

Please see the **Provider Manual Addendum on Provider Express** for more details around the CANS requirements: [Mass General Brigham Health Plan Manual Addendum \(providerexpress.com\)](https://providerexpress.com)

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Cultural Sensitivity



Cultural sensitivity for providers

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

- All services should be conducted in accordance with Title VI of the Civil Rights Act of 1964 and should be provided in a manner that respects the Member's cultural heritage and appropriately utilizes natural supports in the Member's community.
- Remember that statistics do not apply to individuals.
- Be aware that there are differences within cultures and from generation to generation.
- Evaluate each person using all available cultural "clues".
- Ask questions in a culturally sensitive fashion.

Cultural sensitivity for providers

Providers are required to verify the demographic information listed in the provider directory every 90 days, including information on languages spoken and attestation to Cultural Sensitivity Training. Log in to “My Practice Info” on the secure portal from provider express to update and attest to your information as it appears in the provider directory.

The screenshot displays the 'Edit Clinician' interface. On the left, there are sections for 'Personal Details', 'General Information', 'Availability' (with address '8922 Cuming St'), and 'Licenses & IDs'. A callout box on the right provides instructions for the 'Personal Details' section. It states: 'Personal Details: This section is expanded by default. Click 'Edit' to populate any missing data or update existing data. Then click 'Save' to submit changes.' Below this, it lists 'Values Available for Review/Edit' with a 5-7 day cycle icon. The items are: Name (Must Match Current License) *Critical*, Taxonomy, Gender *Critical*, Ethnicity, Languages Spoken, Cultural Competency Training Attestation, Populations Treated, Areas of Clinical Expertise, and Credentialing Dates (for delegated credentialing only). Red arrows point to 'Languages Spoken' and 'Cultural Competency Training Attestation'.

Cultural competency

Some additional resources for information on Cultural Sensitivity:

- [Equal Opportunity and Civil Rights Information | CMS](#)– Office of Civil Rights
- [LEP.gov](#)– Limited English Proficiency (LEP): Site promotes importance of language access to federal programs and federally assisted programs
- [ncihc.org](#)– National Council on Interpreting in Health Care: Organization promotes culturally competent health care

Advancing Health Equity

Our mission is to help people live healthier lives and make the system work better for everyone.

- Promoting and instilling the values of culture, inclusion and diversity are critical to achieving this mission and truly making a difference
- As part of this commitment, Optum offers two Cultural Sensitivity Training courses – **free and on-demand** – for in-network behavioral health professionals:
 - LGBTQ+ Mental Health Training (1.5 CEUs)
 - Unconscious Bias Training (Certification)

Provider Express Resources:
[Provider Express > Clinical Resources > Cultural Sensitivity Trainings](#)

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Provider Clinical Audits



Provider audits

- Organizational providers (including facility-based services, partial hospital programs, intensive outpatient programs, residential programs and most agencies) that do not have a national accreditation [such as The Joint Commission, Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA), etc.] will require on-site clinical audits at the time of credentialing and recredentialing.
- Clinical audits may also be completed to investigate a quality of care (QOC) concern or a sentinel event.
- Record review audits are completed of providers who render services to Mass General Brigham Health Plan members of any age.
- A sample of providers are randomly selected for review on an annual basis.

Documentation standards

Documentation requirements for Mass General Brigham Health Plan providers are described in the Mass General Brigham Health Plan Addendum to the Optum National Manual. From the home page, select Our Network > Welcome to the Network > Massachusetts > Mass General Brigham Health Plan > Provider Manual Addendum.

- 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)

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Adverse Incident Reporting



Behavioral health adverse incident reporting

Behavioral Health reportable adverse incidents include, but are not limited to, the following:

- Any death (include cause of death if known)
- Any absence without authorization (AWA)
- Any serious injury resulting in hospitalization
- Any sexual assault or alleged sexual assault
- Any sexual activity in a 24-hour level of care facility
- Any violation or alleged violation of the Department of Mental Health physical restraint and/or seclusion regulations
- Any physical assault or alleged physical assault on or by a covered individual or by staff
- Any contraband found prohibited by provider policy
- Any injury or illness requiring transportation to an acute care hospital for treatment while in a 24-hour program

Report submission instructions

- When an adverse incident occurs, the provider must complete the applicable Adverse Incident Report form and submit it to Optum within 24 hours of discovery of the incident; if the incident occurs on a holiday or weekend, the form must be submitted on the next business day
- All forms are posted to Provider Express: from the Home page, select Our Network > Welcome to the Network > Massachusetts > Mass General Brigham Health Plan > Adverse Incident Report Forms

Adverse incident report form, MassHealth



Please fax completed forms to Optum at 844-814-5698

Mass General Brigham Health Plan– MassHealth Daily Adverse Incident Report

Notifications: DMH ___ DCF ___ DYS ___ DPPC ___ DDS ___ Other ___

Client: _____ Medicaid RID #: _____

M ___ F ___ DOB: _____ Age: _____

Facility: _____ Unit: _____ City: _____

24-hour facility: ___ Non-24-hour facility: ___

Date and Time of Incident: _____

Date and Time of Discovery: _____

Type of Incident: _____

Describe Incident. If AWA, please include search, notification and commitment status:

Describe Immediate Response to the Incident:

Restraints Used? None: ___ Mechanical: ___ Chemical: ___ Physical: ___ Time in Restraints: _____

Please Check if Recommended: Internal Investigation _____ Policy and Procedure

Review _____ Staff training _____ Disciplinary action to staff _____

Please check if additional information is attached. ___

Person Reporting: _____ Telephone #: _____

Title: _____

Signature: _____ Date: _____

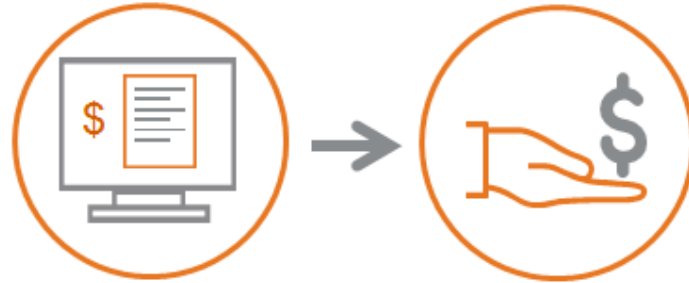
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Claim Billing Reference Guide



Claims filing made easy

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



Benefits of Electronic Filing:

- **It's fast** - Eliminate mail and paper processing delays
- **It's convenient** - Easy set-up and intuitive process
- **It's secure** - Data security is higher than with paper-based claims
- **It's efficient** - Electronic processing helps prevent errors
- **It's cost-efficient** - you eliminate mailing costs, and the solutions are free or low-cost

Claims submission option 1, Online: Provider Express

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



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

Get started today with your One Healthcare ID:

- Register for a One Healthcare ID today by clicking [First-time User](#)
- Need help registering for a One Healthcare ID? Watch this [quick video](#)

Tips for timely and accurate payments, Provider Express

Filing claims electronically on Provider Express can help prevent these common errors.

Missing or incomplete information

Provider Express "Claim Entry" prevents the submission of claim if required fields are blank

Examples: NPI number, ICD-10 derived diagnosis code

Member demographic info has errors

Member information is auto-populated when you use "Claim Entry" on Provider Express

Examples: Name, DOB, ID number

Unclear or illegible information

The Claim Entry form on Provider Express ensures legibility

Examples: Provider or Member information illegible, diagnosis code unclear

Claims submission option 2: EDI/ Electronically

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



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

To learn more about Electronic Data Interchange, visit [Provider Express](#). From the Home Page, select [Admin Resources](#) > [Claim Tips](#) > [EDI/Electronic Claims](#)

Claims submission option 3: Paper

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

- Use an original 02/12 Form 1500 claim form (no photocopies)
- Type information to ensure legibility
- Use a DSM-5 derived ICD-10 code for primary diagnosis (Hint: the DSM-5 includes ICD codes along with the DSM diagnostic info)
 - Please Note: BH preventive pediatric services only requires a symptom code to be billed (z code)
- Complete all required fields (including ICD indicator and NPI number)



Claims submission option 3: Paper

- Institutional claims must be submitted using the UB-04 claim form
- Paper claims submitted via U.S. Postal Service should be mailed to:

Medicaid

Optum
P.O. Box 30760
Salt Lake City, UT 084130-0760

Claim billing reference guide

Independently licensed providers employed by a group

When billing Optum for services rendered by an independently licensed provider for Mass General Brigham Health Plan Health members, the following guidelines apply for Medicaid plans:

- Claims must be billed listing the licensed provider in field 24J and field 31 on the 1500 form
- Independently licensed providers must be credentialed or rostered accordingly if they are affiliated with Groups/Agencies whose Agreement requires submission and maintenance of a provider roster
- When billing for an independently licensed provider employed by a group, payment is issued to the group

The image shows a sample of a medical claim form (NUCC 1500) with several callouts pointing to specific fields:

- Box 24J:** Enter Rendering Independently Licensed Clinician or Supervising Independently Licensed Clinician Type I NPI #
- Box 31:** Enter Rendering Independently Licensed Clinician or Supervising Independently Licensed Clinician Type I NPI #
- Box 33a:** Enter Group/Agency Type II NPI #
- Box 33:** Enter Group/Agency Name, Billing Address

The form includes the following fields:

24. A.	DATE(S) OF SERVICE		B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES		E.	F.	G.	H.	I.	J.				
MM	DD	YY	MM	DD	YY	PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)	MOODIFIER	DIAGNOSIS	PORTER	\$ CHARGES	ICD-9-CM	ICD-10-CM	RENDERING PROVIDER ID #	
1																
2																
3																
4																
5																
6																

25. FEDERAL TAX ID NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (If gov. agency, see back) YES NO 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Ref'd for NUCC Use

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.) 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH # ()

SIGNED DATE NPI NPI NPI NPI

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

Claim billing reference guide

Non-independently licensed providers

When billing Optum for services rendered by a non-independently licensed provider for Mass General Brigham Health Plan Health Medicaid members, the following guidelines apply:

- Non-independently licensed providers are required to have a Type I (individual) NPI number
- Record the non-independently licensed provider's Type I NPI number in Box 24J
- Record the licensed supervising provider's NPI in Box 31
- When billing for a non-independently licensed provider, payment is issued to the group

24. A. DATE(S) OF SERVICE			B. PLACE OF SERVICE			C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS	F. \$ CHARGES	G. DAYS OR UNITS	H. POSIT. FEES	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To						CPT/HCPCS	MODIFIER	POINTER					
MM	DD	YY	MM	DD	YY									
1													NPI	
2													NPI	
3													NPI	
4													NPI	
5													NPI	
6													NPI	

25. FEDERAL TAX ID, NUMBER		SSN	EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. Rsvd for NCUCC Use	
						<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		\$			
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.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()					
SIGNED		DATE		a. NPI		b.		a. NPI		b.			

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

Box 31: Enter Rendering Independently Licensed Clinician or Supervising Independently Licensed Clinician Type I NPI#

Box 33a: Enter Group/Agency Type II NPI #

Box 33: Enter Group/Agency Name, Billing Address

Claim billing reference guide

Paraprofessionals / Peers

- All other codes not listed must be billed in accordance with your Optum Agreement and associated Fee Schedule, as indicated in this sample 1500 form

24. A. DATE(S) OF SERVICE				B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS	F. \$ CHARGES	G. DAYS OR UNITS	H. EPSDT Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
From	To					EXPLAIN UNUSUAL CIRCUMSTANCES	MODIFIER	POINTER					
MM	DD	YY	MM	DD	YY	CPT/HCPCS							
1												NPI	
2												NPI	
3												NPI	
4												NPI	
5												NPI	
6												NPI	

Box 24J: Enter Group/Agency Type II NPI #

25. FEDERAL TAX I.D. NUMBER		SSN	EIN	26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For gov. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. Rsvd for NUCC Use	
		<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO		\$		\$			
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.)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH # ()					
SIGNED		DATE		a. NPI		b. NPI		a. NPI		b. NPI			

Box 31: Enter Group/Agency Name

Box 33a: Enter Group/Agency Type II NPI #

Box 33: Enter Group/Agency Name, Billing Address

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

Claim tips

To support clean claim submissions, remember:

- NPI numbers are always required on all claims
- A complete diagnosis is required on all claims
- The correct date of service corresponding to the date the service occurred must be listed on the claim form; do not list the claim submission date as the date of service

Claims filing deadline:

- Mass General Brigham Health Plan allows claim submissions up to ninety (90) days from the date of service

Claims Processing:

- Clean claims, including adjustments, will be adjudicated within forty-five (45) days of receipt of the claim

Balance Billing:

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

Claim tips

Member eligibility:

- Provider is responsible to verify member eligibility through providerexpress.com

Examples of coding Issues related to claim denials:

- Incomplete or missing diagnosis
- Invalid, missing or incorrect pairing of 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 or incorrect
- Required authorization missing
- Units exceed authorization (e.g., 10 inpatient days were authorized, facility billed for 11 days)

Optum

Appeals

Published March 2023



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.

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 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.

Appeals: contact information

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

Fax: 1-855-312-1470

Phone: 1-866-556-8166

Optum

**Fraud, Waste,
Abuse and Error
(FWAE)**



Optum Program & Network Integrity (PNI) Department

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

The department consists of three main investigative pathways:



What PNI (FWAE) looks for...



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

(Medical Record Auditor, AMA 3rd Edition, 2011)

FWAE market research and collaboration



General Market Research (all markets)

Prospective Flagging & Retro Investigations

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

Algorithms and Analytics

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



Customer Collaboration

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

Optum

Roster and Group Address Maintenance



Roster Maintenance

Groups/Agencies whose Agreement requires submission and maintenance of a provider roster are responsible to ensure their roster data is up to date and on file with Optum. Roster updates may be submitted through providerexpress.com secure “Transactions”.

For Groups/Agencies that use a Supervisory Protocol and are required to submit and maintain a roster, it is essential that providers who are independently licensed and may be acting in a supervisory role be promptly added to the roster for claims to process correctly.

Groups/Agencies that do not use Provider Express may maintain their rosters by submitting them to their Provider Relations Advocates.

Note: Non-independently licensed providers and paraprofessionals are not added to Optum rosters.

Notify us at providerexpress.com within ten (10) calendar days whenever there are changes to your provider roster.

**Roster management is critical to timely and accurate claim processing.
Failure to maintain your group roster creates risks for:**

- **Timely claims adjudication**
- **Potential HIPAA violations**

Supervisory Protocol Addendum

The Supervisory Protocol Addendum allows **non-credentialed providers** to render services while under the supervision of an independently licensed provider.

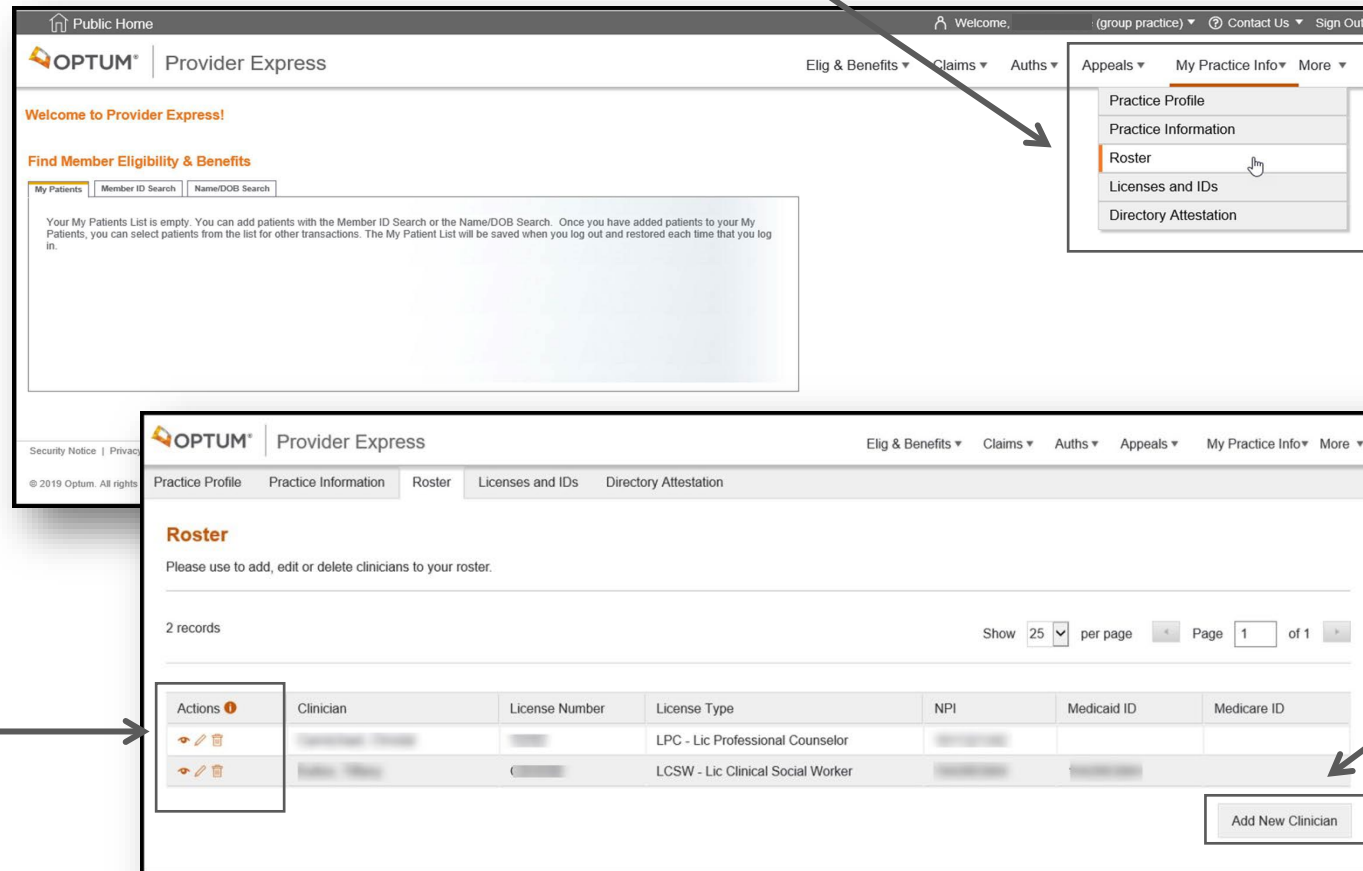
- Providers rendering psychotherapy services must have a minimum of a master's degree
- All services that are rendered must be within the scope of the provider's training
- Supervision must:
 - Occur regularly on a one-to-one basis
 - Be documented
- Optum may periodically conduct chart audits to ensure compliance with Optum policies and procedures.

The Supervisory Protocol option is **available for groups only** – not for solo practitioners.

Eligible Supervising Providers: A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MH/SUD Services are provided, who practices as an employee of a group and has been credentialed or formally rostered and approved by United Behavioral Health (UBH), in writing, as a MHSA Group Participating Supervising Provider. Optum requires all providers to be independently licensed unless the agency or group has executed a supervisory protocol addendum.

Roster Maintenance

After logging in to secure transactions, select *My Practice Info* from the menu bar and then click on *Roster* from the drop-down menu.

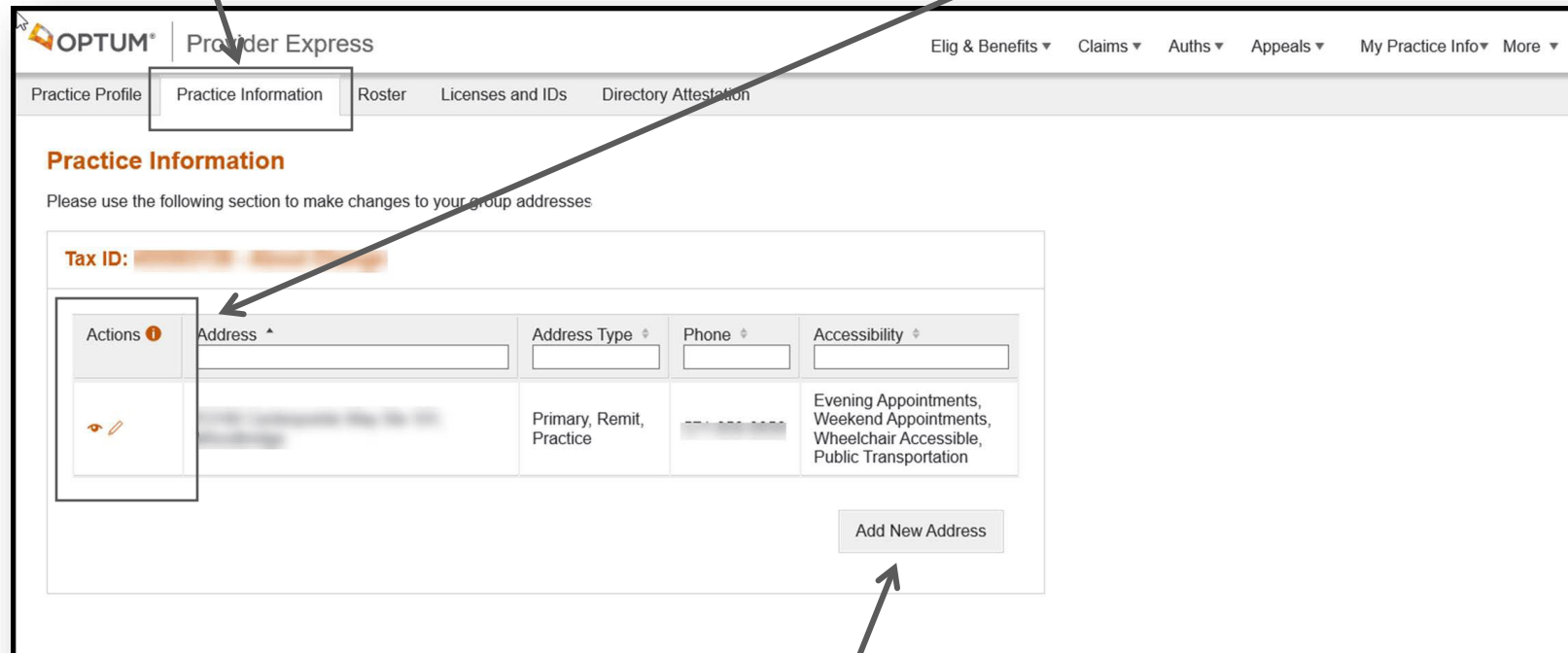


Click on “Add New provider” to add a new licensed provider to your Roster.

Use the options under Actions to view, edit or delete licensed providers on your roster.

Group Address Maintenance

To View or make updates to the Groups Addresses, click on the Practice Information tab and choose an option under Actions.



To add a new practice location or a new mailing or remit address, click on the “Add New Address” button.

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Resources



Mass General Brigham Health Plan Provider Express page

[Welcome Massachusetts \(providerexpress.com\)](https://providerexpress.com)

Mass General Brigham Health Plan

▶ **Mass General Brigham Health Plan Provider Website**

▶ **Adverse Incident Reporting Forms**

▶ **Outpatient Care Engagement**

▶ **Provider Manual Addendum**

▶ **Serious Reportable Events**

▶ **Training Materials**

Provider Resources

Provider Express - providerexpress.com

Our industry-leading provider website:

- Includes both public and secure pages for behavioral health providers
- Public pages
 - General updates and useful information
 - [Behavioral Health Toolkit for Medical Providers](#)
- Secure pages:
 - Require registration
 - The password-protected “secure transactions” offers providers access to provider-specific information including the ability to update your practice information

Optum

Secure Provider Portal



Provider Express: Secure Provider Portal

The screenshot displays the Optum Provider Express website. At the top left is the Optum logo and 'Provider Express' text. On the top right, there are links for 'Log In', 'First-time User', 'Global', and 'Site Map', along with a search bar and a 'Search' button. A dark navigation bar contains links for 'Home', 'Our Network', 'Clinical Resources', 'Admin Resources', 'Video Channel', 'Training', 'About Us', and 'Contact Us'. Below the navigation bar is a main banner with the text 'Working together to coordinate care.' and 'Our updated tools and tips help facilitate best communication practices that benefit patient care.' A 'MORE INFO' button is also present. To the right of the banner is a 'Transactions' menu with items: 'Eligibility & Benefits', 'Claims', 'Authorization Inquiry', 'Appeals', 'My Practice Info', and 'and More....'.

Secure pages require registration

Secure "Transactions" gives you access to Member- and Provider-specific information


Quick Links give easy access to items providers commonly use

Provider Express: Secure Provider Portal

To register, select the “First-time User” link in the upper right-hand corner of the home page

Create One Healthcare ID


One Healthcare ID securely manages your account so that you can use one One Healthcare ID and password to sign in to all integrated applications.

 Already have One Healthcare ID? [Sign in now](#)

Profile Information


First name

Last name

Year of birth 


Sign In Information

Your email address

Create One Healthcare ID 

Your One Healthcare ID must have:

- 6 to 50 characters
- At least one letter
- No spaces
- No letters with accents
- None of these Symbols: % + " & [\] ^ ' { } < > # , / ; () : * = ~

 Copy Image

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

Search:

You will be prompted to create a One Healthcare ID

Provider Express: Secure Provider Portal

Provider Express offers a range of secure transactions

- ✓ Check eligibility and authorization or notification of benefits requirements
- ✓ Obtain authorization or complete notification for higher levels of care
- ✓ Create and maintain My Patients list
- ✓ Submit professional claims and view claim status
- ✓ Make claim adjustment requests
- ✓ Register for Optum Pay including Electronic Funds Transfer (EFT)
- ✓ Update practice information

Training on many of these topics is available on the Video Channel or through the Guided Tours

Receive payments faster

Benefits of Optum Pay



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

Registering for Optum Pay is easy!

- Log in to *Provider Express* with your One Healthcare ID
- Select “Optum Pay” under the “More” heading and follow the prompts to enroll
- Contact Optum Financial Services for assistance: 1-877-620-6194

Provider Express Video Channel

Home About Us Clinical Resources Admin Resources **Video Channel** Training Our Network

Contact Us

Home
Video Channel

Welcome to the Provider Express Provider Video Channel

Here's what providers are watching now

First Time Registering on Provider Express

Welcome to the Provider Express Message Center

Check out our latest videos

• • • •

Sign Up for Electronic Payments & Statements
Optum's Electronic Payments & Statements, the fastest way to get paid and helps your revenue stream keep flowing. Runtime: 2:49

Wellness Assessment Form
This brief guided tour demonstrates how to create and pre-populate a Wellness Assessment Form. Runtime: 2:11

Navigating Optum Webinar
Get up and running quickly with this informative on-demand webinar. Runtime: 30:37

Eligibility & Benefits
Brief overview covers various member search options, viewing eligibility results, benefit

Optum Authorization Inquiry
Quick overview for checking the status of an Authorization for

Claim Entry on Provider Express
Submitting claims using both the short form and the long form. Runtime: 8:25

Optum

**Provider
Customer
Service**



Provider customer service

Because the customer service phone number is different based on the type of business or employer, when calling customer service, you should call the phone number on the back of the member's card. If you do not have a copy of the card, please utilize the numbers below dedicated to the specific line of business:

- Mass General Brigham Health Plan (Medicaid): 1-844-451-3519

Join our network

- The participation process begins with submission of the provider application:
 - Go to Provider Express home page > [Our Network](#). Under “Join Our Network” select “Individually-Contracted providers” and respond to prompts
 - Providers contracting on an individual basis complete the CAQH universal application online at caqh.org
 - Agencies pursuing group contracts complete the Optum Agency application
- Additional required application materials include:
 - Signed Optum Provider Agreement
 - State required credentialing documents (attestation forms, licensures)
- Approval by Optum Credentialing
- 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

Recredentialing

- Recredentialing is completed every 36 months (3 years):
 - Timeline 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

Optum

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