

# OPTUM IDAHO Clinical Model<sup>2.1</sup>

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This document is informational only and intended as supplemental to the Provider Manual; the Provider Manual is the primary document that guides expectations for Optum Providers.

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# OPTUM IDAHO CLINICAL MODEL<sup>2.1</sup>

## Utilization Management Program Overview

Utilization management is one of the most basic ways in which Optum ensures the quality, appropriateness, and effectiveness of treatment services provided to Members of the Idaho Behavioral Health Plan (IBHP). It also is an integral part of Optum network management, quality improvement, and system change efforts. Perhaps most importantly, utilization management is one of Optum's most frequent opportunities to build strong working relationships with Optum network Providers.

Utilization management is the process in which Optum clinicians may interact regularly with Providers from mental health and substance abuse agencies about the needs of the Members we jointly serve. It enables Optum Care Advocates and Chief Medical Officer to reinforce Optum's focus on medical necessity, clinical criteria, evidence-based best practices, and recovery and resiliency.

It is Optum's goal to provide for the open exchange of information between professionals and an efficient authorization process as providers deliver medically necessary care to Optum Members.

In collaboration with the IDHW, Members, and Providers, Optum continues to develop, implement, and maintain a utilization management program for the IBHP to monitor the appropriate utilization of covered services and to:

- Simplify the administrative processes for Providers, enabling them to devote more staff time to treating Members
- Encourage Members to access services at the time they first recognize symptoms in themselves or in a family member
- Ensure that all services provided are medically necessary, focused on measurable outcomes, and are supporting the Member's recovery and/or the family's resiliency

The utilization management program is described in detail in the Provider Manual and explained in the Member Handbook and other relevant Member materials to ensure that everyone who is a part of the utilization management program understands the requirements. Optum's toll-free Member Access and Crisis Line, Customer Service Line and website ([www.optumidaho.com](http://www.optumidaho.com)) are also available for those who need additional clarification.

Optum's utilization management plan for the IBHP is in full compliance with the requirements in 42 CFR §456.22 for the ongoing evaluation, on a sample basis, of the need for and the quality and timeliness of Medicaid services. Should the IDHW or CMS direct that we add additional utilization controls, Optum will work with the IDHW to expand Optum utilization management program.

## Outlier Management

### Optum's ALERT Outpatient Management System

The purpose of all mental health and substance abuse services is to help a Member move toward recovery, independence, and taking personal responsibility for his or her health and well-being. In a managed behavioral health care program, it is important to balance the time required to request and provide authorizations for outpatient services with the responsibility to ensure that

services are moving a Member toward his or her treatment goals and are clinically appropriate and medically necessary.

An approval process that requires a discussion between clinicians for every outpatient service request can be time consuming for the Provider as well as for the managed care organization. Investing clinical resources in labor-intensive authorization processes also diminishes the time those Providers can spend in providing or overseeing treatment for Members.

Therefore, to evaluate each Member's need for services and to monitor each Member's progress in treatment, Optum developed an outcomes-informed outpatient clinical care model, called ALERT® (Algorithms for Effective Reporting and Treatment).

### **A Data-Driven Care Management Approach**

By effectively identifying outliers<sup>1</sup> and guiding interventions, the ALERT® Outpatient Management program helps control direct and indirect outpatient costs while ensuring optimal clinical outcomes.

In other public sector programs, Optum has learned that the most effective way to improve a delivery system—as well as the treatment provided to individual Members—is to focus on those Members who have the greatest clinical needs and on those Providers who may benefit from additional education and resources regarding best practices. This enables us to use Optum Care Advocates efficiently and it also reduces the additional workload often imposed on Providers by managed care organizations.

**ALERT®** is an outcomes and outlier management system that utilizes Member self-reports of symptom severity and impairment as measured by a wellness assessment in combination with claims to identify Members who may be at-risk or who may be over- or under- utilizing outpatient services. It provides decision support for the authorization of outpatient services and also generates Provider profiles that enable quality improvement and clinical staff to take action when trends are identified. In addition, ALERT's clinical algorithms complement claims-based fraud, waste and abuse detection.

The ALERT system is comprised of three integrated components:

- The Optum Wellness Assessment
- Clinical- and claims-based algorithms
- ALERT Online

### **The Optum Wellness Assessment**

The Optum Wellness Assessment provides information that is critical to ALERT's algorithmic analysis of a Member's clinical and medical condition, need for treatment, and progress in treatment. Members must be asked to complete the Optum Wellness Assessment each time their Provider requests authorization to provide services. The Provider must fax in the completed Wellness Assessment where the information becomes part of the clinical information in the Member's record. The Wellness Assessment must be completed in addition to the CAFAS/PECFAS for children receiving Category Three services or the GAIN-I Core for Members diagnosed with a Substance Use Disorder (SUD).

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<sup>1</sup> "Outlier: a statistical observation that is markedly different in value from the others of the sample." Merriam-Webster.com. Merriam-Webster, n.d. Web. 26 Aug. 2014. <<http://www.merriam-webster.com/dictionary/outlier>>.

The Optum Wellness Assessment is based on a psychometrically-tested instrument that uses the Global Distress Scale (GDS) for identifying and monitoring change in psychological distress and identifying chemical dependency risk and medical issues. Optum uses two versions of the Assessment: one for adults and the other for youth under the age of 12. The adult scale includes 24 items that assess symptoms of depression and anxiety, functional impairment, well-being, daily functioning, health and medical co-morbidity, and substance risk and use. The youth scale uses 25 items to assess global impairment in the child (including interpersonal, emotional, academic and behavioral), caregiver strain, parental workplace absenteeism and presentism, and health. Copies of both the adult and youth questionnaires, in English and in Spanish, are available online at [www.optumidaho.com](http://www.optumidaho.com).

Analyses demonstrate that the scales, comprised of items from well-validated public domain scales, are both valid and reliable. Both have been independently validated to ensure psychometric integrity as an outcome tool and to affirm the tool's use as an objective assessment tool with external credibility. A more detailed discussion of the Global Distress Scale, its reliability and validity is available online at [www.optumidaho.com](http://www.optumidaho.com).

### **ALERT's Clinical- and Claims-based Algorithms**

The Optum Wellness Assessment is a key component of the Idaho ALERT program and for that reason, all Providers are **required** to ask all Members to complete the Assessment at the initiation of treatment and to monitor treatment progress whenever the Provider requests authorization to continue treatment. The Optum Wellness Assessment supports the following:

- **Risk stratification of Members** – Using a series of algorithms ALERT identifies initial Member risk based on the Member self-report. This is used in combination with other data to refine the determination of that individual Member's level of risk.
- **Monitoring of progress in treatment** – Optum Care Advocates receive ALERT-generated flags whenever the system identifies potential issues with a Member's medical condition or progress in treatment. Through ALERT Online, Providers also have access to the information generated by ALERT to self-monitor and manage the Member's outcomes and progress in treatment.
- **Monitoring of progress in treatment** – With data from the Wellness Assessment, Optum Quality Improvement (QI) staff are able to measure and report clinical outcomes for the membership of the IBHP.
- **Clinician Effectiveness** – The data from the Wellness Assessment is key to measuring clinician effectiveness. ALERT measures Provider and Provider group severity adjusted effect size every quarter. The effect size is a standard measure in the social sciences for measuring the effectiveness of treatment. The data from the Wellness Assessment shows the amount of change a Provider's patients have reported. Regression modeling is then applied to adjust the change reported given the Member's initial severity. Finally, the Provider's overall effectiveness is measured using the severity-adjusted effect size. By using this methodology Optum is able to compare Providers and determine if a specific Provider has demonstrated clinical effectiveness. This is the core metric used to tier the outpatient Provider network on quality.

ALERT uses two distinct algorithm programs: Member-Centered Risk Algorithms and Provider-Centered Practice Management Algorithms. ALERT generates flags if a Member is at

risk for any one of 15 conditions, supports the creation of Provider profiles, and also augments claims data in detecting fraud, waste and abuse.

**Member-Centered Risk Algorithms** — This is a suite of algorithms that run nightly and identify Members at risk. These rely on data from the Optum Wellness Assessment, behavioral health claims and, if available, psychotropic pharmacy claims. Claims algorithms can be triggered for both in-network and out-of-network Providers. The algorithms and subsequent interventions target different risks.

- Clinical Risk - Elevated clinical risk algorithms are largely based on Member self-report from the Wellness Assessment. If a Member reports severe impairment or distress, Optum notifies the Provider so that they are aware of the risk. Most of these algorithms result in letters to the Provider. However, if a Member triggers three or more of these risk factors, or triggers Optum Facility Predict algorithm indicating the likelihood of imminent facility- based care, a Care Advocate calls the Provider to review the clinical risks identified and ensure adequate treatment planning and coordination of care.
- Utilization Risk - The utilization algorithms are based on claims and do not rely on the Wellness Assessment. These algorithms are identifying Members at risk for over-utilization. These are all directed to Care Advocates who call the Provider to discuss the treatment plan to ensure the provision of evidence based care. Based on the discussion, one of three outcomes is possible.
  - Care provision is determined to be evidence-based and recovery based
  - Care provision is not evidence-based but the Provider is willing to modify the treatment plan. Follow-up is scheduled to ensure that the modification takes place.
  - Care provision is not evidence-based and Provider unwilling to modify treatment plan. Peer Review scheduled.
- Medication Non-Adherence - If Optum is given access to daily pharmacy claims, we can activate the algorithms that target medication non-adherence. These result in letters to the prescriber advising them that the Member may not have refilled their psychotropic medication.

### **Provider-Centered Practice Management Algorithms**

- The Provider-Centered Practice Management Algorithms are run quarterly and support the identification of high cost Provider practices that are outliers based on utilization, billing patterns, and/or consistent provision of non-evidence-based care.
- Practice patterns are analyzed via a proprietary tool: Practice Pattern Analysis (PPA). Based on the PPA results, the Optum ALERT practice specialists coordinate with network, fraud & abuse, and clinical operations to determine the most appropriate Provider outreach strategy. When appropriate, telephonic outreach can occur with the Provider/Group to discuss noted patterns and educate them regarding the provision of evidence-based care and proper billing of actual services provided.

### **Integration with Fraud, Waste and Abuse Detection**

Both ALERT algorithms can result in a referral to Optum Fraud, Waste, and Abuse team, although the practice management algorithms do so more often.

- Member-centered ALERT activities are integrated with and complementary to fraud and abuse interventions. Even when Member-focused, the ALERT team has been responsible for uncovering multiple concerns, such as finding Members who are being reimbursed directly for services not received, the misuse of Health & Behavior CPT codes to obtain coverage for Applied Behavioral Analysis services that are excluded in the Member's benefit plan, and the inappropriate provision of services to nursing home Members with diagnoses of Severe Dementia. In all circumstances where improper and/or potentially fraudulent activity is found, the ALERT Team works closely with the Fraud, Waste and Abuse team to ensure issues are referred promptly and necessary information is communicated.
- Provider-centered ALERT activities are also integrated with and complementary to Optum's Fraud, Waste and Abuse interventions. Examples of this integration include when instances of inappropriate billing behavior are identified and caused by errors or lack of knowledge on the part of the Providers. In these cases, education is provided by the practice management team and the case is then referred to the Fraud, Waste and Abuse team for recoupment of fees inappropriately paid. If it appears that the inappropriate billing is deliberate, then the case is immediately referred to the Fraud, Waste and Abuse team for prepayment flagging, as well as potential recoupment.

Optum follows corporate Optum policies which provide for a compliance plan designed to prevent and detect fraud, waste and abuse of Medicaid funds and resources. The Optum Compliance Program incorporates the seven required elements under the U.S. Sentencing Guidelines:

- Oversight of the Integrity and Compliance Program
- Development and implementation of ethical standards and business conduct policies
- Creating awareness of the standards and policies by education of employees
- Assessing compliance by monitoring and auditing
- Responding to allegations or information regarding violations
- Enforcement of policies and discipline for confirmed misconduct or serious neglect of duty
- Reporting mechanisms for employees, managers and others to alert management and/or the integrity and Compliance Program staff to violations of law, regulations, policies and procedures or contractual obligations

Optum will address health care insurance fraud, waste and abuse aggressively, which includes the operations of Program and Network Integrity (PNI). Optum's Fraud Operations offer fraud, waste and abuse detection products and services that are ideally suited to maximize anti-fraud and abuse program capabilities. PNI focuses most of its fraud, waste and abuse detection efforts at the Provider level; that is, identifying the suspected Providers through various data detection techniques and reviewing their claims prospectively (prior to payment), and as potential recovery cases (post-payment).

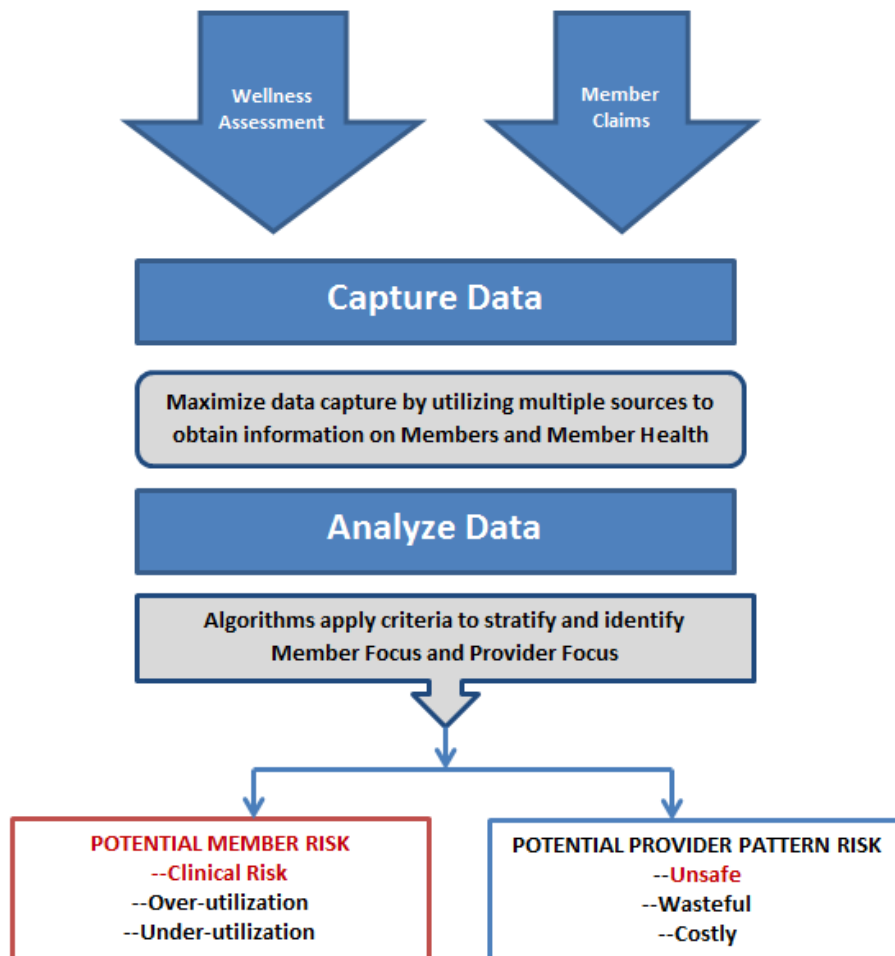
In addition, for Optum, information generated through the ALERT system is available to augment the PNI processes to detect fraud, waste, and abuse. If fraud, waste and/or abuse are suspected, Optum will work with the IDHW to determine the process for further investigation and/or prosecution.



## ALERT Online

ALERT Online is an interactive dashboard that is available to network Providers through a link on the Optum website at [www.optumidaho.com](http://www.optumidaho.com).

Information from the Optum Wellness Assessments completed by the Provider's patients is available in ALERT Online both as a Provider group summary and also individual Member detail. ALERT Online is updated nightly.



## The Review Process

The Provider is required to fax the Member's response to the Optum Wellness Assessment at the time the Provider initiates services and periodically as treatment continues. Depending on the Member and the services being requested, administration of other instruments may be required, such as the CAFAS/PECFAS and GAIN-I Core. As part of the ongoing authorization process, the Optum ALERT Care Advocate and the ALERT system analyzes the Member information.

ALERT generates flags if information in the system does not support the authorization request. ALERT also generates flags if a Member is at risk for any one of 15 medical and behavioral complications ranging from anorexia nervosa to caregiver strain, chemical dependency, depression, and medical/behavioral co-morbidity.

If potential issues are identified, a Care Advocate contacts the requesting Provider for additional information. If, after discussion with the requesting Provider, the Care Advocate is unable to confirm the medical necessity of the requested service, the Care Advocate requests a review by the Chief Medical Officer or a Peer Reviewer.

The Chief Medical Officer or Peer Reviewer reviews the information already available and grants continued authorization if he or she confirms the medical necessity or may contact the Provider for additional discussion. The Chief Medical Officer or Peer Reviewer makes the decision to authorize or not authorize the requested service. Required notifications in the appropriate format are sent to the requesting Provider and to the Member. Ongoing retrospective chart reviews are also conducted to verify that documentation supports the clinical information provided and claims submitted.

## **Authorization Requirements**

### **Utilization Management Begins at Intake**

Optum believes that a “no wrong door” approach is the best way to ensure that Members or their families can access services at the time they first recognize symptoms. Therefore, Optum facilitates immediate access to treatment:

- A Member can simply contact a network Provider’s office and request an appointment
- A family member can contact a network Provider’s office and request an appointment for a Member
- The Optum Member Access and Crisis Line is available 24 hours a day, 365 days a year, and provides a Member or family member with immediate contact with someone who can help identify a network Provider most appropriate to the Member’s needs and preferences. If requested, Optum will contact the Provider on the Member’s behalf and finalize arrangements to help the Member get to the Provider’s office or access emergency/crisis services.

### **Initial Authorization**

At the time of the first appointment, the network Provider must complete a Comprehensive Diagnostic Assessment (CDA). Authorization is not required to complete the CDA and any standardized assessments.

Before or after the Member speaks with the Provider, the Member must be asked to complete the Optum Wellness Assessment without assistance or coaching by the staff. Wellness Assessments are available in Adult and Youth versions, as well as in English and Spanish.

The Adult Wellness Assessment is designed for adult consumers age 18 or older. However, clinicians are free to use their discretion and use the Adult Wellness Assessment with older or emancipated adolescents when clinically appropriate.

The Youth Wellness Assessment is designed as a parent/guardian completed report measure so may be used with children as young as 5 years of age. However, if the youth is being asked to complete the form themselves, Optum recommends using the form with youths aged 12 or older.

In addition to the diagnostic assessment, to help determine whether or not a child/adolescent is experiencing a Serious Emotional Disturbance the Provider may administer the Child and Adolescent Functional Assessment System/Pre-school and Early Childhood Functional

Assessment Scale® (CAFAS/PECFAS) and the Global Appraisal of Individual Need (GAIN-I Core) if the Member is seeking treatment for substance use. When utilized, the results of these assessments *must be documented in the medical record*.

For information on the CAFAS/PECFAS go to <http://www.fasoutcomes.com/>

For information on GAIN-I Core go to <http://www.gaincc.org/index.cfm?pageID=49>

If the Member refuses or is unable to complete the Optum Wellness Assessment at the time of the initial session, the network Provider is allowed to submit an Idaho Outpatient Treatment Request (OTR), but the Optum Wellness Assessment is strongly preferred. The Treatment Plan should be completed within 10 days of the initial assessment.

A copy of the Idaho OTR and directions for submission are available to Providers on the Optum website at [www.optumidaho.com](http://www.optumidaho.com).

### Authorization Categories

For purposes of authorization, Optum covered benefits are divided into four categories:

- **Category One – No Authorization Required**  
Basic services which require no authorization
- **Category Two – Open Authorization Required**  
Routine services, for which a standard twelve-month authorization period is granted (allowing the Member open access to any network Provider) so long as level of care criteria and medical necessity criteria are met for the routine outpatient level of care. The Provider must request the authorization for services in Category Two online at [www.optumidaho.com](http://www.optumidaho.com). The Provider can also contact Optum telephonically, but online requests are *strongly preferred*.
- **Category Three – Provider Specific Authorization Required**  
Specialized outpatient services, which are authorized to the specific Provider typically for no more than four months based on criteria focused directly on each separate service in that category. Services in this category require Provider specific authorization and in some cases submission of additional information and documentation. The Provider must request the authorization for services in Category Three by submitting their completed request through the Secure Message Center. Requests for psychological and neuropsychological testing should be submitted by fax using the request form on the Optum website ([www.optumidaho.com](http://www.optumidaho.com)).
- **Category Four – Threshold Based (Relaxed Prior Authorization Requirements)**  
These services were formerly included in Category Three, requiring authorization (prior or retro) for every request. As of 7/1/14 Optum established certain thresholds or parameters of units per service per member for the services included in this category; these do not require a prior authorization as long as the initial units are not exhausted within the prescribed one year period. The limits for most of the Category 4 services are per calendar year and are reset every year. However, Family Support Services are authorized on a six month (26 week) basis. If more units are needed after the initial limits have been exhausted within the initial authorization time period, the Provider will need to submit a prior authorization request for additional units.

The authorization process for services covered by the IBHP vary depending on the category the requested service falls within; a basic, routine or specialized outpatient service.

Optum recognizes that some SUDS and other services are court related, and that when the Member is Medicaid-eligible, the SUDS and other Providers for these services need to follow the required authorization process. Optum will work closely with the courts and SUDS Providers to facilitate compliance with this process. Optum also recognizes that not all court ordered services will meet medical necessity, in which case Optum will work with the Provider and court to help the Member receive the appropriate services. The details of this process will be developed in collaboration with the SUDS and other Providers, courts and the IDHW.

**Basic outpatient services (Category One),** for which no authorization is required, include:

<b>CATEGORY ONE SERVICES</b>	
<b>No Authorization</b>	
Category One outpatient services will be reimbursed by Optum Idaho when they are provided by a Network Provider to an enrolled Member of the Idaho Behavioral Health Plan. The claim will be paid based on verification of Member eligibility and provider contract status.	
<b>Mental Health</b>	
90791	Comprehensive Diagnostic Assessment (including treatment plan)
90792	Comprehensive Diagnostic Assessment by a Prescribing Professional (including treatment plan)
<b>Substance Abuse</b>	
H0001	Individual Assessment and Treatment Plan for Substance Abuse (including administration of the GAIN)
H0003	Drug/Alcohol Testing
<b>Evaluation and Management Services (Prescribing Professionals Only)</b>	
92201-99205	Office Outpatient- New Patient
99211-99215	Office Outpatient- Established Patient
90833	Individual Psychotherapy by Physician (30 minutes)
90836	Individual Psychotherapy by Physician (45 minutes)
96372	Therapeutic, prophylactic, or diagnostic injection
<b>Telehealth</b>	
T1014-GT	Telehealth Transmission
Q3014-GT	Telehealth Originating Site Facility Fee
<b>Language Services</b>	
T1013	Language Interpretation Services (sign language or oral interpretation)

An Optum network Provider can initiate Category One services to a Member of the IBHP without contacting Optum. After the network Provider provides any basic (Category One) outpatient service to a Member of the IBHP, the Provider must submit the claim to Optum, the claim is then paid after verification through the claims system of the Member’s Plan enrollment, the date of enrollment and the Provider’s network status.

If there is no Optum Provider in the area to serve a Member, Optum will work with Out of Network (OON) Providers to develop an agreement to serve that Member and will attempt to engage that Provider to join the network to ensure other Members in that area receive the services they require.

Providers of basic outpatient services are expected to submit the member’s Optum Wellness Assessment and may administer the CAFAS/PECFAS or GAIN-I Core and document the scores in the medical record as appropriate.

***Routine outpatient services (Category Two)*** for which an open authorization is required include:

<b>CATEGORY TWO SERVICES</b>	
<b>Open Authorization</b>	
<b>The Category Two requirements apply to non-prescribing professionals only</b>	
<b>Mental Health</b>	
90832	Individual Psychotherapy (30 Minutes)
90834	Individual Psychotherapy (45 Minutes)
90846	Family Psychotherapy without patient present
90847	Family Psychotherapy with patient present
90853	Group Psychotherapy
<b>Substance Abuse</b>	
H0004	Individual Drug/Alcohol Counseling
H0005	Group Drug/Alcohol Counseling

The Category Two requirements apply to non-prescribing professionals only. *Prescribing professionals do not need authorization to provide these services.* Non-prescribing professionals must request the authorization for services in Category Two online either at [www.providerexpress.com](http://www.providerexpress.com) or through a link on the Optum website at [www.optumidaho.com](http://www.optumidaho.com). They are also expected to submit the Member’s Optum Wellness Assessment and may administer the CAFAS/PECFAS or GAIN-I Core and document the scores in the medical record as appropriate. If the Member refuses or is unable to complete the Optum Wellness Assessment at the time of the initial session, the network Provider is allowed to submit an Outpatient Treatment Request (OTR), but submission of the Optum Wellness Assessment is strongly preferred. As noted earlier, the OTR is available online at [www.optumidaho.com](http://www.optumidaho.com).

Unless the algorithms in Optum’s ALERT system trigger a flag to an Optum Care Advocate, the Provider receives an authorization to provide routine outpatient services to the Member for a period of up to 12 months, so long as the Member remains enrolled in the IBHP for that period.

If the ALERT system identifies a concern, an Optum Care Advocate contacts the requesting Provider to discuss the Member’s need for treatment and to gather additional clinical information.

***Specialized Outpatient Services (Category Three)*** for which a Provider specific authorization is required include:

### CATEGORY THREE SERVICES

#### Psychological Testing

96101-96103	Psychological Testing
96118-96120	Neuropsychological Testing

#### Rehabilitation Services

H2017	Community Based Rehabilitation Services (CBRS)
H2104	Skills Training and Development (or Partial Care)
H2015	Community Transition Support Services by a licensed clinician and a qualified Peer Support Specialist (initiated by an Optum Idaho network provider at the request of an Optum Idaho Discharge Coordinator or Field Care Coordinator)

Services in this category require Provider specific authorization and in some cases submission of additional information and documentation. When appropriate, the Provider must submit a Wellness Assessment and also administer the CAFAS/PECFAS or GAIN-I Core and document the scores in the medical record. Some Category Three services, including all HCPCS codes classified as Rehabilitation Services (CBRS and/or Partial Care) and the CPT codes for psychological and neuropsychological evaluations, may also require submission of specialized forms that are available online on the Optum website at [www.optumidaho.com](http://www.optumidaho.com). Requests for specialized outpatient services are authorized to the specific Provider for service-specific time periods unless the information submitted generates a clinical concern. If a clinical concern is raised during the review of the information submitted, a Care Advocate will contact the requesting Provider for additional information.

- All HCPCS codes related to Rehabilitation Services (CBRS and/or Partial Care) require prior authorization through submission of a completed UM Authorization Template
- All CPT codes related to psychological and neuropsychological testing require submission of the Optum Psychological Testing Request Form (as noted above, available to Providers online)

***Threshold Based Services (Category Four)*** for which an authorization (prior or retro) is no longer required up to pre-determined thresholds, include:

#### CATEGORY FOUR SERVICES

##### Threshold Based

T1017	BH Targeted Case Management
H0006	Case Management- Substance Abuse
H0023	Telephonic Case Management (either BH or Substance Abuse)
H0038	Peer Support by a qualified Peer Support Specialist
H0046	Family Support by a qualified Family Support Specialist
90837-90838	Extended Office Visits
H2011	Community Crisis Intervention (at earliest opportunity)

##### Assessment and Treatment Plan

H0031	BH Assessment, by a qualified paraprofessional for peer support, family support or CBRS services
H0032	Individualized BH Treatment Plan, by a qualified paraprofessional for peer support, family support or CBRS services

Category Four are specialized outpatient services that can be performed up to a certain threshold before a provider specific authorization is needed. Members will receive a specific amount of hours or units each calendar year before authorization is required for additional services. Claim denials should be pursued through the dispute process.

These services should be used as clinically indicated and as medically necessary. Creation of this new Category will help decrease Provider's administrative burden. Crisis services should be used at the time of the crisis; Provider should request an authorization after providing the service. Treatment Planning applies to CBRS, case management, peer support and family support services, and does not apply to medication management and psychotherapy. Extended Office Visits are more lengthy sessions. BH Assessment includes PECFAS/CAFAS).

Below are the thresholds per service per Member in a calendar year:

- Case Management – Threshold is 240 units per calendar year, additional services must be authorized via prior authorization process (before units run out)
- Peer Support – Threshold is 416 units per calendar year, additional services must be authorized via prior authorization process (before units run out)
- Family Support Services (H0046) – Threshold is 208 units per six month (26 weeks) interval. Additional services must be pre-authorized (before units run out).
- Crisis Services - Threshold is 40 units per calendar year, additional services must be authorized, Retro request through utilization management (current process)
- Extended Office Visits - Threshold is 12 hours per calendar year, additional services must be authorized via prior authorization process
- BH Assessment - Threshold is 4 units per calendar year (PECFAS/CAFAS); 3 units each for case management, family support and peer support. Due to discreet age delineations for the services, BH assessments for family support and peer support should not be completed for the same member. Additional services must be authorized via prior authorization process; updating with a new PECFAS/CAFAS is dependent upon member's clinical presentation at the point of transfer, to be determined by the new provider
- Treatment Plan - Threshold is 16 units per calendar year; additional services must be authorized via prior authorization process (before units run out)

If a member has exhausted the threshold limits within a calendar year, the provider may submit a Prior Authorization request for additional units.

## Concurrent Review

Both routine and specialized outpatient services require concurrent review if the Provider and the Member determine that treatment should be continued after the initial authorization period has expired. Authorization to continue services must be requested following the same process that was required to request authorization to initiate those services. Category Four services have an initial pre-set number of units specific for each category four service. Anticipated continuation of the service beyond the pre-set level will require Care Advocate review with the Provider.

## Coordination of Care

To ensure the effective coordination and management of care between Optum services and those of other professionals, Optum Providers are expected to request the Member's consent to exchange appropriate treatment information with the other professionals. This includes general medical Providers (e.g., primary physicians, medical specialists), other behavioral health clinicians (e.g., psychologists, psychiatrists, counselors, therapists), and alternative service channels (e.g., Child Welfare, Developmental Disability, Children's Mental Health, Juvenile Justice, Adult Corrections, and the problem-solving courts). When the Optum Field Care Coordinators or Care Advocates identify the need for coordination, they take steps with the Optum Provider to facilitate the required communication. Opportunities for coordination and communication include: at the time of intake; during the course of treatment; and at the time of discharge or termination of care. Coordination is also particularly important when a member transitions between levels of care or programs and at any other point in treatment that may be appropriate. While Optum recognizes that detailed coordination may not be clinically required in every case, it is particularly important for all Providers to request a release of information from the Member to coordinate care with the PCP and coordinate as clinically appropriate. Coordination of services improves the quality of care to Members in many ways, including:

- Confirming for a primary physician that his or her patient followed through on a behavioral health referral
- Minimizing potential adverse medication interactions for Members who are prescribed psychotropic medication
- Allowing for better management of treatment and follow-up for Members with coexisting behavioral and medical disorders
- Reducing the risk of relapse with Members in high risk populations who may be receiving services through multiple channels, such as Members who interact with Child Welfare, Developmental Disability, Children's Mental Health, Juvenile Justice, Adult Corrections, and the problem-solving courts

During the orientation of Providers and ongoing auditing and review of cases, Optum reinforces the following guidelines that are intended to facilitate effective communication among all treatment professionals involved in a Member's care.

During the diagnostic assessment session, the Optum Provider must request the Member's written consent to exchange information with all appropriate professionals. Following the initial assessment, the Optum Provider should coordinate and communicate with other relevant medical Providers, behavioral Providers and alternative service channels as authorized by the Member. The Provider is encouraged to coordinate with and integrate PCP participation in treatment planning and document efforts. The Provider is expected to provide other professionals with the following information:



- Summary of Member’s evaluation
- Diagnosis
- Treatment plan summary (including any medications prescribed)
- Primary clinician treating the Member

During the Member’s treatment, the Provider is expected to:

- Update other behavioral health and/or medical clinicians when there is a change in the Member's condition or medication(s)
- Update other health care professionals when serious medical conditions warrant closer coordination
- Attempt to obtain all relevant clinical information that other treating professionals may have pertaining to the Member's mental health or substance use problems

At the completion of treatment, the Optum Provider is expected to send a copy of the discharge summary to the other treating professionals.

Optum recognizes that some Members may refuse to allow for release of this information. This decision must be noted in the clinical record after reviewing the potential risks and benefits of this decision. Optum expects Providers to make a “good faith” effort at communicating with other behavioral health clinicians or facilities and any medical care professionals who are treating the Member, and to address the potential risk of refusing to allow such an exchange to take place.

Coordination of care between agencies is critical to assuring consumers receive the right care at the right time. Coordination is also important in considering a whole-person approach to the myriad of services that may be necessary to support an individual and their family. Collaboration between agencies through development of inter-agency agreements will help to clarify clear communication pathways, division of services (where necessary), and business processes to streamline the consumer’s experience. Optum is working with the IDHW to identify key agencies that should be considered critical for initial development of these agreements, as well as those that will require further development post-effective date. In select cases, inter-agency agreements will be developed that will contain the name(s) of the point-of-contact within the agency who is responsible for coordinating communication and treatment planning for individuals being served by multiple agencies. These agreements will also document agreed-upon business flows as well as confirming joint commitments to ensure collaboration in developing treatment plans and delivering care, partnering to resolve issues, and regular review of policy and program changes that may impact these agreements. To date, with the IDHW’s guidance, Optum has identified Child Welfare, Juvenile Justice, Adult Corrections, Health Homes, DBH programs, SUDS Providers, and the problem-solving court as key partners with whom to pursue these prioritized agreements. Optum also recognizes that this activity will be ongoing – both in reviewing existing agreements and developing new ones. Ongoing responsibility for this activity will fall to the Clinical Leadership and the Field Care Coordinators on the Optum team, with input from the IDHW.

### **Community Agency Liaisons**

The Community Agency Liaisons and Field Care Coordinators meet regularly with designated community agencies including, child welfare, developmental disability, children’s mental health, juvenile justice, adult corrections, schools, social services agencies, staff of the Division of Behavioral Health (DBH), the problem-solving courts, and other parts of the criminal justice

system.

Optum's Community Agency Liaisons work with agencies in other funding streams in the effort to effectively coordinate existing mental health and substance abuse Providers and encourage the expansion of co-occurring capable Providers. They build relationships with stakeholders and are the point of contact for those stakeholders who may request clinical consultation on the appropriate and medically necessary service for a Member. Consultation from the Chief Medical Officer and other Optum clinicians will be available when requested by a stakeholder.

## Focusing Optum Resources on High Need Members and Members in need of Behavioral Health Services

### Intensive Field Care Coordination

As part of the Clinical Model 2.0, Optum expanded Intensive Care Coordination and Discharge Coordination services for Members. Formerly called Intensive Care Management (ICM), Optum has realigned its clinical department staffing and program model, including adding additional positions in the field to focus more robustly and intensely on coordination and discharge needs for Members.

This full service field coordination program is focused on Members getting the right care at the right time through:

- **Intensive Care Coordination:** complex care Members who may have a diagnosis of Serious Mental Illness (SMI), Serious and Persistent Mental Illness (SPMI) or Serious Emotional Disturbance (SED) and/or have co-morbid conditions, and/or with multiple inpatient BH admissions, and/or involved with multiple stakeholders (such as the court systems or Child Welfare)
- **Care Coordination:** Members who need outpatient referrals, coordination and linkages to BH services
- **Discharge Coordination:** Members in BH inpatient psychiatric facilities transitioning to the community

The Field Care Coordination Program services include:

- Coordinating with Utilization Management for Category Three service authorizations on behalf of Members; may be able to do some types of authorizations for Members directly
- Participating at Provider or alternative service channels' MDT (multidisciplinary team) meetings as indicated for Member care
- Working closely with Optum Quality and Optum Network in coordinating onsite Provider visits to provide education and clinical technical assistance on managed care and clinical best practices
- Identifying opportunities for hospital diversion in local communities and working in conjunction with community stakeholders, the IDHW, and other Optum departments to support or develop these opportunities
- Liaison with regional divisions of the IDHW including: Division of Behavioral Health (DBH), and Division of Family and Children's Services (FACS) (for both foster care and developmental disabilities needs)

Optum's Field Care Coordinators work closely with community-based case managers to help Members access, plan, participate in, and benefit from mental health and/or substance use disorder services that are individualized, appropriate, and effective for each Member's condition.

Optum also recognizes that DBH may also be providing Case Management services under court order. Under such circumstances, Optum facilitates coordination with the DBH Case Management services. If care is being coordinated by an existing Optum Provider, the Field Coordinator will defer primary coordination to the Provider and be available to provide additional support the coordinating Provider if needed.

### **Field Care Coordination Program description and Identification for referrals**

Optum's Care Coordination staff includes an independently licensed Manager, independently licensed Field Care Coordinators, and a Discharge Coordinator whose functions are generally distinct from utilization management and from case management activities provided by agencies and schools. Optum care coordination is structurally linked to other Optum functions of Quality Assurance, Member Support Services and Grievances. Areas of assistance and monitoring for coordination of care include, but are not limited to:

1. Identifying Members who are in need of behavioral health services and may benefit from care coordination.
2. Assisting Members with accessing appropriate and necessary behavioral health services. When appropriate, assistance may include collaborations with Care Advocates (Care Managers), Providers, PCPs, and community agencies and organizations.
3. Collaborating with behavioral health Providers to promote the exchange of information across the continuum of behavioral health Providers as authorized by the Member.
4. Collaborating with health plan counterparts to facilitate communication, continuity, and coordination between behavioral and physical health Providers who are concurrently providing services to the Member as authorized by the Member.
5. Assisting Members with obtaining information needed for their recovery.
6. Monitoring outcomes and resources used and helping to organize care to prevent duplication of diagnostic tests and services.
7. Sharing information among health care professionals and family as authorized by the Member and actively managing transition of care such as hospital discharge.
8. Educating and assisting behavioral health Providers regarding proper procedures for making appropriate referrals for physical health consultation and treatment.
9. Collaborating with health plan counterparts to educate and assist Primary Care Providers regarding proper procedures for making appropriate referrals for behavioral health consultation and treatment.
10. Collecting outcome data on the effectiveness of care coordination with Members who are or were active participants in the Optum Care Coordination program.

Optum serves certain populations that may require enhanced, active assistance by Optum Field Care Coordinators and for which there are additional requirements. These populations include the following:

1. Individuals with a diagnosis of SMI, SPMI or SED
2. Members that have co-morbid conditions that require coordination and management of medical and behavioral Providers by the respective physical health Provider and Optum
3. Children and youth served by the IDHW involved with or at risk of being involved with

Child Welfare or Juvenile Justice

4. Individuals involved with adult corrections and problem-solving courts

### ***Identification***

Members who may benefit from field care coordination are identified through the following means:

### **Reports**

- High Utilizer: This report identifies the Members with the highest outpatient utilization and is updated on a monthly basis. It is reviewed by the CMO, Clinical Director, Care Coordination Manager, and Clinical Program Manager. Cases may be assigned to a FCC based on this report.
- IP admission reports: Optum is dependent on the IDHW and the IP facilities in order to obtain this information in a timely fashion to be able to assign a Field Care Coordinator or Discharge Coordinator to follow up on every IP discharge.
- IP and Emergency Department High Utilizer/High Cost: Optum will work with the IDHW to understand high utilizers of emergency services from medical claims and high utilizers of inpatient services.

### **Service Utilization, Clinical Assessment, or Diagnosis**

Field Care Coordinators may also identify Members who might benefit from care coordination through indicators such as the following:

- Members whose pattern of service utilization includes multiple readmissions, frequent changes in Provider
- Members with severe and/or complex behavioral health conditions who also have significant psychosocial challenges such as homelessness or family impermanence
- Members with medical conditions whose treatment is likely to be complicated by a co-occurring behavioral health condition
- Members who are transitioning back into the community after a lengthy inpatient or residential confinement or incarceration

### **Referrals**

Referrals may come from Optum staff, ALERT staff, Members or their authorized representatives, behavioral health Providers, PCPs, stakeholders, or community agencies and organizations. A Field Care Coordinator is assigned preferably from the regional area the Member lives in to reach out to these Members, assess their needs and goals, and determine what form of specialized intervention would be most suitable.

### **Optum Peer Support and Family Support Specialists**

Optum has a Peer Support Specialist and a Family Support Specialist. These specialists may collaborate with Field Care Coordinators, Care Advocates, Providers, parents/guardians, State and community agencies and organizations, and the school system to identify children, youth, and families who may benefit from care coordination and/or family or peer support.

Peer Support Specialists use their lived recovery experience and specific specialist training to assist adult Members with defining their goals for recovery, developing the skills and knowledge needed for the Member's recovery, and accessing community and other Member-run services; supporting Members who need assistance placing complaints; building the Member-centered and

recovery orientation of Optum through training, engagement in quality review, and enhancing the availability and accessibility of community Member-run programs and services.

Family Support Specialists use their lived experience as a family member of a Member with a mental health or substance abuse diagnosis to assist other family members to identify and navigate service systems on behalf of their loved one in need of services.

Peer Specialists and Family Specialists perform duties as required including:

- Collaborating with Field Care Coordinators, Providers, community agencies and organizations, and the State to facilitate access to and transition between services

### **Community-Based Case Management**

Community-based case management services are Category Four services, meaning that an Optum Provider is given a yearly threshold of units to utilize and must conduct an assessment and request a prior authorization before administering any additional units above the yearly threshold for this service. When a Member is receiving community case management services through Optum and is also being offered case management by other community resources, a primary case manager should be identified for each case. All referrals of Medicaid eligible corrections related clients for Case Management will follow Optum standard protocols. Optum will work with the Idaho Department of Corrections (IDOC) and Case Managers to ensure that the Member receives the appropriate services.

After the yearly threshold is met, Optum Care Advocates gather necessary clinical information to determine the appropriateness of the request. If the request is found to be appropriate based on the clinical information provided and Optum's Level of Care Guidelines then the Optum Care Advocate enters an authorization for case management services into the Optum care management system (LINX) for a time period appropriate to the request and Member's needs. The Provider can then deliver the necessary case management services to the Member during the authorized time period. Subsequently, the treatment plan must be updated every 90 days that the Member is receiving case management services.

The services identified on the treatment plan must support the goals that are applicable to the Member's identified needs. The treatment plan must incorporate the need for psychiatric services identified by the comprehensive diagnostic assessment.

The Provider must ensure that the Member/Member's representative has provided informed consent indicating agreement with all of the elements on the treatment plan including choice of Provider, designated services, times, dates, frequencies, objectives, goals, and exit criteria. All Providers involved with a case should maintain the appropriate documentation of informed consent in their medical records.

All Members (and their families) receiving case management services are expected to be educated around diagnosis, signs and symptoms, treatment options, and available community resources/services so Members can build on their strengths and abilities to acquire or improve skills needed to reach their individual goals and aspirations.

Coordination of behavioral healthcare services by the Provider of the behavioral health case management services should occur with both Medicaid's Primary Care Case management program and the IDHW's emerging Health Home program. This is vital to improving outcomes for mental health and substance use disorder treatment services as well as for medical treatment.

Optum Care Advocate staff conducts concurrent reviews for all continued services requests and requests for new and/or additional services. The form used for reviewing for medical necessity is located on the Optum portal under the Forms section at <https://m1.optumidaho.com/web/optumidaho/providers>.

The Optum's goals for case management outcomes are for Members to have:

- Increased community tenure by strengthening and expanding their community resources/services and having a viable recovery plan and crisis plan in place
- Holistic assessment of Members' needs and recommended treatment/community services built on Members' strengths, not illnesses
- Recovery goals that focus on where the Member uniquely wants to go, not where the Member is stuck
- Development of community supports and resources that include Member-run services supporting recovery
- Identification and solutions to bio-psychosocial gaps
- Full partnership with the Member and the Member's family/significant others in treatment decisions, with joint decision-making as a norm
- Crisis stabilization for Members in acute stress and at risk of worsening conditions

Optum Care Advocates, the Provider of the case management service, or the Member (or Member's family) can request that the Member is discharged from case management services for the following reasons:

1. Member no longer exhibits need for case management services as reflected by the demonstrated ability to access needed services/supports and maintain functions of daily living
2. Goals of case management have been substantially met
3. Member has not demonstrated substantial benefit from case management services
4. Member is no longer eligible for services per Optum's Level of Care Guidelines
5. Member is no longer Medicaid eligible; and/or
6. Member requests discontinuation of the services in consultation with and concurrence from the primary Provider of the case management service

When the Provider submits evidence that a Member's condition has not improved or it has worsened, the Optum Care Advocate recommends that the Provider conduct a re-assessment to determine if the diagnosis is accurate, the treatment plan should be modified, or the Member's condition should be treated in another level of care.

The Member's transition out of case management services should be clinically smooth and safe and Providers of case management services must inform all Optum Members receiving case management services of the discharge criteria early in his/her relationship with the case manager. It should come as no surprise to the Member that, when he/she meets their care goal, or in some other way triggers the discharge criteria, that his/her relationship with the Case Manager will be ended. The Provider discharging the Member from case management services is expected to notify all the Providers of the discharge/termination of services and assist the Member in his/her transition to other services as needed.

## **Provider Quality Specialists**

The Provider Quality Specialists will work directly with Providers in a variety of ways to help ensure clinical quality through on-going collaboration via education, audits, and technical assistance to improve the system of care in Idaho. The Provider Quality Specialists will also promote coordination and collaboration between treating Providers (both medical and behavioral) as well as other community resources (probation/parole/schools/etc.). Ongoing monitoring and Provider education may help lead to an increase in requests for services that are medically necessary.

The Provider Quality Specialists will play a role in supporting system transformation through Provider monitoring and education; this process will support on-going improvements to the quality of care provided to Members.

- The audit process assesses several aspects related to documentation:
  - Documentation of medical necessity (appropriateness of care)
  - Compliance with clinical standards and Optum documentation expectations
  - Clear documentation of what services were rendered

Provider Quality Specialists also:

- Request Corrective Action Plans (CAPs) and conduct re-audits based on the initial audit outcome
- Promote understanding and use of best practices
- Participate on Provider Training Teams (comprised of the Provider Quality Specialist, Field Care Coordinator and the Regional Network Manager; these Teams will provide technical assistance, coordination and support to Providers in their location)
- Investigate Quality of Care (QoC) issues
- Link audit data to improvement activities

## Optum Crisis System

Optum is providing a crisis system for Members responsive to individual needs and care coordination. Optum's Member Services and Crisis Line, answers calls for Members enrolled in the IBHP 24 hour a day, 7 days a week, 365 days a year. Optum's Member Services and Crisis Line number is published and promoted via the Optum website, the Member Handbook, and through Providers. Optum provides crisis triage and counseling and emphasizes keeping a Member supported and in the community. This is accomplished through live counseling on the phone, coordination with the Member's Provider, applicable law enforcement, emergency room staff, mobile crisis Providers, and community resources as available. Trained staff works with Members directly on the phone to help keep them safe, assist them to manage symptoms and make plans with the Member to reach out for support from their Provider, NAMI, peer support, and other community-based resources. Hospitalization is only used when it is determined the Member is an imminent danger to self or others.

Optum's Member Services and Crisis staff generate a comprehensive log on a daily basis describing crisis calls received from Members. This report includes pertinent Member identification information, the nature of the crisis, and the Member's disposition. The log enables the Optum Field Care Coordinator to contact Providers of Members who were in crisis. This ensures that the treating Provider knows to reach out to the Member, if the Member has not already contacted their Provider. Field Care Coordinators encourage Providers to meet with Members as soon as possible to ensure the Member's crisis has been resolved, review and update

the Member's existing crisis plan in order to strengthen the Member's ability to implement strategies to prevent a crisis in the future, and explore existing treatment plans for opportunities to improve therapeutic interventions.

Coordination with existing crisis Providers is an ongoing part of the crisis system evaluation and improvement activities. Optum clinical leadership will coordinate crisis services with the DBH to work on methods to communicate effectively between their crisis participants on behalf of Members. This involves regular meetings to work through strategies to improve effectiveness.

Optum also proactively identifies Members who are at high risk of a crisis or hospitalization. Field Care Coordinators reach out to Providers of these Members to coordinate care and develop treatment plans and interventions to minimize the risk of those Members in crisis and seeking crisis services. Clinical management of high risk Members is another method to manage potential Member crisis.

Optum continually assesses network Providers' compliance with contracted performance requirements via Provider auditing of medical records and utilization management data reviews. This includes evaluation of crisis services listed in their contract. Optum will assess the availability and array of crisis intervention services in the Provider network. Optum anticipates expanding the variety and availability of crisis services as we have done in other contracts. This will include issuing RFPs, enabling existing Providers to expand services or new Providers to provide expanded crisis services such as mobile crisis, peer-run living rooms, and warm lines, etc.

### Utilization Management Guidelines

Optum has adopted utilization management criteria and guidelines to interpret the medical necessity of behavioral health services provided to Members and to help improve the clinical outcomes of treatment provided. As part of the process, Optum ensures that we are in compliance with all of the IDHW's requirements as set forth in the above sections.

Optum's core public sector clinical criteria and guidelines were developed by nationally recognized experts and organizations and have been adopted to provide objective and evidence-based admission and continuing stay criteria. Evidence-based admission and continuing stay criteria are based on recognized clinical standards of care, as reflected in published references from the industry's most esteemed professional sources, including the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine, and from the Diagnostic and Statistical Manual of Mental Disorders. The criteria and guidelines are based on the following components and are reviewed annually to ensure that they are updated based on new scientific evidence as well as:

- The broad clinical experience of Optum's staff
- Multi-disciplinary input from Optum's nationwide Provider network
- Input from Members
- Published references from the industry's most esteemed professional sources, as detailed in the paragraph above
- Recognizing and supporting services essential to recovery and resiliency as well as the use of case management services for the comprehensive range of services and programs found in public sector systems. Optum's national Consumer Affairs Department reviews the criteria regularly to ensure that they remain recovery-focused and consistent with the principles of resiliency and well-being.



- In developing and updating Optum’s clinical criteria and guidelines, Optum also solicits input from practitioners in specialties affected by the guidelines, community-based treatment centers, and practitioners in Optum’s programs to assure the full range of opinions, and the highest quality content are fully considered.

### Level of Care Guidelines

The Optum Level of Care Guidelines are finalized in collaboration with the IDHW. Optum has criteria for all services included in the benefit package of the IBHP.

Optum’s Level of Care Guidelines provide objective and evidence-based criteria for mental health and substance use services offered by the Optum Provider network in support of the Member’s recovery/resiliency. They are intended to standardize care management decisions regarding the most appropriate and available level of care needed to support a Member’s path to recovery.

The evidence-base for the Level of Care Guidelines includes generally accepted standards of clinical practice, as well as governmental standards such as CMS’ National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs).

The IBHP criteria and guidelines are applied to all utilization management decisions. The criteria are clearly written, objective and evidence-based whenever possible, and appropriate.

Requirements established by the IDHW, including that criteria and guidelines be clearly written, objective and evidence-based whenever possible, are the basic standards on which the criteria and guidelines are evaluated.

Criteria and guidelines are posted on the Optum website and updated when revised. Criteria and guidelines are available on the web to any interested party and are provided in writing to Providers and Members at their request. The Member Handbook provides a simplified version of all Guidelines used by Optum and the Provider network.

The Level of Care Guidelines are based on the following principles:

- **Care Should Promote the Member’s Recovery/Resiliency:** Members have the right to be treated with respect and recognition of their dignity, strengths, preferences, right to privacy, and unique path to recovery. Members also have the right to information that informs decision making, promote participation in treatment, enhance self-management, and support broader recovery/resiliency goals.

- **Care Should be Accessible:** Optimal clinical outcomes result when access to the most appropriate and available level of care is facilitated at admission and when transitioning between levels of care. A Member’s transition between levels of care should be timely and occur in a safe manner, and pertinent clinical information should be communicated to the Provider at the next level of care.
- **Care Should be Appropriate:** Optimal clinical outcomes result when evidence-based treatment is provided in an appropriate level of care that is available, structured and intensive enough to safely and adequately treat the Member’s presenting problem and support the Member’s recovery/resiliency. Evidence-based treatments are interventions that have been shown to be safe and effective, not been deemed experimental or investigative, and are appropriate for the treatment of the Member’s current condition. Treatment planning should take into account significant variables such as the Member’s current clinical need, age and level of development, whether the proposed services are covered in the Member’s benefit plan, whether the proposed forms of treatment, the organization of the treatment plan, and the frequency and duration of treatment are evidence-based, whether the proposed services are available in or near the Member’s community, and whether community resources such as self-help and peer support groups, consumer-run services, and preventive health programs can augment treatment. A change in a Member’s condition should prompt a reassessment of the treatment plan and selection of level of care. When a Member’s condition has improved, the reassessment should determine whether a lower level of care may be structured and intensive enough to safely and adequately treat the Member’s current condition, or whether the Member no longer requires treatment. When a Member’s condition has not improved or it has worsened, the reassessment should determine whether the diagnosis is accurate, the treatment plan should be modified, or the Member’s condition should be treated in another level of care which is structured and intensive enough to safely and adequately treat the Member’s current condition. However, failure of treatment in a lower level of care is not a prerequisite for authorizing coverage for a higher level of care. Authorizing coverage of a level of care is dependent on the request for services meeting the criteria for the proposed level of care.
- **Care Should Be Effective:** There must be a reasonable expectation that evidence-based treatment delivered in the appropriate level of care improves the Member’s presenting problems within a reasonable period of time. Improvement in this context is measured by weighing the effectiveness of treatment and the risk that the Member’s condition is likely to deteriorate or relapse if treatment in the current level of care were to be discontinued. Improvement must also be understood within a recovery/resiliency framework where services support movement toward a full life in the community.

### Idaho-Specific Criteria and Guidelines

It is critical that the clinical criteria and guidelines developed and implemented for the IBHP be appropriate—both for the services included in the benefit plan and for the people who use those services. The guidelines will be reviewed annually.

### Sharing Criteria and Guidelines

The IBHP Criteria and Guidelines are posted on the Optum website so they are readily available to all Providers as well as others interested in reviewing them. They

are reviewed annually through the QAPI Committee structure. The Member Handbook provides a simplified version of all Guidelines used by Optum and the Provider network.

### **Direct and Timely Access to Services**

The utilization management process for the IBHP is designed especially to encourage Members' direct access to outpatient mental health and substance abuse treatment, ensuring that individuals have timely access to services. In particular:

- The behavioral health Provider is required to encourage the Member to visit a Primary Care Provider regularly and to authorize the sharing of behavioral health information with the Primary Care Provider.
- Optum requires no prior authorization for initial behavioral health services, such as treatment evaluations, which is the first step in seeking treatment.
- Optum enables the Provider to offer an array of routine outpatient services based on an authorization that is valid for routine services with any Optum network Provider for up to twelve months. This enables the Provider and the Member to use the treatment modalities most appropriate for the Member as the Member progresses in treatment without requiring additional authorization.

### **Long-term Services and Access to Several Services Concurrently**

While the benefit package for the IBHP contains some requirements for authorization of new services and the continuation of services, Optum recognizes the need for some Members to receive services for an extended period of time and for some Members to access several services concurrently. Nothing in the Optum benefit package limits the Member's access to covered services available so long as the services are medically necessary; these needs are recognized for both children and adults.

### **Ensuring Required Use of the Criteria**

Optum ensures that contracted Providers use the clinical criteria and guidelines established for the IBHP even when authorization is not required. This is accomplished in two ways: by the Field Care Coordinators who work with Providers serving Members who are high need and/or high risk. These Field Care Coordinators also provide other consultation and oversight of Providers in their assigned Regions.

### **Timeliness of Decisions**

The timeframe for Optum to respond to outpatient service requests is 14 days from the day of the request.

Optum takes steps to address the timeliness of utilization management decisions made on the basis of medical necessity. Optum requires that a Provider be notified immediately by telephone if a service request is not approved. Written notification follows and is sent to the Provider within one working day of the initial notification by phone. Notification is also sent to the Member.

Relating to the timeliness of utilization decisions, standards have been established to address the timeframes for which prior authorization, concurrent and retrospective review decisions are made.

Adherence to the timeframes is assessed as part of the quarterly chart audits described previously. Optum has formalized the chart audit process.

### **Limitation, Modification or Denial of Payment**

Optum limits/modifies payment to only those services that Optum has authorized or otherwise approved for reimbursement (for example, Category One Basic Outpatient Services that require no authorization) under the guidelines which Optum has developed and the IDHW has approved. Optum understands that any denial of payment for services funded through the Medicaid capitation payment is subject to appeal to the IDHW pursuant to standards in both state administrative rules and the State Plan or waiver.

### **Involvement of Practicing Providers and Nationally Recognized Standards**

Optum's core clinical criteria and guidelines were developed by nationally recognized experts and organizations and have been adopted to provide objective and evidence-based admission and continuing stay criteria. The criteria and guidelines are based on the following components and are reviewed annually to ensure that they are updated based on new scientific evidence as well as:

- The broad clinical experience of Optum's staff
- Multi-disciplinary input from Optum's nationwide Provider network
- Input from Members
- Published references from the industry's most esteemed professional sources, including the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry, American Society of Addiction Medicine, and from the current version of the Diagnostic and Statistical Manual of Mental Disorders.

Optum's public sector clinical criteria also recognize and support services essential to recovery and resiliency, and support case management for the comprehensive range of services and programs found in public sector systems. Optum's national Consumer Affairs Department reviews the criteria regularly to ensure that they remain recovery-focused and consistent with the principles of resiliency and well-being.

In developing and updating our clinical criteria and guidelines, Optum also solicits input from Members and their families as applicable, as well as practitioners in specialties affected by the guidelines. To further assure a full range of opinions, community-based treatment centers and practitioners in Optum's regions are also asked to provide input.

### **Practitioner Suggestions for Utilization Management Guideline Revisions**

Optum provides a forum to receive practitioner suggestions for Utilization Management Guideline revisions at least annually, and documents all changes made subsequent to practitioner input.

The Provider Advisory Committee of the QI program is one of the groups responsible to review and submit recommendations for revisions to the utilization management criteria and guidelines each contract year. Practitioners and agencies have other venues to recommend revisions as well, including but not limited to:

- Regional staff meet regularly with Regional Behavioral Health Advisory Boards and include a time for questions and recommendations from Providers and others in attendance
- Regional staff meet with Providers in their area and accept recommendations related to utilization management criteria and guidelines as well as improvements to other parts of Optum's operations
- All staff members accept complaints, grievances and compliments, which are logged into Optum's CARTA tracking system
- Optum provides ongoing training for Providers, and includes a time during each training session for questions and recommendations from Providers
- Optum meets regularly with the IDHW Contract Manager and records suggestions made to the IDHW about the criteria and guidelines or other parts of Optum's operations

Optum also has a Peer Review Committee which reports to the QAPI Committee. The Peer Review Committee reviews quality of care concerns with specific Providers and adverse incidents.

The Chief Medical Officer chairs the Peer Review Committee which is charged with:

- Reviewing quality of care concerns and/or complaints/grievances about a specific Provider
- Requesting and reviewing Provider treatment records in response to quality of care concerns
- Determining appropriate action plan(s) that involve(s) Network Services staff and the Provider in question
- Requesting audits of Provider offices when indicated
- Following up with Provider and agency-specific improvement action plans and incorporating quality of care concerns into the credentialing decision-making process
- Reviewing Critical Incidents/Adverse Events necessitating committee input

### **Annual Review**

Utilization management criteria, which have been customized for Idaho, are reviewed annually through the QAPI Committee structure. Optum includes Provider involvement in this development, review and modification through their participation in the Provider Advisory Committee.

### **Guideline Approval and Modification**

All guidelines and any modifications made to the guidelines are submitted to the IDHW for approval and are shared with Providers at least thirty (30) calendar days prior to implementation of the guidelines. After Optum's corporate level clinical committee reviews and approves recommended clinical criteria and guidelines for Optum, we submit them to the IDHW for approval. Optum follows the same basic process when requesting approval for any revision of the criteria or guidelines so we can provide at least 30 days' notice before implementing changes.

### **The IDHW as the Final Authority**

Optum recognizes that the IDHW is the final authority for all disputed decisions reviewed through the Medicaid appeals process.

## Qualification of Staff

Optum specifies the qualifications of personnel responsible for each level of utilization management decision making (e.g., review, potential denial), which allows a master's level independently licensed mental health or substance abuse clinician to authorize a service request but only a licensed physician or psychologist with training in mental health or substance abuse services to deny a service request.

Based on our experience, the most effective utilization and care management happens when qualified and experienced clinicians become an integral part of a delivery system and establish strong working relationships with the Providers and other stakeholders who comprise that local delivery system. All Optum Care Advocates, Field Care Coordinators, our Field Care Coordination Manager, our Clinical Program Manager, Clinical Director, and Chief Medical Officer have been assigned either to Optum's Meridian office or to a region of the state. This allows them to work directly with and through Optum network Providers to coordinate care and ensure the quality, appropriateness, and effectiveness of their services. In addition, clinical staff provide clinical consultation to PCPs as requested.

Optum ensures that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, is made by a licensed physician or psychologist who has appropriate clinical expertise in treating the Member's condition or disease per 42 CFR § 438.210(b)(3).

The Optum Chief Medical Officer has overall accountability for the clinical program of the Idaho Behavioral Health Program. This includes a broad array of responsibilities including:

- Providing overall medical oversight of the care management and Quality Improvement programs
- Providing clinical guidance through the Executive Management Team with oversight of all Optum policies and operations
- Providing consultation to the Quality Improvement team and the Quality Improvement Director including chairing the Quality Assurance and Performance Improvement (QAPI) Committee
- Providing guidance related to the review and adoption of utilization management criteria, Clinical Practice Guidelines, and best practices as well as other strategies for improving the quality and appropriateness of services
- Staffing complex cases
- Making denial and appeal determinations
- Participating in the training program, leading in-service training sessions for Optum staff as well as network staff and other stakeholders; conducting grand rounds and difficult case reviews

The physician selected as Chief Medical Officer must have the following qualifications:

- An unrestricted license to practice medicine
- Completion of an accredited psychiatric residency program
- Certification by the American Board of Psychiatry and Neurology

- A minimum of five years of post-licensure experience, including experience in an organized healthcare setting and supervisory responsibility

### **Appropriateness of the Assigned Clinician**

To the greatest extent possible, Optum Clinical Care Advocates are assigned to review requests for services in their own area of expertise such as mental health services for adults, mental health services for children, and substance abuse services. Because Optum has hired only experienced clinicians to be Care Advocates, many have experience in the full array of services covered by the IBHP.

Cases are reviewed by licensed clinicians with at least three years of post-licensure clinical experience. In addition, Optum requires the following:

- A master's-level clinical degree with independent licensure (e.g., Licensed Clinical Professional Counselors, Licensed Social Workers, Psychologists) or a Registered Nurse with behavioral health experience
- In-depth experience in the full range of treatment settings
- Complete knowledge of the available treatment modalities and their relative effectiveness

When hiring clinicians, as well as other staff, Optum gives preference to candidates who have experience in the Idaho behavioral health care delivery system, because their local knowledge supports Optum's commitment to be an effective participant in the Idaho community.

To enable us to provide the best utilization management decisions and care coordination support, Optum hires clinicians who have a variety of backgrounds, including those who are familiar with children's mental health services, those who have worked with individuals diagnosed with SMI and/or SPMI, and those who have worked in the delivery of substance abuse services.

Optum's Idaho-based clinicians have direct access to clinical specialists who are available to provide consultation on challenging areas such as child and adolescent disorders, domestic violence, and PTSD. At the corporate level, Optum recruits a variety of clinical specialists who are available to consult with our Optum team in a number of particularly challenging areas, including: child and adolescent disorders, AIDS, eating disorders, domestic violence, post-traumatic reactions, and critical incident response services.

### **Formal Staff Training Designed to Improve the Quality of Utilization Management Decisions**

Optum identifies a Training Lead who is responsible for organizing a comprehensive training program for Optum Clinical staff. A key responsibility of the Training Lead is to maintain documentation of all training provided as well as the names of those in attendance. When pre/post tests or other evaluations are conducted, they ensure that records include the findings. The Optum training program is also designed to improve the quality of utilization management decisions, by providing in-service training on new evidence-based practices, difficult case reviews, or grand rounds.

The QI team may also identify opportunities to improve the quality of utilization management decisions through monitoring of utilization data or other quality improvement initiatives. Training conducted as part of a quality improvement plan is documented by the Clinical staff.

In some instances, the inter-rater reliability findings or the results of one-on-one supervision may indicate the need for additional training of an individual clinician. The corrective action plan, including training provided, will be part of the clinician's employment record.

Records of all formal staff training are available to the IDHW upon request.

## **Ensuring Appropriate Oversight of Optum Network of Behavioral Health Providers**

Optum ensures that Providers are compliant with all clinical and non-clinical Scope of Work requirements through the monitoring processes and tools described below:

### **Provider Contracting and Education**

The first step in ensuring Scope of Work compliance is informing Providers of all requirements through the Provider contract, Provider Manual, Optum Website, and other routine and episodic Provider communications. Optum Regional Network Managers also provide initial and ongoing training and technical assistance to Providers to ensure a clear understanding of contractual requirements and Optum expectations.

### **Utilization Management and Care Coordination**

Optum applies utilization management guidelines to ensure that Members get the most appropriate care for their needs. In addition, we work closely with Optum's Provider network to ensure that they coordinate with other behavioral health Providers, with PCPs and with other community support systems.

### **Desktop and On-Site Record Audits**

Optum staff performs audits of providers, including record reviews, to assess both clinical and administrative compliance. All providers are subject to review; providers who are high volume (serving high numbers of Idaho members) and those found through monitoring to need improvement will receive more frequent audits. At the time of credentialing and recredentialing, organizational providers (groups/agencies/CMHCs) who do not have a national accreditation (for example, The Joint Commission, CARF, COA, etc.) will receive a site audit. All types of audits include a review of treatment records. Site audits include a review of the physical environment and policies and procedures.

### **Continuous Quality Improvement (CQI) Procedures for Quality Issues**

To assist Providers who do not comply with clinical and non-clinical Scope of Work requirements, Optum uses the CQI process. Optum provides training and technical assistance to implement corrective action plans based on monitoring of data against benchmarks and goals, an analysis of barriers to meeting goals, specific interventions to improve performance, and evaluation of the results of the interventions.

## **Utilization Management Document for Providers**

Within 12 months of operations, Optum will post a utilization management document for Providers including the program's goals, program structure, scope, processes, and information sources. Covered services fall only within the outpatient level of care and the program description enumerates the benefits covered under the IBHP.



## Consistent Application of Review Criteria for Authorization Decisions

Optum has a formal process relating to inter-rater reliability testing developed to evaluate and improve the consistency with which Optum staff applies Level of Care Guidelines.

Optum complies with all Optum's existing requirements that evaluate inter-rater reliability among clinical staff. On a regular basis, corporate clinical staff administers testing of all clinicians who review and/or approve treatment services requests. A new case is developed each time inter-rater reliability is tested using a three-step process:

- **Question Development:** A series of draft multiple-choice questions, based on case vignettes, are drafted and grouped into three subgroups: General Items, Mental Health Items and Substance Abuse Items. The draft questions are sent to Clinical Operations and Care Advocacy Center staff for input, and are then revised as necessary.
- **Testing:** The multiple-choice questions are put into a confidential Web-based environment. Respondents are given ten days to complete the instrument, and receive immediate feedback including overall score and the correct answers for incorrectly answered questions.
- **Data Analysis:** Responses are scored, an item analysis is conducted, and findings are reported to the Clinical Policy and Operations Committee as well as to each office location.

Test results are reviewed and a corrective action plan is developed to rectify deficiencies. Optum's Clinical Learning department assists with developing and delivering retraining as needed.

## Utilization Management Audits

At Optum, audits of utilization management, denial and appeal decisions are conducted as a means of assessing the degree to which clinical Level of Care criteria are consistently applied. These audits are conducted by the Optum Clinical Director and Medical Director and cover decisions by Optum Care Advocates and Peer Reviewers.

Every quarter an Optum clinical review team audits at least five charts from each of the following categories of cases:

- Warm transfers of calls from Call Center staff to Care Advocates of Members who are at potential risk
- Members who have been identified as high risk
- Members under the age of 18 receiving services
- Members ages 18 and over receiving services

A pattern of deficiency related to the reliable and consistent use of the criteria or guidelines will prompt a more thorough audit of a Care Advocate's records. Any deficiencies identified will be addressed through the clinical supervision process.

Every quarter the Quality Director and the Medical Director or a designee, will audit at least two adverse determinations and two appeal charts per Peer Reviewer. The Chief Medical Officer is responsible for auditing a random selection of Peer Reviewer records. Any deficiencies identified will be addressed through the clinical supervision process.

## Monitoring of Over- and Under-Utilization

The Optum Quality Improvement Director, Clinical Director, and Chief Medical Officer work together to monitor utilization in the aggregate through the reports generated in the ALERT system and also by analyzing claims data to identify trends. The QI Data Analyst gathers and trends the data and then analyzes it as follows:

- Quantitative analysis with comparison to established thresholds
- Qualitative analysis of causes and consequences
- Agency-level analysis whenever the data falls outside of the thresholds
- Identification and implementation of potential interventions

Because of the significant role psychosocial/community based rehabilitation services play today in the array of Medicaid-funded mental health and substance abuse services in Idaho, Optum is designing an additional set of algorithms that augment ALERT's ability to identify clinical issues in Members for whom Providers are requesting authorization to initiate or continue the provision of any of the CBRHS HCPCS codes.

If trends are identified, Optum will develop training and/or implement a corrective action plan with Provider(s) with whom issues are identified.

Reports generated by ALERT as well as reports directly generated from claims data are regularly reviewed to detect under-utilization and over-utilization. Optum's Performance Improvement guides the identification and management of quality improvement activities that may be implemented if either situation is identified in an individual Provider or across multiple Providers.

Optum is contractually required to routinely trend and analyze services provided, including services that do not require prior authorization, by Provider as well as by region and statewide.

## Ensuring Appropriate Oversight of Delegated Triage and Referral Functions

### ProtoCall

Optum contracted with ProtoCall Services, Inc., 621 SW Alder, Suite 400, Portland, OR 97205, to operate the toll-free IBHP Member Access and Crisis Line. The toll-free line is live-answered within 30 seconds by a behavioral health clinician 24 hours a day, 365 days a year. It provides the telephonic Member Services support as well as a new telephonic statewide crisis triage and counseling service.



### Detailed Description of Subcontractor Involvement

The IBHP Member Access and Crisis Line provide Members with immediate access to a behavioral health clinician 24 hours a day. The clinician answers Member inquiries about the Plan and also provides crisis intervention and counseling via telephone when necessary. As part of that process, the Member Access and Crisis Line:

- Functions as a central point of access and coordinates with Provider agencies, emergency rooms, law enforcement, and others to ensure Members' access to the right care;
- Helps divert unnecessary emergency room visits;

- Collects and reports data that support Optum’s ongoing efforts to identify gaps in services and help Regions plan for enhancements to their local delivery systems.

### *Operating the Line*

The Optum Behavioral Health Plan Member Access and Crisis Line toll-free number is:

855-202-0973

This toll-free number has been included prominently in all Member materials.

The Member Access and Crisis Line is answered by ProtoCall staff in Portland, OR and back-up services when required are handled by ProtoCall staff in Grandville, Michigan. All ProtoCall staff who respond to Members from the IBHP is fully trained on the Plan’s benefits, Idaho community resources and the Optum Provider network using the same curriculum that has been developed for Optum clinicians.

ProtoCall staff, who are licensed behavioral health clinicians, are fully qualified to provide Members with referrals to network Providers. Because of Optum’s commitment to ensuring easy access to services, all network Providers are able to complete a comprehensive diagnostic assessment on a referred Member without authorization. When ProtoCall receives a call from a Provider or another stakeholder who is not a Member, the call is warm-transferred to the Customer Service line unless the call relates to a Member in crisis.

ProtoCall staff provides a comprehensive report to Optum on a daily basis, reporting every Member call, its disposition, and other relevant information. Optum Care Advocates and the Discharge Coordinator follow up with Members who were referred for services, whether they were hospitalized or sent to a network Provider. When appropriate, the Discharge Coordinator may contact a Field Care Coordinator to provide closer support for the Member involved. In addition, clinicians from Optum and ProtoCall have regular conference calls to discuss clinical and administrative issues, including ProtoCall’s compliance with standards established by the IDHW.

### **Oversight by Optum**

Optum is adopting and adapting procedures that Optum has established in our other contracts with ProtoCall to ensure that ProtoCall meets all Business and Scope of Work Requirements. While other requirements may be negotiated in the future, Optum:

- Executed a contract with ProtoCall that incorporates the Optum contract with the IDHW and holds ProtoCall responsible for compliance with all standards relevant to the Member Line referred to in the IDHW Request for Proposals and for any penalties that may accrue to Optum because of performance by ProtoCall;
- Executed a Business Associate Agreement between Optum and ProtoCall;
- Required a comprehensive daily report from ProtoCall reflecting information on all calls received, the identification number and name of the caller, the disposition of the call and recommendations for follow-up, interface with DBH or the Idaho Suicide Crisis Line, and related information;
- Required a monthly report from ProtoCall reflecting data on calls received, answering speed, and other required reporting parameters;

- Established monthly calls between the ProtoCall President/CEO, the Optum Contract Manager and other Optum and ProtoCall staff as appropriate to address ProtoCall's performance in relation to standards and any administrative issues or Member/clinical concerns that may require corrective action;
- Established that Optum participate in all special ProtoCall reviews related to adverse events or sentinel events for Members of the IBHP.

## Data and Communication

Requirements related to data and communications have been established.

Members and Providers can contact Utilization Managers to discuss utilization management issues and decisions. The information is included in Member and Provider materials.

Category Two authorizations are requested and confirmed online. In general, the requirements for Category Three Provider Specific authorization are that an Optum Care Advocate, Chief Medical Officer or designee provides immediate notification telephonically to the requesting Provider if a request for a service is not authorized. Written notification is sent within one working day to the Provider or agency. When a Category Three service is authorized, written notification is sent to the Provider within the following business day. Those services included in Category Four are authorized to a preset limit within the calendar year. Requirements for services beyond these limits may be preauthorized with a Provider request or determined through the Provider dispute procedure when preauthorization for continued services is not elected.

### Obtaining Clinical Information to Support Utilization Management Decision Making

Optum obtains relevant clinical information and consults with the treating Providers when making a determination of medical necessity. All clinicians who make utilization management decisions are trained to use Optum's criteria as guidelines, and always to follow their professional judgment in authorizing services.

When a Care Advocate is unable to authorize a service request based on the information provided the Care Advocate requests additional information from the treating Provider, generally via telephone. If care cannot be authorized, the Care Advocate refers the request to the Chief Medical Officer or a Peer Reviewer. The Chief Medical Officer will contact the requesting Provider. The purpose of this peer-to-peer review is to offer the requesting Provider the opportunity to share additional or new information about the case to assist the Chief Medical Officer or Peer Reviewer in making a determination about the medical necessity and clinical appropriateness of the request. The Chief Medical Officer or Peer Reviewer makes the decision using clinical judgment and a review of the case against Optum's clinical criteria and guidelines, the availability of community resources, and the Member's individual needs.

To facilitate the decision-making process, Optum has developed a standard outline of clinical information that a Provider should prepare when requested to provide additional information or to talk with a Care Advocate. The outline of information is similar for all services, and an integral part of all information distributed to Providers about the utilization management process.

The outline of required information will be reviewed annually as part of the overall review of the utilization management process to ensure that all required information is listed and no information is required that is not pertinent to the authorization decision.

## Obtaining Missing Information

Should a Care Advocate require additional clinical information, the Care Advocate contacts the requesting Provider to explain the additional information needed. In the same way, if the Chief Medical Officer or Peer Reviewer becomes involved in the review process, that Reviewer may offer the requesting Provider the opportunity to share additional or new information about the case to assist the peer reviewer in making a determination about the appropriateness of the treatment setting.

## Communicating to Providers the Process to Obtain the Utilization Management Criteria

Providers are given information on the process to obtain the utilization management criteria for the IBHP. In general:

- Comprehensive information, including the level of care (utilization management) criteria are available for Providers on the Optum website at [www.optumidaho.com](http://www.optumidaho.com)
- The Provider Manual is posted at the Optum website and is also provided in hard copy upon request and includes links to the criteria

## Health Information System (HIS) in Utilization Management

Currently, the IDHW's Division of Medicaid does not require mental health Providers to operate any uniform HIS. The IDHW's Division of Behavioral Health (DBH) operates the "Web Infrastructures for Treatment Services" (WITS) system. The network of substance use disorder Providers currently uses this system. The IDHW requires the Contractor to maintain a health information system that:

- Supports WITS or at the very least, uses a system that shall interface with WITS
- Supports the utilization management process by collecting, analyzing, integrating, and reporting necessary data
- Collects data on Member and Provider characteristics as specified by the IDHW and on services furnished to Members through an encounter data system
- Makes all collected data available to the IDHW and/or designee and upon request by CMS
- Ensures that data received from Providers is accurate and complete by:
  - Verifying the accuracy and timeliness of reported data
  - Screening the data for completeness, logic, and consistency
  - Collecting service information in standardized formats to the extent feasible and appropriate
- The Contractor shall use a system, such as Health and Effectiveness Data and Information Set (HEDIS), to conduct comparative analysis

The Optum management information system must interface with WITS. It also fully supports the utilization management process described in this document including the ALERT outpatient management system and allows Optum to collect and verify all the information as specified above and also to conduct comparative analyses using HEDIS or other performance measures.

## Evaluation of New Technology and New Applications of Existing Technology

Optum benefits from the Optum process for evaluating new technology and new applications of existing technology to include behavioral health procedures.

The National Clinical Technology Assessment Committee reviews new behavioral health technologies and new applications of existing behavioral health technologies. This process includes review of medical and behavioral procedures, pharmaceuticals, and devices. The following categories of information are included in each review:

- **Review of Scientific Evidence:** All technology assessment reviews consist of a comprehensive yet succinct review of the current scientific evidence about the proposed new technology. The final report includes complete and accurate citations for all scientific evidence reviewed.
- **Regulatory Review:** Statements and information generated by regulatory agencies (e.g., the Food and Drug Administration) are reviewed. Every attempt is made to determine if there are laws that have been passed by the Federal or State government that regulate the use of a new technology. A review of State regulations on specific procedures is undertaken when appropriate. The APA and AMA Web sites are systematically reviewed for position papers describing these technologies.
- **Appropriate Professionals:** The Clinical Assessment Technology Committee consists of at least eight professionals, including the chairs, who represent the different business segments within Optum, and an external MD representing the academic setting. These professionals include physicians, psychologists, nurses, pharmacists, and other appropriate professionals who can represent business segments in the evaluation of new technology. Based on the nature of a particular technology, the committee may seek input from other relevant specialists and professionals who have expertise in the technology.

## Documentation and Reporting

Optum maintains documentation that supports the utilization management activities as part of the Quality Improvement program. Optum's management information system also provides a longitudinal view of each Member's case history and access to a host of Member-specific information, such as claims history, available benefits, and other pertinent information.

Optum provides service utilization reports by type of service to the IDHW on a monthly basis.

### Supporting Documentation

Optum maintains supporting documentation, including committee meeting minutes, job descriptions, signatures on related materials, and utilization management notes. Committee minutes, in particular those from Quality Improvement committees that do not include Member-specific or Provider-specific information may be posted on the Optum website if stakeholders indicate an interest in reviewing them.