IDAHO PROVIDER MANUAL UPDATES – January 2022 Edition

Section & Page #	Previous Content	New Content
Introduction (page 11)	We are pleased to have you in our network. We are focused on creating and maintaining a structure that helps people live their lives to the fullest. At a time of great need and change within the health care system, we are energized and prepared to meet and exceed the expectations of consumers, customers and partners like you. Our relationship with you is foundational to the recovery and well-being of the individuals and families we serve. We are driven by a compassion that we know you share. As we work together, you will find that we seek and pursue opportunities to collaborate with you to set the standard for industry innovation and performance. We encourage you to make use of our industry-leading website Provider Express where you can get news, access resources and conduct a variety of secure transactions at the time and pace you most prefer. We continuously expand our online functionality to better support your day-to-day operations. Visit us often. Please take time to familiarize yourself with all aspects of the Provider Manual. We've included an easy reference Resource Guide and FAQs to get you started. There is much work to be done. We are interested in your contributions to constructive innovation. Let us hear from you!	Thank you for becoming a part of our network. We are happy to welcome you and have you as a partner. Optum is dedicated to helping people live healthier lives and making the health system work better for everyone. We connect people to an extensive network of QUALITY providers and OFFER innovative tools that help members access care, at the right time, in the setting of their choice. Our focus is on driving better overall health outcomes for members while making the care they receive more affordable, improving the provider experience and generating insights that drive high-impact, integrated behavioral health services. We encourage you to utilize our industry-leading website, Provider Express where you will find access to resources, relevant news, and conduct a variety of secure transactions at your preferred time and pace. We continuously expand our online functionality to better support your day-to-day operations, so be sure to check back regularly for updates. Please take time to familiarize yourself with all aspects of the Provider Manual. We've included an easy reference Resource Guide and FAQs to help get you started. Optum is confident that together we can tackle the challenges facing the behavioral health industry and bring greater precision, speed and ease to how people obtain behavioral health services. Your voice is important and we encourage you to reach out with feedback, ideas or questions. We'd love to hear from you.

Section & Page #	Previous Content	New Content
Glossary of Terms (page 26)	EPS (Electronic Payments and Statements)/EFT (Electronic Fund Transfer) A service which supports electronic claim payments and remittance advices. Claim payments are deposited directly into the designated bank account with access to all payment and remittance advice information via *Provider Express*.	Optum Pay (Electronic Fund Transfer) Optum Pay: Optum Pay is the standard method for receiving payments and provider remittance advice (PRA) from Optum. Optum Pay delivers electronic payments and provides 835 files for health care providers or facilities.
Child and Family Team (CFT) Interdisciplinary Team Meeting (page 73-75)	**Description** Child and Family Team (CFT) is a group of individuals the youth and family select to help and support them while receiving treatment. The Child and Family Team (CFT) Interdisciplinary Team Meeting is a face-to-face meeting which is facilitated to develop, monitor, or modify a person-centered service plan that includes both formal and informal supports. The CFT Interdisciplinary Team Meeting is scheduled by the assigned Targeted Care Coordinator, who is chosen by the family (See "Targeted Care Coordination"). At a minimum, the CFT interdisciplinary team meeting will include the member (the youth is encouraged to attend to ensure they are in agreement with the PCSP. If the youth is not present for the CFT there must be documentation explaining their absence), the member's family (at least one parent or legal guardian must be present), the member's independently licensed clinician (or a master's level clinician under supervisory protocol and is facilitated by a TCC. The clinician may participate face-to-face or telephonically. Child and Family Team (CFT) Interdisciplinary Team Meetings may include network provider attendance face-to-face or telephonically, when appropriate. It is an expectation that all providers directly involved with the member's care attend the meeting (see provider qualifications). An	**Description** Child and Family Team (CFT) is a group of individuals the youth and family select to help and support them while receiving treatment. These individuals selected by the youth and their family are individuals the youth/family believe should be involved with the development and implementation of their person-centered service plan. For example, the member and member's family may request that extended family, teachers, friends and other supports participate in the CFT. The Child and Family Team (CFT) Interdisciplinary Team Meeting is intended to be an in-person meeting which is facilitated by a Targeted Care Coordinator to develop, monitor or modify a person-centered service plan that includes both formal and informal supports. The CFT Interdisciplinary Team Meeting is scheduled by the assigned Targeted Care Coordinator who is chosen by the family (See "Targeted Care Coordination"). **Attendance guidelines**: • At a minimum, the CFT interdisciplinary team meeting will include the Targeted Care Coordinator, the member, the member's family, the member's independently licensed clinician (or a master's level clinician under supervisory protocol). • Those required to attend in person are: Targeted Care Coordinator, member and member's family.

Section & Page #	Previous Content	New Content
	agency cannot have one clinician attend all CFTs for the agency-the treating provider must attend the CFT for the youth they are treating. Additionally, a child and family team are comprised of individuals selected by the youth and their family who the youth/family believes should be involved with the development and implementation of their person-centered service plan. For example, the member and member's family may request that extended family, teachers, friends, and other supports participate in the CFT. The CFT meeting is conducted in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs. The CFT team members work together to recognize and encourage the youth and family's strengths, identify the youth and family's needs, learn what the youth and family want to accomplish, set realistic short and long-term goals and find solutions that build on the family's strengths that lead to necessary changes. The youth's treatment goals should align with the youth's PCSP. **<u>Removed from Payment Methodology</u>** (8 hours per year per member) *** ****Note: Hours per member are guidelines. Optum will analyze claims information to identify outlier cases that may benefit from a clinical review when utilization exceeds the guidelines. These guidelines do not indicate there is a hard limit and there is no requirement for an authorization to exceed the indicated hours.*	• The youth is encouraged to attend to ensure they agree with the PCSP. If the youth is not present for the CFT there must be documentation explaining their absence. • At least one parent or legal guardian must be present. • The clinician may participate in-person, virtually, or telephonically (see provider qualifications). • An agency cannot have one clinician attend all CFTs for the agency; the treating provider must attend the CFT for the youth they are treating. • If a youth is not receiving individual or family therapy, the clinician that completed the youth's Comprehensive Diagnostic Assessment must attend CFT meeting. • It is an expectation that all IBHP network providers directly involved with the member's care attend the meeting. • If unable to attend CFT meeting, a signature is still required on the PCSP form confirming the provider agrees to work on the goals identified in the PCSP plan in the specific service(s) recommended within the PCSP plan and intends to render the service to the member. Child and Family Team (CFT) Interdisciplinary Team Meetings may include other provider attendance either in-person. virtually or telephonically. (see provider qualifications). The CFT meeting is conducted in a manner that is strengths-based, culturally competent and responsive to each member's individual psychosocial, developmental and treatment needs. The CFT team members work together to recognize and encourage the youth and family's strengths, identify the youth and family's needs, learn what the youth and family want to accomplish, set realistic short and long-term goals and find solutions that build on the family's strengths that lead to necessary

Section & Page #	Previous Content	New Content
		changes. The youth's treatment goals should align with the youth's PCSP. **Additional Information** Person-centered service plans must be facilitated by a Targeted Care Coordinator chosen by the family or an IDHW Case Manager. Families who are working with a case manager with IDHW's Children's Developmental Disabilities Program or CMH for Wraparound or 20-511A do not need a TCC to create their PCSP to remain eligible for YES. If a family has already developed a PCSP or Plan of Service and is actively working with an IDHW Case Manager, they will not need an additional plan developed and are not required to work with a TCC, as it may be considered a duplication of services. However, families working with a Case Manager through IDHW's Child Protection Services (CPS) may also receive TCC, as it is not considered a duplication of services ~~(and TCC is not required for CPS children to maintain YES eligibility).~~ Families have the same access to services, regardless of whether their PCSP or Plan of Service was developed by an Optum TCC or an IDHW case manager. If you are unsure if a family is working with an IDHW Case Manager, you can contact Medicaid for more information at 1-866-681-7062.
Respite (page 82)	New Content	**Additional Information** Mileage reimbursement is available for this service if provided to the member outside of the office setting. See the Mileage Reimbursement section for additional information.
Targeted Care Coordination (TCC) (page 112)	Revised Content	**Additional Information** • Families who are working with a case manager with IDHW's Children's Developmental Disabilities Program or CMH for Wraparound or 20-511A do not need a TCC to create their

Section & Page #	Previous Content	New Content
		PCSP to remain eligible for YES. If a family has already developed a PCSP or Plan of Service and is actively working with an IDHW Case Manager, they will not need an additional plan developed and are not required to work with a TCC, as it may be considered a duplication of services. However, families working with a Case Manager through IDHW's Child Protection Services (CPS) may also receive TCC, as it is not considered a duplication of services ~~(and TCC is not required for CPS children to maintain YES eligibility)~~. Families have the same access to services, regardless of whether their PCSP or Plan of Service was developed by an Optum TCC or an IDHW case manager. If you are unsure if a family is working with an IDHW Case Manager, you can contact Medicaid for more information at 1-866-681-7062.
Mileage (page 136)	Revised Content	**Payment Methodology** Providers should review the Optum Idaho Professional Reimbursement Schedule for more details related to allowable procedure codes (90791, 90792, 90846, 90847, 90832, 90833, 90834, 90836, 90837, 90838, H1011, H0031, H0036, H2033, S5150 and T1017).
Person-Centered Service Plan (PCSP) (page 139)	Revised Content	Families who are working with a case manager with IDHW's Children's Developmental Disabilities Program or CMH for Wraparound or 20-511A do not need a TCC to create their PCSP to remain eligible for YES. If a family has already developed a PCSP or Plan of Service and is actively working with an IDHW Case Manager, they will not need an additional plan developed and are not required to work with a TCC, as it may be considered a duplication of services. However, families working with a Case Manager through IDHW's Child

Section & Page #	Previous Content	New Content
		Protection Services (CPS) may also receive TCC, as it is not considered a duplication of services ~~(and TCC is not required for CPS children to maintain YES eligibility)~~. Families have the same access to services, regardless of whether their PCSP or Plan of Service was developed by an Optum TCC or an IDHW case manager. If you are unsure if a family is working with an IDHW Case Manager, you can contact Medicaid for more information at 1-866-681-7062. Optum Idaho Network Providers may bill for attending a CFT meeting using G9007, regardless of whether it's facilitated by the Optum TCC or IDHW case manager, as it is important for the providers to engage in all of the care for the child or youth. Person-centered service plans must meet federal requirements and YES practice standards. In order to do so, the Principles of Care and Practice Model are used to meet the criteria listed below: • The child, youth and family lead the process as much as possible. • The planning process is timely and occurs in a location convenient for the child, youth and family. • The plan includes cultural considerations for the child, youth and family. • Guidelines are included to resolve conflicts and disagreements. • The child, youth and family are given choices for services and supports and for who will provide them. • The plan includes strengths, preferences, needs and goals that the child, youth and family identify. • The plan identifies services, both established and projected, to support the child in meeting their goals. If a provider has not been identified for a specific service, the provider's name is

Section & Page #	Previous Content	New Content
		not required on the PCSP form. At least one provider must be identified within the PCSP form. • The plan identifies risks and includes a plan to minimize them. • The child and youth's signature and the signatures of the family, providers and other Child and Family Team members are on the plan. • If a provider is unable to attend the CFT meeting, a signature is still required on the PCSP form. The provider signature confirms agreement to work on the goals identified in the PCSP plan in the specific service(s) recommended within the PCSP plan and intends to render the service to the member.
Revised in all locations	Child and Adolescent Service Intensity Instrument (CASII)	Child and Adolescent Level of Utilization System/Child and adolescent Service Intensity Instrument (CALOCUS-CASII)