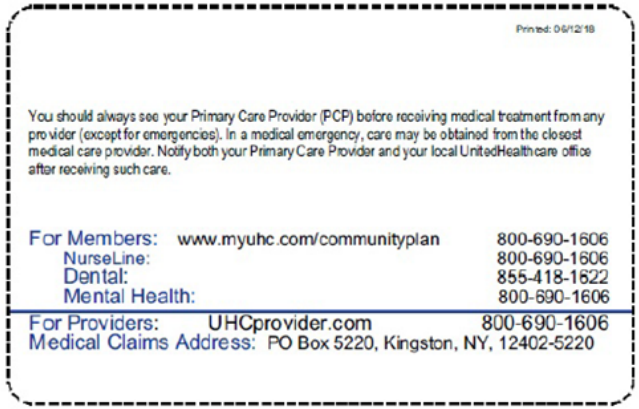
Provider Orientation

ABA Member Information

United Healthcare
Community Plan

Member ID Card

- ID cards are sent directly to the member
- The member's ID number, group number, primary care provider (PCP), name, etc. will be listed on the front of the card
- All relevant contact information will be on the back of the card for both medical and behavioral customer service



Please note this image is for illustrative purposes only.

Applied Behavior Analysis (ABA) Program Services

ABA Program Provider Credentialing Criteria

Individual Board Certified Behavior Analysts – Solo Practitioner

- Board Certified Behavior Analyst (BCBA) with active certification from the national Behavior Analyst Certification Board

AND

- State licensure in good standing
- Medicaid state certification without sanctions
- Medicaid ID in addition to individual TN Attestation
- Compliance with all state mandate requirements, as applicable to behavior analysts
- A minimum of 6 months of supervised experience or training in the treatment of applied behavior analysis/intensive behavior therapies
- Minimum professional liability coverage of $1 million per occurrence/$3 million aggregate

ABA/Intensive Behavior Therapy (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 state Medicaid certification in good standing and 6 months of supervised experience or training in the treatment of applied behavior analysis/intensive behavior therapies
- Group Medicaid ID and group TN Attestation
- Compliance with all state/autism mandate requirements, as applicable to behavior analysts/ABA practices
- BCBAs must have active certification from the national Behavior Analyst Certification Board and appropriate state certification
- Behavior Technicians must have state registration and receive appropriate training and supervision by BCBAs or licensed clinicians
- BCBA or licensed clinician on staff providing program oversight
- BCBA or licensed clinician performs skills assessments and provides direct supervision of Behavior Technicians /BCBAs in joint sessions with client and family
- $1 million/occurrence and $3 million/aggregate of professional liability and $1 million/$1 million of general liability if services are provided in a clinic setting
- $1 million/occurrence and $3 million/aggregate of professional liability and $1 million/$1 million of supplemental insurance if the agency provides ambulatory services only (in the patient’s home)

Steps in Providing Treatment

Who is eligible?

- To be eligible for ABA services, a member must meet all the following criteria:
- Be covered under Medicaid
  - Exhibit the presence of excesses and/or deficits of behaviors (e.g., aggression, self-injury, elopement, etc.), deficits in communication or deficits in social interaction that significantly interfere with home or community activities. There are acute changes in the member's signs and symptoms, and/or psychosocial and environmental factors and the member's current condition can be safely, efficiently and effectively assessed and/or treated in this setting.
  - Examples include:
    - Reducing problem behavior, such as aggression or self-injury
    - Increasing socially appropriate behavior, such as reciprocity
    - The acquisition of communication, self-help and social skills
    - Learning to tolerate changes in the environment and activities
- Have been diagnosed with a condition for which ABA-based therapy services are recognized as therapeutically appropriate, including autism spectrum disorder, intellectual and developmental disabilities (IDD) and traumatic brain injury (TBI), by a qualified health care professional
- Had a comprehensive diagnostic evaluation by a qualified health care professional

Intake

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

Suggested information:
- Provide subscriber with your HIPAA policies
- Always get a consent for services
- Release of Information to communicate with other providers, if necessary

Prior Authorization Review

- First step to reviewing the authorization request is to confirm eligibility
  - **Eligibility**: Covered under Medicaid: Include member ID, DOB and/or SS#. Utilization management needs 2 forms of ID to complete the eligibility process.
  - **Behaviors**: Exhibit the presence of excesses and/or deficits of behaviors (e.g., aggression, self-injury, elopement, etc.), deficits in communication or deficits in social interaction that significantly interfere with home or community activities. The UnitedHealthcare Community Plan Initial Template requests that providers indicate severity and estimated frequency of problematic behaviors.
  - **Diagnosis**: Have been diagnosed with a condition for which ABA-based therapy services are recognized as therapeutically appropriate by a qualified health care professional. Diagnosis should include summary of evaluations utilized as part of the diagnostic process.
  - **Referral**: BCBA/Licensed Behavior Analyst (LBA) and other licensed professionals allowed to make a referral/recommendation without a script. Referral should also include reason for ABA services, including reference to why ABA is recommended now.

Prior Authorization Request

- Initial Assessment Request - The provider will need to attach the following documents to the fax submissions:
    - Initial Assessment Request: The LBA/BCBA completes an ABA Assessment Template (see attached)
    - A valid DSM diagnosis, justification/rationale for the request for services and recommendations for treatment
        - Number of hours of service requested, for each code. Include a schedule of services. The BCBA/LBA is requesting units to complete FBA (Functional Behavior Analysis) through direct observation, direct assessment and indirect assessment.
        - Complete list of diagnoses and the evaluations/assessments used to determine the diagnoses must be included. A comprehensive diagnostic evaluation should be available upon request, if needed.
        - Initial treatment request needs to include:
            - Description of the problem behavior, including severity and frequency of the behavior, and/or deficits in communication and social interaction
        - If a billing agency is submitting initial paperwork, contact information for both the billing agency and clinical supervisor needs to be included

Prior Authorization Request (cont.)

- Treatment Request- The provider will need to attach the following documents to fax submission:
  - Treatment Request for ABA (see template) is considered a Concurrent Review. When the BCBA/LBA completes the above and develops the Behavior Intervention Plan (BIP; also called a Behavior Support Plan - Treatment Request):
    - Behavior Treatment Request
    - IEP, if appropriate to the member
    - Schedule of services
  - As part of the concurrent treatment request, the provider needs to include:
    - Graphs through the prior authorization period
    - Measurable, Obtainable, Individualized goals targeting the deficits identified in the comprehensive evaluation and FBA
    - Level of caregiver involvement, parental competence with implementing ABA skills, specific caregiver goals for ABA
    - Barriers to treatment and a plan to address
    - Address any regression, lack of progress, or slow progress
    - Discharge Plan, including when the member can discharge care and when they can begin to lower the hours per week of services received

Services Requiring Prior Authorization (CPT)

CPT Code/Modifier(s)	Service (all services are expressed in 15-minute increments)
97151 / HN	Behavior identification assessment, by professional
97152 / HN, HM	Behavior identification supporting assessment, by 1 technician, under direction of professional (QHP may substitute for the technician)
0362T	Behavior identification supporting assessment, by technician, requiring: administration by professional on site, with assistance of two or more technicians, for patient w/destructive behavior, in customized environment
97153 / HN, HM	Adaptive behavior treatment by protocol, by technician under direction of professional (QHP may substitute for the technician)
0373T	Adaptive behavior treatment with protocol modification, by technician, requiring: administration by professional on site, with assistance of two or more technicians, for patient w/destructive behavior, in customized environment
97154 / HN, HM	Group adaptive behavior treatment by protocol, by technician under direction of professional (QHP may substitute for the technician)
97155 / HN	Adaptive behavior treatment with protocol modification, by professional
97156 / HN	Family adaptive behavior treatment guidance, by professional (with or without patient present)
97157 / HN	Multiple-family group adaptive behavior treatment guidance, by professional (without patient present)
97158 / HN	Group adaptive treatment with protocol modification, by professional
T2002	Transportation, per diem (available for 1 provider per day roundtrip if traveling 30 miles or more to a member's home)

Modifiers are to be used in billing to reflect the credentials of staff delivering services and to allow for proper claims payment (HN = Bachelor's degree level – BCaBA; HM = less than Bachelor's degree level – Behavior Technician, when not otherwise indicated per code description)

Prior Authorization

- For authorization requests, questions or submission, please contact:
  - **Questions** – National ABA: call Behavioral Health number on the member's card and request ABA services
  - **Prior authorization** – Fax submission: 877-217-6068

Coding, Billing and Reimbursement

Claim Submission

Required claim form
- CMS-1500 form

Claims/Customer service number
- Phone: 800-690-1606

Electronic claims payer ID: 95378

Paper claims
- When submitting behavioral claims by paper, please mail claims to:
  UnitedHealthcare Community Plan
  P.O. Box 5220
  Kingston, NY 12402-5220

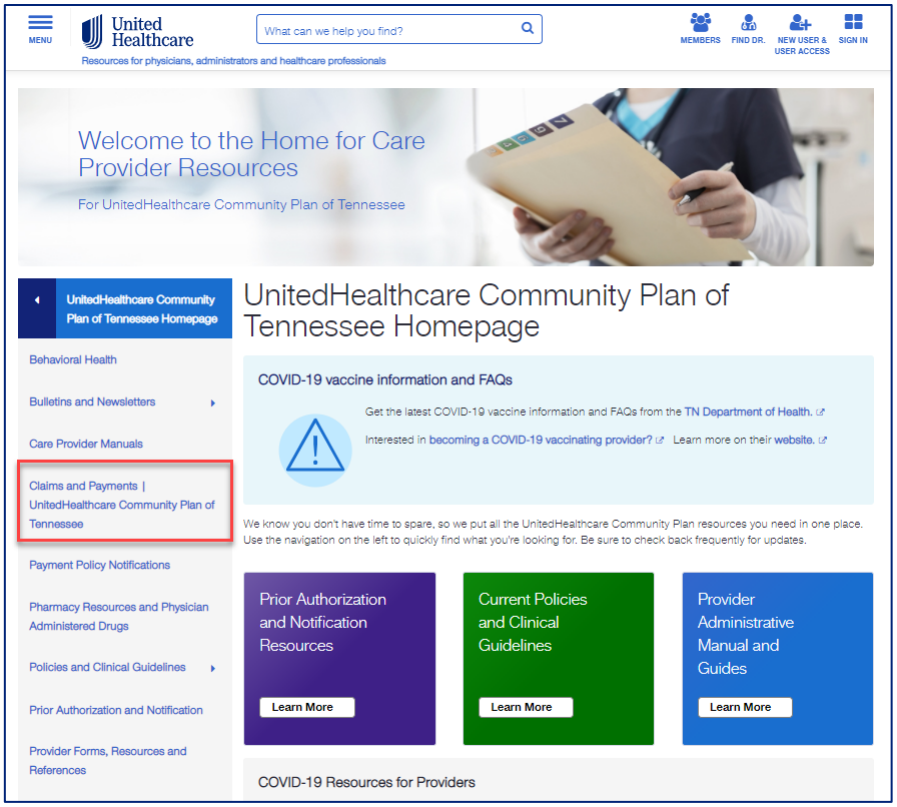
Claim Submission (cont.)

- If not submitting claims online, providers must submit claims using the current 1500 Claim Form with appropriate coding
- Providers must initially submit claims within 120 days of the date of service
- When a provider is contracted as a group, the payment is made to the group, not to an individual
- All claim submissions must include:
  - Member name, member date of birth, member identification number
  - Dates of service, type and duration of service
  - Name of clinician (e.g., individual who provided the actual service) along with group name (if applicable)
  - Provider credentials, tax ID and National Provider Identifier (NPI) numbers
  - Taxonomy Numbers
  - Appropriate ICD-10 code for billing
- Providers are responsible for billing, in accordance with nationally recognized Centers for Medicare and Medicaid Services (CMS) Correct Coding Initiative (CCI) standards. Additional information is available at www.cms.gov

Billing Option 1

Claim Submission Option 1 – Online

- Log on to UnitedHealthcare Community Plan of Tennessee Homepage | UHCprovider.com
  - Secure HIPAA-compliant transaction features streamline the claim submission process
  - Performs well on all connection speeds
  - Submitting claims closely mirrors the process of manually completing a CMS-1500 form
  - Allows claims to be paid quickly and accurately
  - Providers must have a registered user ID and password to gain access to the online claim submission function



Billing Option 2

Claim Submission Option 2 – EDI/Electronically

- Providers may use any clearinghouse vendor to submit claims
- Payer ID for submitting claims is 95378

Additional information regarding EDI is available on:

UHCprovider.com/edi.

Claim Submission Option 2 – EDI/Electronically (cont.)

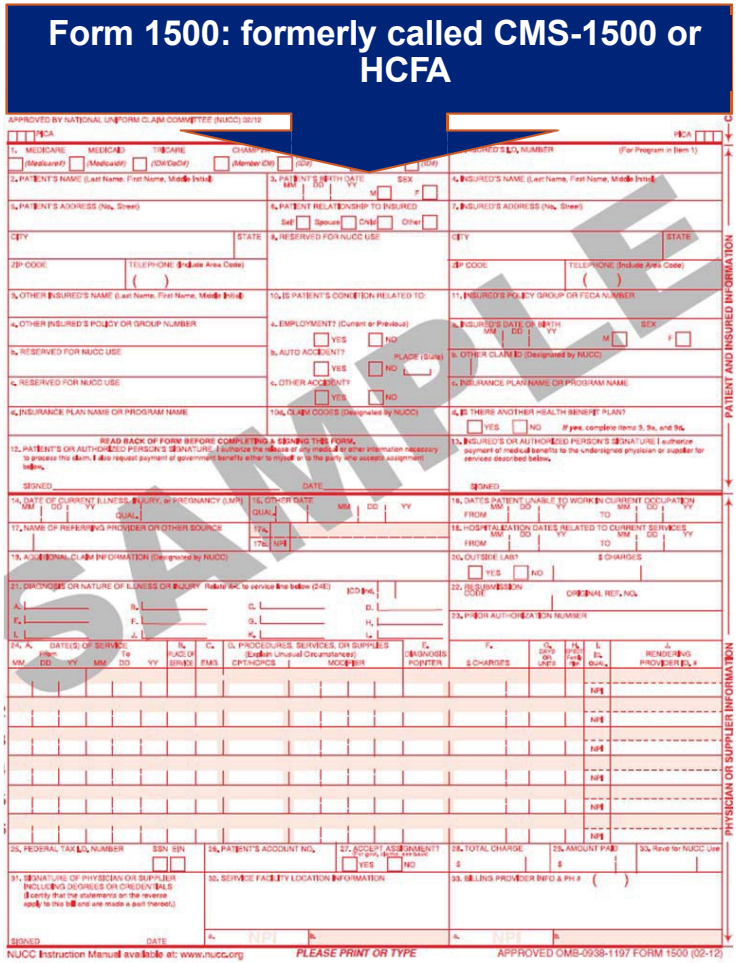
- Electronic Data Interchange (EDI) is an exchange of information
- Performing claim submission electronically offers distinct benefits:
  - **Fast:** eliminates mail and paper processing delays
  - **Convenient:** easy set-up and intuitive process, even for those new to computers
  - **Secure:** higher data security than with paper-based claims
  - **Efficient:** reduces pre-submission errors so more claims auto-adjudicate
  - **Notification:** gives providers feedback that payer received claims; distributes error reports for claims that fail submission
  - **Cost-efficient:** eliminates mailing costs, the solutions are free or low-cost

Billing Option 3

Claim Submission Option 3 – Hard Copy

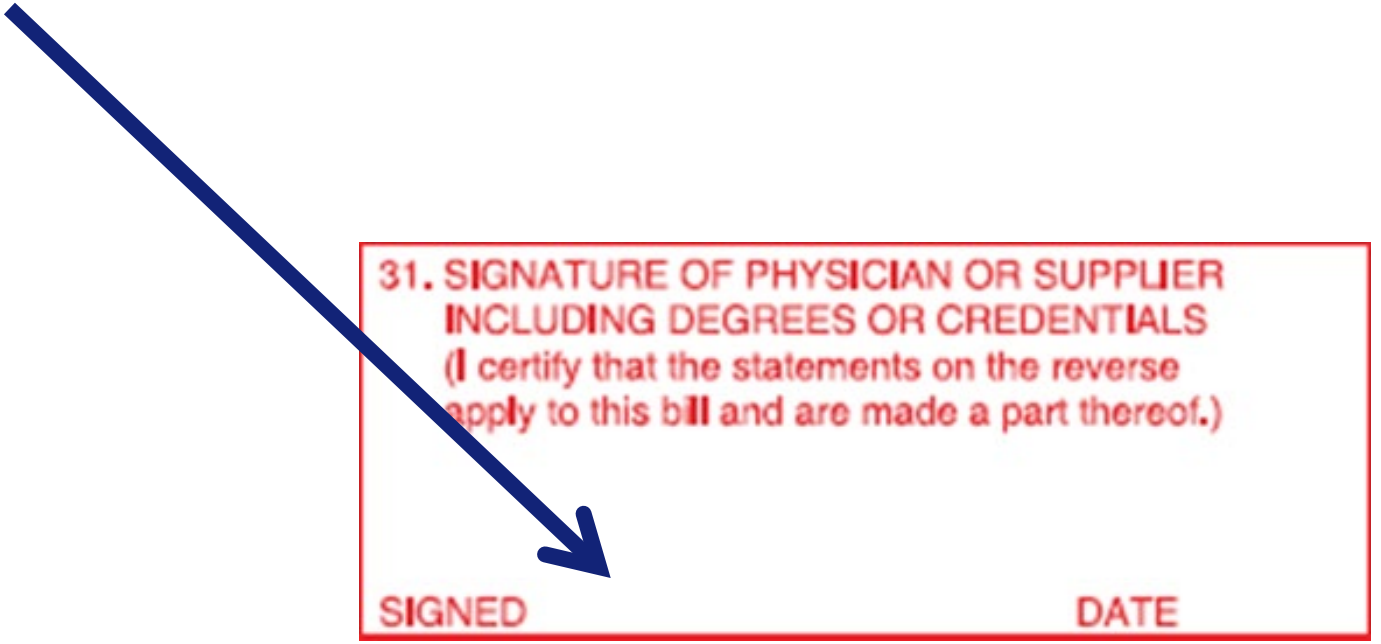
- Use the CMS-1500 claim form
- All billable services must be coded
- Coding can be dependent on several factors:
  - Type of service (assessment, treatment, etc.)
  - Appropriate modifier for specific provider type
  - Rate per unit
  - Place of service (home or clinic)
  - Duration of therapy (15-minute units)
  - Only 1 date of service (DOS) per line
- *Provider must select the code that* most closely describes the service(s) delivered and aligns with the service that was requested and authorized

Please note: Field 24j must have a rendering provider's NPI number and name in field 31.



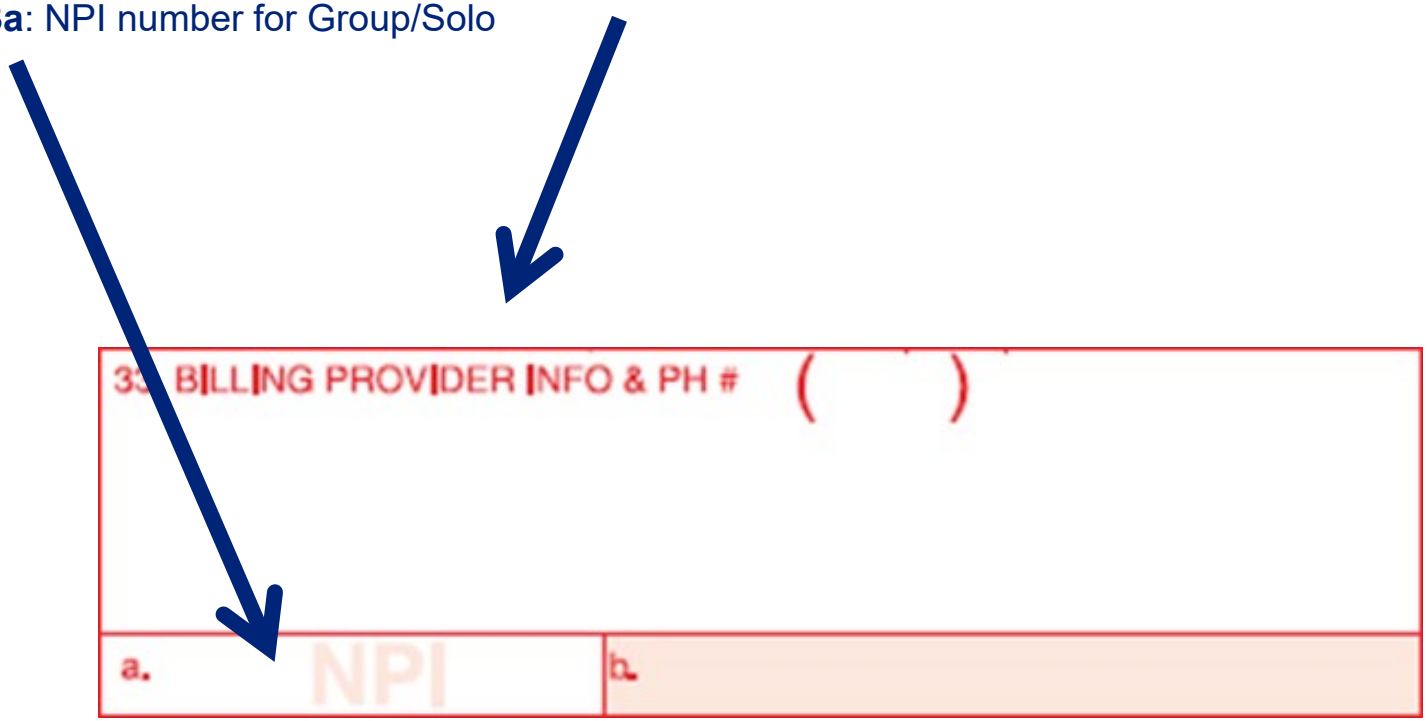
Claim Form – CMS Form 1500 Provider Section

Box 31: Rendering Group supervisor/Solo **(BCBA/Licensed Clinician)** enter their name and licensure in Box 31



Claim Form – CMS Form 1500 Provider Section (cont.)

Box 33: Name, address and phone number for Group/Solo
Box 33a: NPI number for Group/Solo



Optum Pay™

Optum Pay™

- **Optum Pay** is our solution for electronic remittance advice (**ERA**) and electronic funds transfer (**EFT**)
- **Optum Pay** allows you to access your explanation of benefits (**EOBs**) online and receive direct deposit of claim payments into your checking or savings account
- **Faster payments, better cash flow**
  - Eliminate mail delivery and check-clearing time to receive your payments faster
- **Less work, more time**
  - No more envelopes to open, paper checks to track or trips to the bank
  - More than 850,000 physicians, health care professionals, facilities and billing companies use Optum Pay today for its easier reconciliation experience, reduced paperwork and the greater efficiency it brings to administration

Optum Pay™

- With Optum Pay, providers will receive electronic funds transfer (EFT) for claim payments; plus, their 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, providers will need to enroll at **myservices.optumhealthpaymentservices.com**. The following information is needed:
  - Bank account information for direct deposit
  - Voided check or bank letter to verify bank account information
  - Copy of the provider 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

- ***Note:*** *For more information, providers can call* ***866-842-3278****, option 5, or go to* ***UHCprovider.com/en/claims-payments-billing/electronic-payment-statements.html***

Tools for Success

Claim Tips

- **To ensure clean claims**
  - NPI number is always required on all claims (Field 24j)
  - Complete diagnosis also required on all claims
- **Claim filing deadline**
  - Providers have 120 days from the date of service to file Medicaid claims
  - The member cannot be balance billed for behavioral services covered under the contractual agreement

Claim Tips (cont.)

- **Member eligibility**
  - Provider is responsible for verifying member eligibility
- **Coding issues**
  - Incomplete or missing diagnosis
  - Invalid or missing HCPCS/CPT; examples include:
    - Submitting claims with codes that are not covered services
    - Required data elements missing (i.e., number of units)
- **Provider information missing/incorrect**
  - Example: provider information has not been completely entered on the claim form or place of service is missing or incorrect
- **Prior authorization required**
  - Prior authorization is required for all ABA services, including when additional units are requested

Claim Tips (cont.)

Rejections/Denials

- **Rejected claim** – Claim that is rejected prior to hitting UnitedHealthcare's claim system
  - Claim could be rejected for missing claim data (e.g., missing NPI, Tax Identification Number [TIN] or other required data element)

- **Denied claim** – Claim that is denied by UnitedHealthcare's claim system
  - Claim could be denied automatically during auto adjudication (e.g., eligibility or timely filing issues)
  - Or claim could be denied during processing (e.g., no authorization on file, etc.)

- For assistance with rejected or denied claims, contact the Claims/Customer Service Team
  - Phone: **800-690-1606**

Resources

Online Claim Submission

- 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 all EDI-related issues
  - Providers may also call us at **800-210-8315** or email us at **ac_edi_ops@uhc.com**

- Provider Services Technical Support Team: **866-842-3278**
  - Providers experiencing technical problems, needing assistance in using **unitedhealthcarecommunityplan.com** or those having login or User ID/Password issues, please call Provider Services for support

Thank you

PCA-2-21-00767-TN-ABA_03012021