Quick Reference Guide

Florida Statewide Medicaid Managed Care Behavioral Analysis Program

Effective Feb. 1, 2025, United Behavioral Health, operating under the brand Optum, manages the Medicaid Managed Care Behavioral Analysis (BA) program for Florida residents with coverage through UnitedHealthcare Community Plan of Florida. This quick reference guide outlines information and resources to help you provide behavioral analysis services to these members and manage claims for those services.

Patient Support

Continuity of Care

The 120-day continuity of care period begins on Feb. 1, 2025. During this period, UnitedHealthcare Community Plan of Florida and Optum shall:

- Honor any existing prior authorizations for behavior analysis services for the entirety of the 120-day continuity of care period.
  - This includes extending any existing prior authorizations that may expire during the initial continuity of care period for the remainder of the continuity of care period.
- Reimburse non-participating providers at the same rate they received for services rendered to the member immediately prior to Feb. 1, 2025, when the member's coverage transitioned to UnitedHealthcare Community Plan of Florida and Optum.
  - This rate shall be paid for a minimum of 60 days or in accordance with a plan-specific continuity of care period.
- For members that change plans during the initial continuity of care period, UnitedHealthcare Community Plan of Florida and Optum shall coordinate with the previous plan to ensure existing prior authorizations will be honored.

ID Cards

Interpreter Services

Call the Language Interpretation Line 24/7 at 1-888-225-6056 for help with more than 240 non-English languages and hearing-impaired services. (Client ID 209677)

Checking Benefits and Requesting Authorization

Provider Express Secure Portal

Providerexpress.com > Log-In (requires One Healthcare ID)

The Provider Express secure portal is a self-service tool – available 24/7 – to help you complete administrative tasks and responsibilities whenever it's most convenient for you. Need help? Contact the Provider Express Web Support Center at 1-866-209-9320.

- **Verifying member eligibility and benefits**
  It takes less than 2 minutes to check a member's benefits and eligibility using the secure portal. (Use this guide to get started.) You may also call the number on the back of the member's ID card. (Wait times to speak with a representative vary based on call volume.)
- **Submitting prior authorization requests**
  All behavioral analysis services require prior authorization. Requests must be submitted via the secure portal. Go to Providerexpress.com > Log-In (requires One Healthcare ID) > Auths > Auth Request > Request a new authorization. Select ABA Assessment or Treatment from the drop down menu. Enter the required information and submit. (This guide has step-by-step instructions.)

Claims Submissions, Status and Appeals

Behavioral analysis claims must be submitted to UnitedHealthcare Community Plan within 180 days from the date of service(s). The Payer ID is 87726.

- **First-time submitter?** You must include your W9 and a copy of your Florida license the first time you submit a claim to Optum.
- **Need more guidance?** Review these claim tips and resources for more information

Claim Submission

There are 3 ways to submit a claim:

1. **Via Electronic Data Interchange (EDI)**
   All claims should be billed using either EDI 837I (Institutional) / UB04 or EDI 837P (Professional). You may choose any clearinghouse vendor to submit claims through EDI.
   - Electronic Remittance Advice (ERA) Payer ID: 86047

   For EDI support, call **1-800-210-8315** or email ac_edi_ops@uhc.com
2. **Through the Provider Express secure portal**
   Go to Providerexpress.com > Log-In (requires One Healthcare ID) > Claims > Claim Entry. Complete the required information and submit. (Use this claim guide to get started.)
3. **By mail**
   Use Form 1500 to bill for behavioral analysis services. Complete the form – be sure to include the ICD diagnosis codes and identify other services by the CPT/HCPCS and modifiers. Mail paper claims to:

   Optum
   PO Box 31365
   Salt Lake City, UT 84131-0348

To Check Claim Status

Regardless of how a claim was submitted – via EDI, through the secure portal or by mail – you can check status in just a few minutes through the Provider Express secure portal.

Go to Providerexpress.com > Log-In (requires One Healthcare ID) > Claims > Claim Inquiry. Complete the required information and submit. You may also call the number on the back of the member's ID card. (Wait times to speak with a representative vary based on call volume.)

To Appeal a Claim

If you disagree with a claim denial or reimbursement amount, you can submit an appeal. The process will be outlined in the Remittance Advice you receive for the claim. Mail appeals to:

Optum, Appeals & Grievances
PO Box 31364
Salt Lake City, UT 84131-0364

Claim Payments

Payment Timeline

Generally, behavioral analysis claims that contain all required information* will be processed within 15 calendar days after receipt of the claim. The provider or designee will be paid or notified that claim payment is denied. The notification of a denied claim will include an itemized list of denial reasons/codes, as well as any additional information or documents necessary to process the claim for payment.

*This may exclude claims which require an exception process, such as coordination of benefits (COB) and student status verifications, which can delay this process.

Payment Method

UnitedHealthcare Community Plan of Florida reimburses claims via electronic payments. We no longer send paper checks for payment. There are 2 options for electronic payment – both allow you to get paid quickly and securely:

1. **Automated Clearing House (ACH)/direct deposit via Optum Pay®** are deposited directly into your bank account.
2. **Virtual Card Payments (Virtual Card)** are processed as a credit transaction through the same terminal used for patient copays.

Review details about these payment options.

Provider Resources

Clinical Criteria

These guidelines are used to standardize coverage determinations, promote evidence-based practices and inform discharge planning for behavioral health benefit plans managed by Optum. When determining coverage, the member's specific plan benefits must be referenced.
Review criteria

Network Provider Manual

The provider manual supplements your participation agreement (contract). It has important process, protocol and guideline information, as well as contact information such as websites, phone numbers, emails and addresses. Review manual

Optum Behavioral Health Provider Services

Call **-877-614-0484** if you have additional questions.