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MOLINA HEALTHCARE

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COMMUNITY HEALTH PLAN of Washington™

The power of community

How To Work With The Managed Care Organizations

United Healthcare Community Plan

WAAGP-CD-007515-22 September 2022

Where to start?

1

Credentialing is a method of verifying that healthcare professionals are certified. This process requires multiple steps and can take 90-days to complete.

How to start the Credentialing process:

- Complete the Manage Care Organization (MCO) application.
  (Must be WA state licensed)
- Following the receipt of your application, an MCO credentialing specialist will contact your office.
- The MCO credentialing specialist will advise you on the requirements necessary to complete the credentialing process.

2

Contracting

Your contract defines the relationship between the provider and payer. The contract outlines obligations, compensation, references to policies/procedures and, etc.

Participating providers:

- To become a participating provider with the MCO your contract must be fully executed.
- After your contract has been fully executed, your provider profile will be set up in the MCO systems, and you can start scheduling appointments with MCO members.

3

You will receive a welcome packet from the Managed Care Organizations. Key contacts are included in your welcome packet. Please feel free to contact your support team.

Provider resources:

Provider Manual –

- The provider manual offers an overview of the healthplan and important forms, procedures, and references to help you deliver the best possible care to your patients.

Provider Portals –

- Eligibility/Benefit verification
- Claims submission and status
- Prior Authorization submission and status
- Provider demographic updates and changes

Provider Participation Requirements

State Requirements:

- Valid Washington State License
- Registered with State
- Medicaid ID
- Enroll as Billing Provider for Managed Care
- NPI-Apply for an NPI at: https://nppes.cms.hhs.gov/#

MCO Requirements:

- Complete the Mange Care Organizations application

(Must be WA state licensed)

Lack of compliance with this HCA requirement can IMPACT claims payment, please ensure you are properly registered and obtain the ProviderOne ID!

The Member Seeks Out Treatment

- What's Next?

Appointments with MCO Members

Appointment Check-In:

- Copy front and back of the member's insurance card and photo ID.
- Collect and record member demographic information.
- Verify eligibility and benefits before rendering services. (See next slide)

It is important to follow specific steps to ensure you are prepared to bill the correct MCO with accurate member information.

Suggested information:

- Provide subscriber with your HIPAA policies
- Provide subscriber with consent for billing using protected health information, including signature on file
- Always get a consent for services
- Informed Consent: services, to leave voicemail, email, etc.
- Billing policies and procedures

<u>Informed Consent includes:</u>

- Decision capacity
  - Informed Consent for Members who do not have the ability to make informed healthcare decisions – RCW 7.70.065
- Disclosure of information including degree, in scope and out of scope, payment expectations, confidentiality, member access to records, voluntary vs involuntary, grievance process, treatment options, potential risks, and alternative treatments available.
- Documentation of Consent including providing member a copy.

How do you know what MCO they are working with and why is that important

Eligibility should be verified *before every service*. HCA updates eligibility daily, therefore retrospective or mid-month changes can exist.

Methods to confirm eligibility:

Each MCO Portals

HCA ProviderOne: https://www.waproviderone.org/

HCA Eligibility Manual: https://www.hca.wa.gov/assets/billers-and-providers/manual_verifyclienteligibility.pdf

Why it is important to know?

Are you contracted? If not, you may need to submit a Prior Authorization.

Are the services you offer covered by their insurance?

Does the benefit require a Prior Authorization by that MCO?

Links to MCO PA pages

Member Eligibility and Benefits Verification

- **What are the most important steps in the billing process?**

- Call the phone number on the back of member's insurance card or use the MCO's provider portal to -
  - Verify eligibility to ensure the member is currently enrolled with the MCO
  - Verify benefits to ensure services and diagnoses are covered

- When you verify eligibility and benefits, you should have the following information available:
  - Member's Name
  - Member ID#
  - Date Of Birth
  - Address
  - Type of services and diagnoses

ProviderOne and Medicaid Coverage

Does the client have an Apple Health (Medicaid) managed care plan?

In the "Managed Care Information" area of the Apple Health Client Eligibility ProviderOne webpage, you need to see if the client has managed care coverage.

- Sort by the End Date (click the down-caret) with highest value at the top.

If one of the Integrated Managed Care Plans (see list to the right) is under "Plan/PCCM Name", that means the client has a managed care plan and the client is not covered by Apple Health (Medicaid) fee-for-service.

If none of the Integrated Managed Care Plans is under "Plan/PCCM Name", that means the client has Apple Health (Medicaid) fee-for-service coverage also known as Apple Health coverage without a managed care plan. Note: PCCM is not a managed care plan.

Integrated Managed Care Plans

AMG Fully Integrated Managed Care
CCC Fully Integrated Managed Care
CHPW Fully Integrated Managed Care
Coordinated Care Healthy Options Foster Care
MHC Fully Integrated Managed Care
UHC Fully Integrated Managed Care

Managed Care Information

Insurance Type Code	PCCM Code	Plan/PCCM Name	Plan/PCCM ID	Plan/PCCM Phone Number	PCP Clinic Name	Start Date	End Date
HM: Health Maintenance Organization	MC: Capitated	AMG Behavioral Health Services Only	201599811	(800) 600-4441		01/01/2019	12/31/2999
HM: Health Maintenance Organization	MC: Capitated	Community Choice - Health Home Only	203039501	(888) 509-0563		08/01/2018	12/31/2999
HM: Health Maintenance Organization	MC: Capitated	Spokane Behavioral Health Organization	105021302	(509) 477-5722		08/01/2018	12/31/2018
HM: Health Maintenance Organization	MC: Capitated	Spokane Behavioral Health Organization	105021302	(509) 477-5722		01/01/2017	07/31/2018

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Message(s):

Medicare Eligibility Information

Prior Authorization

Prior Authorization (PA) review is the process of reviewing certain medical, surgical, and behavioral health services according to established criteria or guidelines to ensure medical necessity and appropriateness of care are met prior to services being rendered.

How to check if a PA is required:

- Go to the MCO's website and click on the Provider section or use the Provider Manual to find information on PA requirements.

How to request a PA:

- Complete a PA request as directed on the MCO's website or Provider Manual.
- Your office can submit a PA request via the provider portal or via fax.

Appointments Standards for Behavioral Health Providers

MCO appointment standards comply with the Health Care Authority (HCA) and the National Committee for Quality Assurance (NCQA) requirements. Providers must also adhere to these standards.

Type of Care	Appointment Standard
Non-life threatening	Within 6-hours
Urgent Care	Within 24-hours
Routine care – initial visit	The earlier of 10 business days or 14 calendar day
Routine care – follow-up visits	Within 30 days

Documentation

*Content may vary based on electronic health record

1. Clinical Assessment completed by appropriate credentialed provider
2. Person Centered Treatment plan
    - Include natural supports, treatment modalities, other services which may support the member's recovery

3. Documentation of each visit including Date, time, rendering provider, length of session, appropriate billing code (link to HCA billing guide or SERI), type of treatment provided, progress or barriers, use of evidence based practices and core components if applicable. signature

Clinical Documentation

Licensed Mental Health Providers/Agencies billing Medicaid must follow the clinical documentation guidelines outlined in WAC 246-341-0640

Documentation must include a mental health assessment, a diagnosis, treatment plan, and clinical notes.

Please reference the WAC for a comprehensive list of documentation requirements: WA 246-341-0640

For Applied Behavior Analysis (ABA) documentation requirements, please reference WAC 182-531A

Claims Submission

We encourage providers to submit claims electronically in one of two ways:

- Online through Provider Portal
- Using Electronic Data Interchange (EDI) through a clearinghouse vendor

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

Claims Submission (continued)

If you are not submitting claims online, providers must submit claims using the current 1500 Claim Form or UB-04 with appropriate coding

Managed Care Organizations requires that you initially submit your claim within 365 days of the date of service

When a clinician is contracted through a group, the payment is made to the group, not to the individual clinician

All claim submissions must include:

- Member name, Medicaid identification number and date of birth
- Provider's Federal Tax I.D. number
- National Provider Identifier (NPI)
- Providers are responsible for billing in accordance with nationally recognized CMS Correct Coding Initiative (CCI) standards. Additional information is available at cms.gov

Electronic Claims Submission Option 1- Online

Log on to MCO Provider Portal:

- 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

You must have a registered user ID and password to gain access to the online claim submission function:

Go to The MCO Portal link, and select

- New User to set up your access.
- Once you are logged in, you can submit claims on our portal

Claims Submission Option 2 - EDI

- You may use any clearinghouse vendor to submit claims
- Payer ID for submitting claims is listed per MCO here

Electronic Payment & Statements (EPS)

- With EPS, you receive electronic funds transfer (EFT) for claim payments and your Explanations of Benefits (EOBs) are delivered online:
  - Lessens administrative costs and simplifies bookkeeping
  - Reduces reimbursement turnaround time
  - Funds are available as soon as they are posted to your account
- To receive direct deposit and electronic statements through EPS you need to enroll The MCO links.
- You'll need:
  - Bank account information for direct deposit
  - Either a voided check or a bank letter to verify bank account information
  - A copy of your practice's W-9 form **If you're already signed up for EPS with UnitedHealthcare Commercial or UnitedHealthcare Medicare Solutions, you will automatically receive direct deposit and electronic statements through EPS for UnitedHealthcare Community Plan when the program is deployed.**

Claims Tips

To ensure "clean claims" remember:

- An NPI number is required on all claims
- A complete diagnosis is also required on all claims

Claims filing deadline

- Providers should refer to their contract with United to identify the timely filing deadline that applies

Claims processing

- Clean claims, including adjustments, will be adjudicated within 14 days of receipt

Balance billing

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

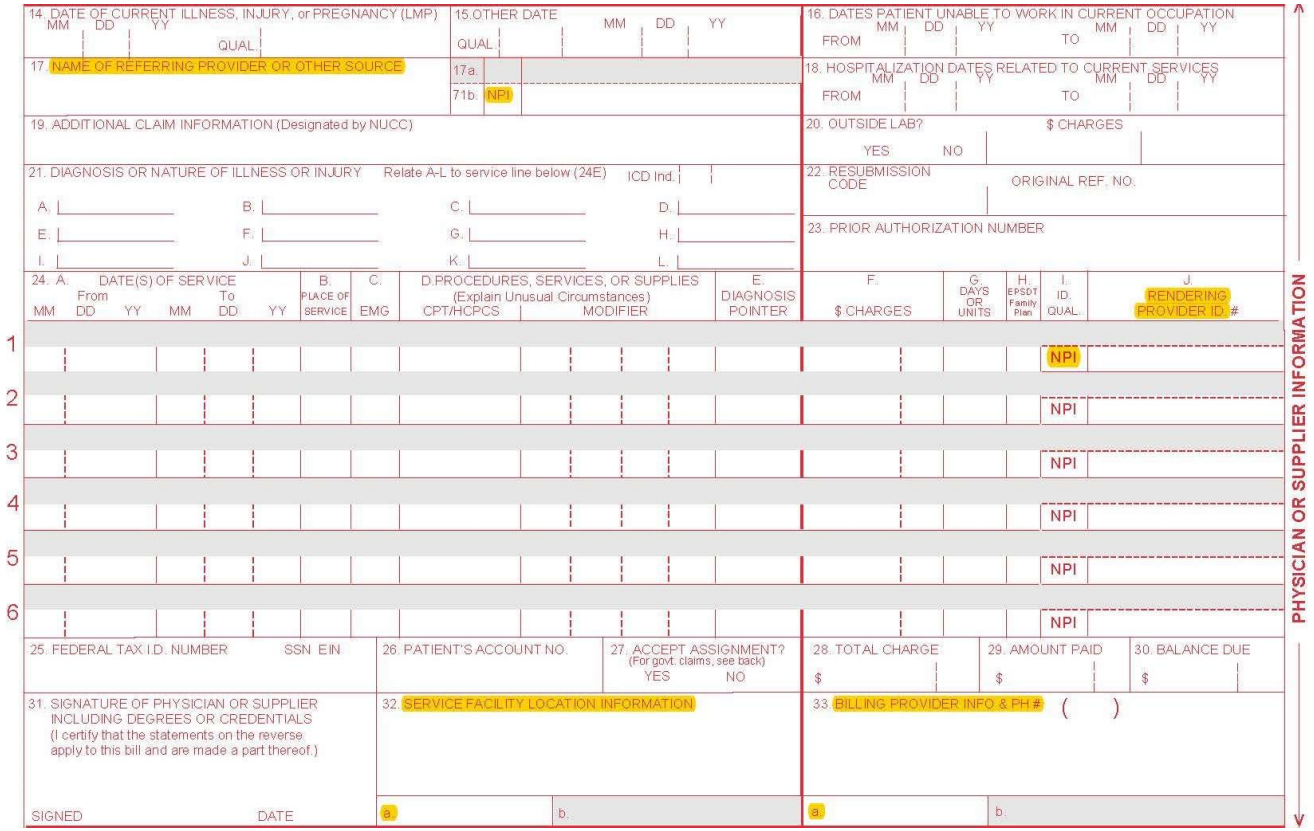
Claims Tips (continued)

- **Member Eligibility**
- Provider is responsible to verify Member eligibility through Provider one website
- **Coding Issues**
- Coding issues including incomplete or missing diagnosis Invalid or missing HCPC/CPT examples:
  - Submitting claims with codes that are not covered services
  - Required data elements missing, (e.g., number of units)
  - Ensure add on codes are billed together, (Example: 96164, 96165)
- **Provider information missing/incorrect**
- Example: Provider information has not been completely entered on the claim form, or place of service
- **Prior Authorization Required**
- Prior Authorization is required for all IP services, or when additional units are being requested.

1500 Claim Form (continued)

- The HCFA 1500 Form has 4 sections where provider information is stored, they have been highlighted for easy reference. The CRE Edit will review each section when a provider name and NPI number is populated.

- 17b – Referring, Prescribing physician and NPI number
- 24J – Rendering physician and NPI number
- 32A – Service location and NPI number
- 33A – Billing provider and NPI number



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